Original Article

Palliative Care Physicians' Attitudes Toward Patient Autonomy and a Good Death in East Asian Countries

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Abstract

Context. Clarification of the potential differences in end-of-life care among East Asian countries is necessary to provide palliative care that is individualized for each patient.

Objectives. The aim was to explore the differences in attitude toward patient autonomy and a good death among East Asian palliative care physicians.

Methods. A cross-sectional survey was performed involving palliative care physicians in Japan, Taiwan, and Korea. Physicians' attitudes toward patient autonomy and physician-perceived good death were assessed.

Results. A total of 505, 207, and 211 responses were obtained from Japanese, Taiwanese, and Korean physicians, respectively. Japanese (82%) and Taiwanese (93%) physicians were significantly more likely to agree that the patient should be informed first of a serious medical condition than Korean physicians (74%). Moreover, 41% and 49% of Korean and Taiwanese physicians agreed that the family should be told first, respectively; whereas 7.4% of Japanese physicians agreed. Physicians' attitudes with respect to patient autonomy were significantly correlated with the country (Japan), male sex, physician specialties of surgery and oncology, longer clinical experience, and physicians having no religion but a specific philosophy. In all 12 components of a good death, there were significant differences by country. Japanese physicians regarded physical comfort and autonomy as significantly more important and regarded preparation, religion, not being a burden to others, receiving maximum treatment, and dying at home as less important. Taiwanese physicians regarded life completion and being free from tubes and machines as significantly more important. Korean physicians regarded being cognitively intact as significantly more important.

Conclusion. There are considerable intercountry differences in physicians' attitudes toward autonomy and physician-perceived good death. East Asia is not culturally the same; thus, palliative care should be provided in a culturally acceptable manner for each country. J Pain Symptom Manage 2015;50:190–199.

Key Words

Culture, end of life, Asia, good death, autonomy

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Introduction

An understanding of cultural differences is very important for providing quality palliative care.[1] What patients and families believe is appropriate at the end of life is heavily influenced by culture, and culture also determines what is regarded as appropriate in a variety of medical practices, such as disclosure of malignancy, end-of-life discussions, advance care planning, and nutrition and hydration.[1–6] A common view is that the world can be divided into two cultures: individualist (e.g., North America and Northern Europe) or collectivist/family focused (e.g., Asia and Southern Europe), and many studies have predominantly focused on understanding the differences between these two cultures.[7–11] Recent studies, however, have more thoroughly investigated differences and similarities among countries within the same cultural category, such as within European countries.[12–16]

East Asia is traditionally regarded as a typical family centered region, but there have been no large systematic studies regarding cultural differences in end-of-life care within East Asia.[17–19] Among East Asian countries, Taiwan is unique because it was the first county to approve that withdrawal/withholding of life-sustaining treatment is completely legal, by the Natural Death Act.[20–22] Recent studies have suggested that patient autonomy is becoming a more important element in Taiwanese populations.[20–22] Korea is characterized by a Confucian culture, and filial piety (devotion to and respect for parents) influence on end-of-life decisions.[19,23–25] For instance, sons/daughters of a patient usually make maximum efforts to provide parents with medical treatments, such as hydration, hospitalization, or mechanical ventilation. Traditionally in Japan, unawareness of impending death and *pokkuri* (sudden death) is one type of good death; and letting authorities make decisions rather than self-determination (*omakase*) is one type of socially accepted decision-making style.[9,10,19] In all these countries, the situation is rapidly changing, and clarification of the potential differences in end-of-life care among East Asian countries is valuable for providing palliative care that is individualized for each patient.

The primary aim of this study was to explore the potential differences in attitudes toward patient autonomy and physician-perceived good death in East Asian palliative care physicians.

Methods

This was a cross-sectional survey in Japan, Taiwan, and Korea. We distributed a questionnaire to palliative care physicians. Because there was no physician registry in one country and feasible survey methods (e.g., postal, web, or handout) were different among countries, we decided to adopt the most feasible methods according to the actual situation in each country.

Subjects and Procedures

In Japan, all 605 palliative care physicians certified by the Japanese Society of Palliative Medicine by June 2012 were recruited. Physicians' names and affiliations were obtained from the Web site of the Society, and questionnaires were distributed by mail with two reminders (a total of three). No incentive was provided.

In Taiwan, all 578 palliative care physicians certified by the Taiwan Academy of Hospice Palliative Medicine by November 2013 were recruited. Physicians' electronic mail addresses were obtained from the Academy, and questionnaires were distributed using the Web site, with two reminders (a total of three). A small incentive was given to each participant completing the survey.

In Korea, because of the lack of a nationwide registry of palliative care physicians, questionnaires were distributed via three methods. One was five spot surveys at academic congresses or symposiums related to palliative medicine from October 2013 to January 2014, and a total of 97 responses were obtained. The second was an electronic mail survey, and a total of 32 responses were obtained from a convenience sample of 110 palliative care physicians through a local network. The third method was an additional hospital-based survey involving palliative care physicians working at three hospitals, and 82 responses were obtained. A small monetary reward was given for each response.

In all countries, responses to the questionnaire were voluntary, and confidentiality was maintained throughout all investigations and analyses. No identification numbers were linked with the original data. The ethical and scientific validity were approved by institutional review boards of each country.

Measurements

Measurement outcomes included Likert-type scales about physicians' attitudes toward patient autonomy and physician-perceived good death in addition to demographic data. These measurement outcomes were developed based on a systematic literature review on this topic,[1–16,20–30] discussion among research groups, and preliminary in-depth interviews. Face validity was confirmed by pilot testing, and the questionnaire was simultaneously developed in Japanese, Taiwanese, Korean, and English.

In terms of demographics, we collected data regarding the physicians' clinical experience (years), sex, specialty, working area (urban vs. rural), religion, and perceived importance of religion. Religion was asked about using the question: "What do you consider