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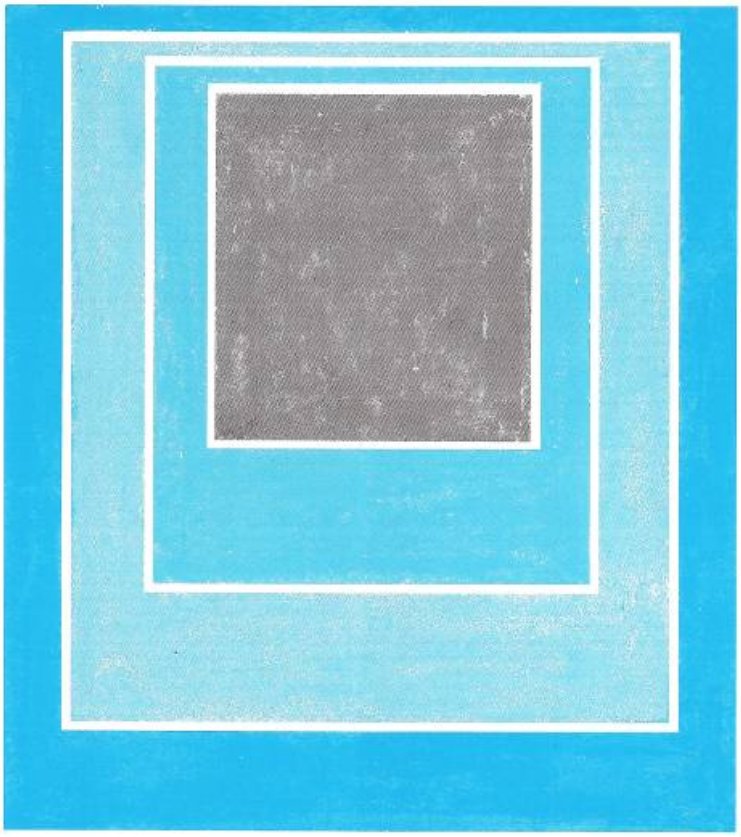

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A Comparison of Japanese and American Psychiatrists' Attitudes towards Patients Wishing to Die in the General Hospital

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Abstract

Background: The attitudes of the psychiatrists in Japan and the US were compared in order to investigate their ideas on whether patients in general medical hospitals who have a desire to die should be allowed to do so or be assisted in this regard, and whether they require psychiatric evaluation and intervention, and the cultural influences on these attitudes. **Methods:** Japanese and American general hospital psychiatrists' attitudes towards the reasonability of suicide, physician-assisted suicide, and removal of life supports under various medical and psychosocial situations were compared. Seventy-two American and 62 Japanese psychiatrists' data were collected using the Suicidal Attitudes Inventory. **Results:** The majority of both American and Japanese psychiatrists agreed that there may be times when suicidal ideation or completed suicide in med-surg patients could be reasonable. Significantly more Japanese psychiatrists responded with some agreement to the reasonability of suicide when one is unable to fulfill social role expectations, and had more concern about causing suicidal ideation by informing terminal patients of their diagnosis. **Conclusions:** The results indicate that psychiatrists' attitudes towards the relationship of psychopathology with suicidal ideation, the effect of depression, and other cultural factors on the desire to die in the medically ill are issues that need better clarification among both the medical profession as well as within society. Looking at how other societies handle these matters may help to understand one's own approach to them.

Key Words
Suicide
Medical patients
Euthanasia
Japan

Introduction

The current background in Japan on the issue of medical patients who desire death began in 1961 when the son of a hospitalized man suffering from severe pain after a stroke was requested by his father to kill him [1]. Because the procedure was not carried out by a physician, and because the method used could not be considered ethical, the court ruled this as a case of 'requested murder'. Since the victim acted on his own free will, however, the defendent was sentenced to a 1-year prison term and 3 years' probation.[1]

The most recent case in Japan of a hospital-based killing took place in 1991 at the Tokai University Medical

[1] Just as I was putting the finishing touches to the revision of this manuscript I received a call from the police that the Japanese mother of a psychotic patient had killed the patient, and then killed herself. This was a cruel reminder that these topics are not just theoretical issues on paper in a journal, and stresses the importance of the role of human relationships in suicidal behavior. D.B.

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Center in Kanagawa [2–4] where the doctor testified that the patient's family had urged him to perform euthanasia (via potassium chloride injection) to ease the patient's suffering. The police investigation reported, however, that the family had not meant for the patient to be killed when they requested intervention to ease his suffering. Although the court ruled that the physician's actions were unlawful because euthanasia was not the expressed wish of the patient because of the family's suspected pressure to end the patient's suffering, and the lack of a system to manage this kind of situation in the terminally ill, the doctor was given a 2-year suspended sentence.

Although brain death is felt to be equal to clinical death by the vast majority of Japanese physicians, neither the legal system nor the general public seems ready to accept lack of brain activity as legal death in Japan. In 1994 however, the Japan Science Council approved a report advocating 'passive euthanasia' (i.e. letting a patient die while providing palliative treatment for pain with morphine) for patients in a deep, irreversible coma, provided the patient has previously stated opposition to life-prolonging measures [4, 5]. Because suicide is culturally more acceptable in Japan than in western countries [6], there is a concern that this might put too much decision making power into the hands of physicians. There are also concerns that if dignified death is overvalued in Japan, rescue efforts that can save some patients may be overlooked [7].

The US Congress passed the Patient Self-Determination Act in 1990 requiring hospitals to inform patients and their families of their legal right to refuse life-sustaining procedures through advanced directives (living wills and proxy documents) [8]. Unfortunately, only 10–20% of Americans have signed an advanced directive, and conflict over how to handle the wishes of terminal patients still arises in the courts. These ongoing problems may have helped to boost support for physician-assisted suicide reflected by two recent decisions. In March 1996, a jury ruled that retired physician Jack Kevorkian who admitted to assisting 27 patients in committing suicide had not violated Michigan State law. In the same week a federal court of appeals ruled a Washington State law prohibiting euthanasia invalid [8].

The Oregon Death With Dignity Act, which was passed by 51% of the residents in 1994, however, was ruled in violation of the Equal Protection clause of the Constitution by a US District Court in 1995 [9]. The court stated that the law 'withholds from terminally ill citizens the same protections from suicide the majority enjoys.' One example of inadequate protection noted was that nonpsychiatric attending physicians who would evaluate the reasonability of a request to die could overlook a psychiatric disorder. Appeal is now underway [9].

The Japanese Neuropsychiatry Association has no official comment on the issue of euthanasia, while the Japanese Medical Society is officially against active euthanasia and supports passive euthanasia. The American Psychiatric Association and the American Medical Association are both officially opposed to euthanasia. This is thought to be due to the desire to maintain the image of the physician as protector of life and that there is the danger of abuse in legalizing these procedures [10].

Studies of suicide victims in both the west and in Japan have consistently found high rates of preexisting mental disorders, and psychiatrists will need to determine when depression in the terminally ill may affect one's decision to forgo life-sustaining medical treatment [11–15]. Ganzini et al. [13] found that remission of major depression with hopelessness in psychiatric patients increased the preferences of these patients for life-saving treatment, while Chochinov et al. [15] and Berger [16, 17] found the desire for death in med-surg or terminal patients to be associated with clinical depression: this desire for death was often transient, and improvement in family support and treatment of pain could diminish desire for death.

A recent study of more than 9,000 patients in the US, the Study to Understand Prognoses and Preferences for Outcome and Risks of Treatment (SUPPORT), confirmed substantial shortcomings in the care for seriously ill hospitalized adults [18]. This study found that less than half of the doctors knew their patients wishes regarding resuscitation, 50% of the patients that died and were conscious were in moderate to severe pain in the last 3 days of life, and 38% spent 10 or more days in an ICU. An intervention using specially trained nurses to facilitate communication between patients, families, and doctors did not improve the quality of care. A large study of physicians in Washington State found that 48% felt that euthanasia was never ethically justified, while 42% felt the opposite [19]. A slight majority favored legalizing euthanasia in at least some situations, but most would be unwilling to participate. Physicians themselves may be compulsively and perfectionistically dedicated to the treatment of disease [10]. While medically ill patients' refusal of life-saving treatment is more and more viewed as 'allowing to die', in psychiatric settings, a patient's desire to die is generally considered as evidence of a mental disorder and disturbed decision-making capacity [20].

It is clear from the above that a more unified and educated approach to this issue is needed within the medical

profession in both countries. Issues of whether patients in general medical hospitals who have a desire to die should be allowed to do so, or be assisted in this regard, and whether they require psychiatric evaluation and intervention are important areas for both Japanese and American psychiatrists to take the lead in guiding their medical colleagues. The present study compared the attitudes of the psychiatrists in these two countries in order to investigate the status of psychiatrists' ideas on these issues and the cultural influences on these attitudes.

Method and Subjects

In the US, 200 randomly selected psychiatrists in the Academy of Psychosomatic Medicine (a Consultation/Liaison psychiatry organization), and 161 psychiatrists in the American Psychosomatic Society who indicated Consultation/Liaison as a specialty were sent the Suicidal Attitudes Inventory (SAI) for a total of 361 mailed questionnaires. The total number of returned questionnaires was 80 (22%), 8 of which stated that because they were not seeing general hospital patients they could not participate, leaving a total of 72 (20%) completed SAI data bases for analysis. Repeat mailing or inquiry to those who did not respond was not done. 84% of the US respondents were male and 16% female. The average age was 49.3 ± 14.9 (range 33–79 years). The average number of years of experience of the US psychiatrists was 18.9 ± 11.5 years (range 2–52 years).

In Japan, five data base sets with return address-stamped envelopes were sent to 18 psychiatrists working at 18 different university hospitals chosen from a list of members of the Japanese Society of General Hospital Psychiatry. These psychiatrists were then requested to have up to 5 members of their department who do C/L work fill out the questionnaires. These psychiatrists were known by one of the authors (T.H.) to be active in seeing patients on medical services but otherwise there was no knowledge of their attitudes toward medical patients with suicidal ideation, physician-assisted suicide or euthanasia.

Fifty-nine data bases were returned from 15 of the hospitals within 1 month and on remailing after 2 months 1 more hospital responded for a total of 62 data bases (89.3% male and 10.7% female, average age 36.3 ± 0.9 years, range 25–55 years). The mean number of years of experience of the Japanese psychiatrists was 10.2 ± 6.52 years (range 1–29 years). Number of years of experience was found to correlate with age ($r = 0.92$, $t = 18.3$, $p = 0.0001$).

Average years of experience as well as average age significantly differed between the US and Japanese psychiatrists (for years of experience $t = 5.9$, $p < 0.001$, for age $t = 5.0$, $p < 0.001$). Because age was not found to correlate with any other variable on the SAI in the US group, it was felt that there was no need to match the groups for age. For years of experience, although there was a low but significant relationship between years of experience and increased agreement on questions 3d ($R = 0.25$, $p = 0.045$) and 3f ($R = 0.26$, $p = 0.034$), because this correlation would have actually weakened any difference between the Japanese and US groups, this data was included in the analysis. Breakdown by sex or hospital was not examined due to the small number of respondents from each hospital and the low ratios of female respondents in both groups.

For this study, we developed the SAI data base [21], the items of which are presented in table 1. The questions were designed to tap the issues discussed in the introduction and were based on prior surveys and literature on these topics [13, 19, 20]. The instructions for completing the SAI were given as follows:

> This questionnaire is aimed at understanding the attitudes of psychiatrists working in general hospitals toward medical/surgical inpatients who exhibit suicidal ideation or behaviors while in the hospital for a medical/surgical illness. Your answers should be directed towards patients with medical or surgical illnesses who exhibit suicidal ideation or behaviors to staff or family. Do not include those patients brought to or admitted for the medical consequences of a suicidal attempt. Please circle the choice or fill in the circle that best fits your answer, or fill in the blank where appropriate.
>
> Your name: _____
>
> Age _____ Sex _____
>
> Hospital name: _____
>
> Number of years experience as a psychiatrist _____

The SAI given to the Japanese psychiatrists was in Japanese, and was reviewed for consistency with the English translation by three bilingual psychiatrists (D.B, T.H, and Y.T.). To avoid bias, we did not use the term 'euthanasia' in the data base. Anonymity was optional.

Data was analyzed as described in the results section. Pearson product-moment correlations with significance at $p = 0.05$ were considered statistically significant. Values significant after Bonferroni adjustment to $p = 0.002$ are noted in table 1. We have reported the nonadjusted data in this paper as statistically significant in order to include those items that appear to have strong trends and to err on the side of avoiding false negatives. Numbers in the Results section that do not add up to the total number of respondents indicate no response on that item.

Results

Summary of responses on the SAI for both the Japanese and American psychiatrists with the χ^2 statistics for those items showing statistically significant differences are presented in table 1.

Reasonability of Suicidal Ideation or Committing Suicide

While there was remarkable similarity in questions 1 and 2 which inquired about whether there might be times when suicidal ideation or committing suicide could be reasonable, significant differences appeared when the reasonability of committing suicide was examined under various social, medical, and psychiatric conditions (question 3, b through j), with more Japanese psychiatrists responding with some agreement to the reasonability of committing suicide in these cases.

Table 1. Summary of responses for both Japanese and American psychiatrists

		Respondents, %		Significant items	
		Japanese	American	χ^2	p
Question 1	Do you feel there may be times when suicidal ideation is logical or reasonable?				
	Yes	92	94		
	No	8	6		
Question 2	Do you feel there may be times when committing suicide is logical or reasonable?				
	Yes	78	80		
	No	22	20		
Question 3	In which of the following cases do you feel that committing suicide is logical or reasonable? Put an 'x' next to those cases that apply. Use one x for 'feel slightly' two x's for 'feel moderately', and three x's for 'feel strongly'.				
Question 4	In which of the following cases do you feel that a physician assisting the suicide (assuming legal restrictions and safeguards are in place) is logical or reasonable? Put an ○ next to those cases that apply. Use one ○ for 'feel slightly' two ○'s for 'feel moderately', and three ○'s for 'feel strongly'. (Assuming the patient is competent and knows the diagnosis and prognosis.)				
		Question 3	Question 4	Question 3	Question 4
	a _____ Terminal illness with poor QOL, no major depression				
	Does not feel logical or reasonable	34	58	35	46
	Feel slightly	34	27	33	31
	Feel moderately	21	11	17	18
	Feel strongly	11	3	15	8
	b _____ Terminal illness with poor QOL, has major depression			11.7	0.00
	Does not feel logical or reasonable	52*	89	74*	90
	Feel slightly	16*	8	17*	7
	Feel moderately	16*	2	7*	3
	Feel strongly	16*	2	3*	0
	c _____ Terminal illness with good QOL, no major depression			12.1	0.007
	Does not feel logical or reasonable	65*	82	86*	93
	Feel slightly	24*	13	14*	7
	Feel moderately	6*	2	0*	0
	Feel strongly	5*	3	0*	0
	d _____ Terminal illness with good QOL, has major depression			14.2	0.003
	Does not feel logical or reasonable	65*	94	90*	96
	Feel slightly	23*	3	8*	4
	Feel moderately	8*	2	1*	0
	Feel strongly	5*	2	0*	0
	e _____ Patient is not terminal but will be a burden on family for care			10.5	0.01
	Does not feel logical or reasonable	68*	92	89*	99
	Feel slightly	26*	5	11*	1
	Feel moderately	5*	3	0*	0
	Feel strongly	2*	0	0*	0
	f _____ Patient is not terminal but has been unable to fulfill work duties			6.3	0.01+
	Does not feel logical or reasonable	81*	95	96*	99
	Feel slightly	18*	3	4*	1
	Feel moderately	0*	2	0*	0
	Feel strongly	2*	0	0*	0

Table 1 (continued)

		Respondents, %				Significant items	
		Japanese		American		χ^2	p
		Question 3	Question 4	Question 3	Question 4		
	g _____ Patient is not terminal but has been unable to fulfill family duties					10.6	0.001
	Does not feel logical or reasonable	77*	95	97*	99		
	Feel slightly	21*	3	3*	1		
	Feel moderately	0*	2	0*	0		
	Feel strongly	0*	0	0*	0		
	h _____ Patient is not terminal but feels responsible for a superior's failure					11.0	0.004
	Does not feel logical or reasonable	82*	95	99*	99		
	Feel slightly	16*	3	1*	1		
	Feel moderately	2*	2	0*	0		
	Feel strongly	0*	0	0*	0		
	i _____ Patient is not terminal but cannot care for his/her children					11.0	0.012
	Does not feel logical or reasonable	82*	95	99*	99		
	Feel slightly	15*	3	1*	1		
	Feel moderately	2*	2	0*	0		
	Feel strongly	0*	0	0*	0		
	j _____ Patient is not terminal but cannot care for his/her children, and it would also be logical or reasonable to commit suicide along with his/her children					21.1	0.0001+
	Does not feel logical or reasonable	74*	94	100*	100		
	Feel slightly	18*	5	0*	0		
	Feel moderately	2*	2	0*	0		
	Feel strongly	6*	0	0*	0		
Question 5	A competent non-depressed patient with an incurable though non-terminal illness (i.e. quadriplegia due to an accident) who requires life support (i.e. ventilator or tube feeding) requests termination of this support because of poor QOL. You would describe termination of the medical care by the physician as						
	A: Suicide	11		14			
	B: Killing	26		11			
	C: Allowing the patient to die naturally	61		75			
Question 6	Suicidal ideas among the terminally ill are linked to psychiatric disorder						
	Rarely	8		1			
	Sometimes	56		60			
	Usually	33		34			
	Always	4		4			
Question 7	Medically ill patients who desire death have distorted thinking						
	Rarely	5		3			
	Sometimes	63		67			
	Usually	32		28			
	Always	0		2			
Question 8	Before acceding to a medical patient's wish to refuse life saving treatment it is important to give optimal medical and psychiatric treatment (i.e. treat pain and depression)					10.5	0.005
	Rarely	0*		0*			
	Sometimes	8*		0*			
	Usually	32*		18*			
	Always	60*		83*			

➤

Table 1 (continued)

		Respondents, %				Significant items	
		Japanese		American		χ^2	p
		Question 3	Question 4	Question 3	Question 4		
Question 9	It is valuable to accept a medical patient's decision to die even if he/she is depressed						
	Rarely	67		67			
	Sometimes	25		33			
	Usually	8		2			
	Always	2		0			
Question 10	Psychiatric patients' wishes to die are rooted in psychopathology					26.0	0.0001+
	Rarely	2*		4.5*			
	Sometimes	5*		42*			
	Usually	84*		46*			
	Always	10*		7.5*			
Question 11	Medical patients' wishes to die are rooted in psychopathology						
	Rarely	5		9			
	Sometimes	56		69			
	Usually	39		21			
	Always	0		1			
Question 12	Withholding a patient's diagnosis can cause suicidal ideation						
	Rarely	15		31			
	Sometimes	78		66			
	Usually	5		2			
	Always	2		2			
Question 13	Informing patients of a diagnosis of cancer or other terminal illness can cause suicidal ideation					33.3	0.0001+
	Rarely	5*		39*			
	Sometimes	66*		60*			
	Usually	26*		2*			
	Always	3*		0*			

* Items significantly different between Japanese and American psychiatrists.
\+ Items significant after Bonferroni adjustment to p = 0.002.

Attitudes toward Physician-Assisted Suicide

Attitudes towards physician-assisted suicide (question 4) did not differ. Only on item 4a, terminal illness with poor quality of life (QOL) and no major depression, was there any considerable agreement for both groups on this being logical or reasonable (42% of Japanese and 57% of US psychiatrists responding with some agreement).

As regards question 8, 40% of Japanese psychiatrists compared to 18% of US psychiatrists responded that it is 'sometimes' or 'usually' important to give optimal medical and psychiatric treatment before acceding to a medical patient's wish to refuse medical life saving treatment. The US responses weighed higher on the 'always' response, (83% vs. 60% of Japanese, statistically different).

Psychopathology and Informing of Diagnosis

On question 10, 84% of Japanese psychiatrists felt that psychiatric patients' wishes to die were 'usually' rooted in psychopathology, while the US psychiatrists split this between 'sometimes' (42%) and 'usually' (46%), and this difference in response pattern reached statistical significance.

The responses to question 13 were also significantly different. Although 60% and 66% respectively of US and

Japanese psychiatrists responded 'sometimes' to the statement that informing patients of a diagnosis of cancer or other terminal illness can cause suicidal ideation, 5% of Japanese psychiatrists compared with 39% of US psychiatrists responded 'rarely', and 29% of Japanese, and only 2% of US psychiatrists responded 'usually' or 'always' to this item.

Significant differences in the patterns of response were not found for items 5–7, 9, 11, and 12.

Item Correlation Testing

Comparison testing among the questions on the SAI for both groups was done in order to study those factors that had significant relationships. A description of those items with significant findings on this analysis is presented below.

Correlation to Termination of Life Supports

The Japanese psychiatrists who responded to question 5, that termination of life support in an incurable nonterminal patient with poor QOL who requests termination is a 'suicide' had greater degrees of agreement on question 3g (that committing suicide is logical or reasonable in cases where a nonterminal patient cannot fulfill family duties) compared with those who labeled termination of life support as a 'killing' or 'letting the patient die naturally' (ANOVA $p = 0.03$). For the Americans, however, a response of 'suicide' to question 5 was significantly correlated with greater degrees of agreement on question 4b, 4c, and 4d, that physician-assisted suicide could be reasonable in 4b: terminally ill with low QOL and major depression (ANOVA $p = 0.0001$), 4c: terminally ill with good QOL and no major depression (ANOVA $p = 0.0009$), 4d: terminally ill with good QOL and major depression (ANOVA $p = 0.003$).

Correlation with Giving Optimal Medical/Psychiatric Care

Japanese psychiatrists responding to question 8, that it is 'sometimes' important to give optimal medical and psychiatric treatment before acceding to a medical patient's wish to refuse life-saving treatment, had a significantly greater degree of agreement on question 4 items f, g, h, i (that physician-assisted suicide is reasonable in situations related to failure in duty to others) than those subjects who responded 'usually' or 'always' to this item (ANOVA $p = 0.03$). For the Americans, those responding 'sometimes' to question 8 had significantly greater degrees of agreement on question 3a – committing suicide is reasonable in terminal illness with low QOL and no major depression (ANOVA $p = 0.01$) – and question 4a – that physician-assisted suicide is reasonable in terminal illness with low QOL and no major depression (ANOVA $p = 0.04$) – compared to those subjects who responded 'usually' to this item.

Correlation with Accepting a Patient's Desire to Die Even if Depressed

The American psychiatrists who responded 'sometimes' to question 9 – it is valuable to accept a medical patient's decision to die even if depressed – had increased agreement on the following items compared to those who responded 'rarely': 3a (reasonable suicide in terminal illness with low QOL and major depression; ANOVA $p = 0.007$), 4b (terminally ill with low QOL and major depression; ANOVA $p = 0.008$), 4c (terminally ill with good QOL and no major depression; ANOVA $p = 0.001$), 4d (terminally ill with good QOL and major depression; ANOVA $p = 0.014$). There was no significant correlation found on question 9 in the Japanese group.

Correlation with the Role of Psychopathology in Medical Patients' Wishes to Die

The Japanese psychiatrists who responded that medical patients' wishes to die are 'rarely' rooted in psychopathology (question 11) had significantly greater degrees of agreement on question 4e (that physician-assisted suicide is reasonable in cases where a nonterminal patient's care is a burden to the family) than those subjects who responded 'sometimes' or 'usually' to this item (ANOVA $p = 0.047$). For the Americans, increased agreement on question 11 was correlated with increased agreement on question 10 (psychiatric patients' wishes to die are rooted in psychopathology; ANOVA $p = 0.0001$).

Correlation with Years of Experience

The Japanese who responded to question 5 that termination of life support in an incurable nonterminal patient who requests termination is a 'suicide' had a significantly greater number of years experience as a psychiatrist (20 ± 4.8) compared with those who labeled termination of life support as a 'killing' (11.7 ± 5.1), or those labeling this as 'letting the patient die naturally' (8.1 ± 5.7) (ANOVA $p = 0.0001$). Also, Japanese responding that medical patients' wishes to die are 'rarely' or 'sometimes' rooted in psychopathology (question 11), had a significantly lower number of years of experience (8.7 ± 5.8) than those subjects who responded 'usually' to this item (years experience 12.8 ± 6.8; $t = 2.54$, $p = 0.014$).

For the Americans, years of experience correlated positively with degree of agreement to questions 3d (that suicide could be reasonable in terminal illness with good QOL and major depression; $r_{65} = 0.25$, $p = 0.045$), 3f (that suicide could be reasonable in a nonterminal patient unable to fulfill work duties; $r_{65} = 0.26$, $p = 0.03$), and 4b (that physician-assisted suicide could be reasonable in terminal illness with poor QOL and major depression; $r_{65} = 0.33$, $p = 0.007$).

Discussion

Reasonability of Suicidal Ideation or Committing Suicide

The most striking findings were the significant differences found between the Japanese and American psychiatrists in their responses to the reasonability of committing suicide under 9 of 10 of the various social, medical, and psychiatric conditions presented (question 3, b through j). The overall pattern was significantly more Japanese psychiatrists responding with some agreement to the reasonability of suicide in these cases. Although the vast majority of both American and Japanese psychiatrists agreed that there may be times when suicidal ideation, or completed suicide in med-surg patients is logical or reasonable, most Japanese psychiatrists did not agree even slightly that committing suicide could be logical or reasonable in terminal illness with major depression irrespective of the QOL, or in terminal illness with good QOL and no major depression. This was despite the fact that 18–33% of Japanese psychiatrists had some degree of acceptance of suicide in nonterminal cases with inability to function in various social roles, 26% agreeing at least slightly that a murder-suicide could be reasonable (question 3e through j).

These results may reflect the value a number of Japanese psychiatrists put on the Japanese concept of duty and responsibility to others that may even include one's life. The value of loyalty to others tapped by this study in the medical setting can also be seen, sometimes dramatically, in other aspects of Japanese culture. Sacrifice of one's life for others in Japan was perhaps most visible to Westerners in the World War II 'Kami Kaze' suicide bombers. 'Karoshi' is an often used term that means death from overwork due to intense devotion to one's company. 'Inseki jisatsu' is a suicide in order to take responsibility for a defeat or shame by persons who feel loyal to their superiors that can sometimes be seen in the news in Japan [22–24].

This degree of loyalty to the group is anathema to the American individualistic way of thinking (Americans do not have specific terms for 'karoshi', 'inseki jisatsu', or 'kamikaze' etc.) where it might even be acceptable to pose a risk to the group in order to protect the individual (i.e. the right to bear arms, early parole of violent offenders etc., that go against Japanese norms). We speculate that the psychological stress incurred when positive relations fail may be stronger in Eastern culture due to the greater degree of importance Eastern culture puts on the harmony of relationships for psychological well-being [25].

The finding of 26 and 7% of Japanese, and 0 and 0% of US psychiatrists' responses to questions 3j and 4j respectively (items inquiring on agreement to the reasonability of suicide and physician-assisted suicide along with one's children) is also probably related to these dynamics.

Optimal Care/Psychopathology

Differences between the Japanese and US psychiatrists on questions 8 and 10 may relate to differences in training or the emphasis put on these issues in the psychiatric literature between these countries, although it is not clear at this point.

Informing of Diagnosis

The differences in responses to question 13 between Japanese and US psychiatrists (29% of Japanese psychiatrists vs. 2% of US psychiatrists responded 'usually' or 'always' to this item) probably reflect the trend in Japan not to tell patients their diagnosis directly for fear of inciting suicidal ideation by then making the patient feel a burden to their family. It has even been reported that while most Japanese physicians answer that terminal diagnoses should be told to patients, this is rarely performed in actuality [26].

Item Correlation Testing

Differences between the two groups on the correlation between answers seemed to reflect the attitudes of the groups in general. For example, the differences on question 5 point to Japanese psychiatrists' association of labeling a request to terminate life supports as a suicide for being unable to fulfill family duties (similar to being a burden), while the US psychiatrists were more likely to associate this with terminally ill cases in whom physician-assisted suicide might be reasonable, possibly reflecting increased public interest in legalizing physician-assisted suicide and euthanasia in the US [27]. Differences in the attitudes of the two groups as described above also seems to be reflected in the differences in cor-

relation seen on questions 8, 9 and 11 as described in the results section.

Correlation with Age and Experience

Japanese respondents who felt that only 'rarely' or 'sometimes' was distorted thinking or psychopathology involved in medical patients' wishes to die had a significantly lower mean number of years of experience. This younger and less experienced group, which was also more likely to rate termination of life support in an incurable nonterminal patient with poor QOL as 'letting the patient die naturally' rather than a 'suicide' or a 'killing', may not be as sensitive to the relationship of psychopathology to suicidal ideation in this group of patients as their more experienced colleagues.

This may be somewhat in contrast to the Americans where there was some correlation of age with degree of agreement to the reasonability of suicide and physician-assisted suicide under three of the conditions presented (3d, f, 4b). Whether this reflected an experiential influence or a life-phase influence is not clear from the data. It could be that some of the older psychiatrists have more personal concern for end-of- life issues and can empathize with more choices for terminal patients.

Effect of Depression on Desire to Die

These findings also emphasize the importance of sensitizing psychiatrists on both sides of the Pacific to the need to determine when depression in the terminally ill may affect the decision to forgo life-sustaining medical treatment [13–15]. While 92% of Japanese and 100% of US psychiatrists responded that it is 'usually' or 'always' important to give optimal medical and psychiatric treatment to medical patients who refuse life saving treatment, 25% of Japanese psychiatrists responded 'sometimes', and 10% that it is 'usually' or 'always' valuable to accept a medical patient's decision to die even if they are depressed. 33% of US psychiatrists responded 'sometimes', and 2% 'usually' to this question.

In addition, while both the relationship of suicidal ideas to psychiatric disorder among the terminally ill and the assumption of distorted thinking in medically ill patients who desire death were thought to be at least sometimes the case in the opinion of well over 90% of both Japanese and American psychiatrists respectively, there was a significantly stronger trend for the Japanese psychiatrists to feel 'usually' or 'always' that psychiatric patients are more likely to have their wishes for death rooted in psychopathology (Japanese 94% vs. American 53.5%) when compared with this response for medical patients' psychopathology (Japanese 39% vs. American 22%, difference not significant). This kind of finding may indicate that Japanese psychiatrists are less likely to view medical patients who desire death as having a psychiatric condition.

Courts should actively consider the role of affective impairment in the determination of decision-making capacity [13]. Even if there is a will that coincides with the patient's request, the patient could have been affectively disturbed at the time of making the will. Legislation permitting assisted suicide or euthanasia would need to specify the need for evaluation of depression, unrecoverable poor QOL, and, in Japan, degree of distortion in the estimation of failure in duty to others; as well as degree of priority placed on the family's wishes as opposed to the patient's. Development of a competence standard that assesses the patient's appreciation of their clinical situation in addition to whether they understand their situation is one way to evaluate a depressed patient's refusal of life-saving treatment [20].

Study Limitations

Our study has several strengths and several limitations. One of the major limitations is the relatively small sample size. On the Japanese side we chose psychiatrists known to be actively involved in general hospital work who were likely to have actually encountered the proposed situations. Hospitals known to the authors were chosen because of the predicted difficulty obtaining cooperation on these sensitive issues. Although the exact number of Japanese psychiatrists who declined to complete the questionnaire in each institution was not reported, 16 of 18 hospitals replied. The high degree of cooperation by the Japanese respondents and the manner of their selection may have carried with it some inherent bias that we are unaware of. On the US side, a larger subject pool was used with a much lower response rate. Whether the responses we obtained would differ from those who did not respond is not known.

Although we discussed the rationale for including the non-age-matched samples in this study, there may have been influences nonetheless. The major purpose of the study, however, was to get a feel for the overall similarities and differences between the two groups.

Finally, there may have been some linguistic and/or cultural differences in interpretation of the questions, and although the fixed-response format of the questionnaire could have limited the respondents' ability to evaluate the

whole picture as in a real-life situation, this may also have elicited their uncensored responses.

In conclusion, this study indicates that the items used in the SAI data base may be helpful in clarifying health care workers' attitudes toward desire to die in medical patients. Issues of when and how to die will necessarily be dictated by the history and culture of each society, and debated by the differing opinions of individuals within each society. Looking at how other societies handle these matters may help to understand one's own approach to them.

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