Journal of Philosophy and Ethics in Health Care and Medicine, No.7, pp.18-37, December 2013

Scientific Contribution

Wit and Japanese Professionals: A Case Study in Adapting a Western Educational Resource for Use in a Non-Western Cultural Context

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Abstract:

The concept of “medical humanities” was born in the United States in the late 1960s. Since then courses and programs devoted to it have been offered not only throughout the U.S. and elsewhere in the West, but also in non-Western countries including Japan. Courses and programs of medical humanities are therefore now being implemented in a large number of different cultural contexts.

In Japan, a non-Western country, medical educators of medical ethics, one of the disciplines of medical humanities, have sometimes borrowed from the educational resources including topics and the materials such as literary works and films in Western countries. However, while it is the case that such resources have their uses in Japanese medical education, they also contain elements that can conflict with Japanese cultural values even when the different medical systems are in alignment. The process of using such materials, I believe, may prove useful to other non-Western medical educators who also face the problem of how to adopt and adapt Western educational resources to the circumstances of their own cultures.

In this paper, I will outline some of the differences between the medical culture of the West and that of Japan as a non-Western country in referring to the use of the American film, *Wit*. This case study of what non-Western medical professionals can learn from Western educational materials, and what non-Western medical educators need to be aware of before they use them, will illustrate the advantages and problems connected with the use of such Western resources in educating non-Western medical professionals.

Keywords: medical humanities, medical ethics, Japan, US film *Wit*, cultural differences, truth-telling, respect for patient autonomy, family involvement in decision-making process, Japanese way of communication

Introduction

The concept of “medical humanities” was born in the United States in the late 1960s. Since then courses and programs devoted to that have been launched not only throughout the U.S. and elsewhere in the West, but also in non-Western countries including those in East Asia such as Japan. Why has this movement spread so rapidly around the world?

One reason is that medical educators in many countries share a concern about the impact on students of the great emphasis that is now placed on the biomedical sciences in medical curricula. Fearful of the danger that a scientifically oriented curriculum might dehumanize medical students, and believing that humanities education could prevent this, medical educators across the globe have embraced the teaching of “medical humanities” as a panacea. Courses in it are therefore now being offered in a large number of different cultural contexts.

One such is Japan, where elements of the medical humanities, especially medical ethics, have been taught since the 1980s. My own experience of teaching medical ethics in Japan has confirmed my belief that the educational topics (for example, the specific ethical issues raised by medical practice), and the materials (such as particular literary works and films) that we have borrowed from Western countries are valuable resources when medical humanities programs are established in Japan. However, while it is the case that such resources have their uses in Japanese medical education, they also contain elements that can conflict with indigenous Japanese cultural values even when the different medical systems are in alignment. I believe the lessons I have learned in the process of using such materials may prove useful to other non-Western medical educators who also face the problem of how to adopt and adapt

Western educational resources, such as literary works and films, to the circumstances of their own cultures.

In this paper, I will outline some of the differences between the medical culture of the West and that of Japan as a non-Western country. To highlight some of these differences I will refer quite extensively to my use of the American play (later made into a film), *Wit*. This case study of what non-Western medical professionals can learn from Western educational materials, and what non-Western medical educators need to be aware of before they use them, will illustrate the advantages and problems connected with the use of such Western resources in educating non-Western medical professionals[1].

Using *Wit* in a Japanese Educational Context

In seeking to determine what non-Western medical professionals can learn from Western educational materials, and why non-Western medical educators should be careful about using Western educational materials, I will take Japan as an example of a non-Western country and examine how materials from the U.S., specifically the film *Wit*, are deployed in the teaching of Japanese learners. This will exemplify the lessons that non-Western medical professionals can learn and the issues that medical educators should consider, and allow us to identify the differences in the practice of medicine that are embedded in the dissimilar cultural contexts of the U.S. and Japan.

The Emmy Award-winning HBO film, *Wit*, is one of the most widely used educational materials in U.S. medical humanities education.[2] It was used in the 'Wit Film Project,' which was originally designed to bring the theatrical version of *Wit* to 32 medical schools in the U.S. and Canada and so provide a unique educational opportunity to medical trainees. The film itself is based on a Pulitzer Prize-winning play, written by Margaret Edson and directed by Mike Nichols, that focuses on the nature of the suffering of a patient with an incurable disease.[3] A brief synopsis of its plot will illustrate how this is done.

The main character, Vivian Bearing, Ph.D., an English Literature professor specializing in the work of the seventeenth century metaphysical poet, John Donne, is a strict taskmaster, perhaps rather 'non-humanistic' in her approach; she had lived an isolated life (her love being given to teaching and research) before being diagnosed with terminal metastatic ovarian cancer. She agrees to participate in an experimental treatment program involving aggressive chemotherapy, but as she gradually loses her fight against the disease, her physical and emotional suffering becomes ever more obvious.

Dr. Jason Posner, a young cancer researcher and Vivian's attending physician, seems to view his responsibilities towards her as an inconvenient distraction from what is really important, namely his research. His emotionless and awkward interplay with Vivian marks him out as an inhuman medical professional, in strong contrast to Susie, a compassionate nurse designated as Vivian's primary caregiver who tries to ensure that she is treated with dignity and respect in her last days, in the face of the physicians' temptation to use her as an experimental subject for research down to the end.

In what seems to be a reflection of her own detached approach to life, Vivian faces doctors and a medical system that emphasize technique above caring. She does in the end, though, experience compassion from Susie, who prevents the medical team from carrying out a CPR or cardiopulmonary resuscitation attempt that she does not want.

1. The Commonalities to be Found in *Wit*

Is there anything that Japanese medical professionals can learn from *Wit*? There are some commonalities in the way medicine is practiced in the U.S. and Japan, and in the ethical issues that medical practice creates, that are worthy of attention here.

(1) Aspects of Medical Practices

Japanese physicians should be able to recognize aspects of medical practice that are common to Western and non-Western countries in the film. Examples of these, which transcend cultures, include the importance of taking a patient's point of view seriously, and the requirement to take care of patients humanely.

By its focus on the patient's point of view, *Wit* can enhance the understanding of all medical trainees and professionals in the following areas: the role that disease plays in deranging the lives of patients; the nature of their feelings; and the quality of their experiences in hospital.

Disease comes without advance notice or regard for individual convenience, changing the lives of patients dramatically and instantaneously. It is one of the most unexpected events that can happen to anyone. In *Wit*, Vivian becomes a patient without the least warning; disease cuts across her ordinary life of college teaching and literary research, and then terminates it prematurely. Her introduction to her disease is presented in a flashback to a poetry lecture she is giving in a large hall at her college. In the midst of this, Susie the nurse interrupts the lecture to remove Vivian for a lab test at the hospital, bringing her back into the current world. The point of this scene is that serious disease erupts suddenly into one's life, irrevocably changing one's routine existence.

Hospitalization involves further radical, and very uncomfortable, changes. Before the onset of her ovarian cancer, Vivian could manage everything by herself. Her disease was the first event in her life that she could not control, and it changed her existence completely. She began to suffer not just physically, but psychologically as well. Hospital is an uncomfortable environment because one cannot live a "routine" life longer there.

Medical professionals can reduce or exacerbate a patient's discomfort in hospital, and in *Wit*, Dr. Posner's attitude toward Vivian typifies the way they can dehumanize a patient. He does not look her in the face, focusing only at her medical chart when visiting her room; the exclusive object of his interest in his research. He treats Vivian as an experimental subject rather than a human being, and is simply incapable of seeing his patient's personal or emotional condition. His behavior is a dramatic example of how a doctor can make a patient uncomfortable in a hospital.

Medical professionals can also see in *Wit* how different patients' lives become after they are admitted to hospital, how they struggle there, and how they can come to feel dehumanized. For medical professionals, recognizing the feelings and perspectives of patients is the first step to understanding how to treat them holistically.

A second lesson that *Wit* exemplifies for medical professionals is how to take care of patients humanely. In *Wit*, Susie, Vivian's primary nurse, is depicted as a magnanimous caregiver, in contrast to Dr. Posner, as when we see Vivian in her room, sitting on the bed with Susie, the two sharing popsicles. In this scene, Vivian talks about her fear of death for the first time (until this point in the film, she had never had the chance to express her emotions to anyone, and had felt completely isolated). Now, thanks to Susie, she could finally express and share her emotions.

Susie's behavior sets Vivian free from the prison of a dehumanized condition, and allows her to broach important matters about her current condition, such as the chemotherapy treatment and upcoming decisions that she will need to make regarding life and death, in particular the choice between "full code" and "do not resuscitate" or a DNR order.[4] Their conversation over popsicles seems to move beyond the patient-caregiver relationship; they sit side by side and talk as if they have been good friends for a long time. Before this scene, Vivian has only spoken and expressed her true emotions to the viewer via the camera, not to anyone else in the film; she had never spoken like this with Susie previously. This reflects how isolated Vivian had felt because she had had nobody to talk with in hospital.

Susie's attitude toward Vivian shows medical professionals how to care for a patient humanely. Compassion allows Susie to alleviate Vivian's feelings of isolation and fear of death, and she shows respect for Vivian's decision about the manner of her death, treating her not as an experimental subject but as a human being. Thanks to Susie's care, Vivian recovers her humanity.

The perspectives discussed here are necessary for medical professionals, and raise issues that can be shared by professionals in non-Western societies as well as in Western ones. It can help Japanese medical professionals understand how to enter into the patient's point of view, to grasp the role that a serious disease plays in one's life, to appreciate the difficult conditions that patients face in hospital, and how humane care can improve a patient's condition even in cases of terminal illness.

(2) Ethical Issues Common to Medical Practice in both the U.S. and Japan

Wit can also help to raise awareness among Japanese medical professionals about the kind of ethical issues that are found in the West and the non-West (including Japan) alike. John D. Skykes Jr. notes that "most writers have taken the medical aspects in the movie, and used *Wit* to discuss "patient rights" and "research ethics,"[5] focusing on the fact that Vivian is a research subject in an experimental study by Dr. Posner and his advisor, Dr. Kelekian, who clearly and unapologetically see her as such. In terms of the way the study was conducted, some might question whether the risks of the research protocol were clearly explained, or whether Vivian understood the seriousness of her diagnosis.[6] This raises the issue of "informed consent" as an indispensable standard for protecting patient rights in research ethics.

Taking research ethics seriously and protecting patients' rights are global standards for medical and/or research professionals. So *Wit* can remind Japanese physicians how to engage in ethical practices in accordance with global ethical standards.

2. Differences and Conflicts in Using *Wit* in a Japanese Context

We have seen how *Wit* can act as a valuable educational resource for both Western and non-Western medical professionals, allowing them to recognize the importance of common aspects of medical practice and the ethical issues that arise from it despite differences in the cultural context. *Wit* did, nonetheless, originate within the world of Western medical culture and values, and since it is therefore an educational resource with a Western background, it includes elements that may conflict with medical customs and values embedded in Japanese and other non-Western cultures.

(1) The Bioethical Principle of Respect for Patient Autonomy

One major element that might create conflict is the principle of respect for patient autonomy, which is highly valued in U.S. medical culture. *Wit* begins with Vivian's doctor informing her of her very serious condition. She receives the news without any family or friends by her side, being depicted as an independent American woman. *Wit* illustrates a medical practice common in the U.S., that of revealing to patients their true medical condition directly, regardless of its seriousness. Telling patients about their medical condition allows them to make decisions about treatment based on their own values. Informing patients of their diagnoses can thus be seen as a medical practice based on the principle of respect for patient autonomy. *Wit* accepts this biomedical ethical principle as a dominant concept in the U.S. medical setting, one that forms the core of U.S. medical ethics, without discussion. But the principle of respect for patient autonomy may not be held, nor found completely acceptable, in Japanese medical culture, even though Japanese bioethicists have been drawing attention to its significance for almost three decades.

Since Tom Beauchamp and James Childress first advocated the principle of autonomy or respect for autonomy as one of the core ethical principles (the other three being non-maleficence, beneficence, and justice) in medical practice in the late 1970s, it has become very influential, to the point indeed where it has dominated, the U.S. bioethics field.[7] *Principles of Biomedical Ethics*, their widely used textbook, describes the principle of respect for autonomy as "a norm of respecting the decision-making capacities of autonomous persons."[8] From this it is inferred that an autonomous person has the traits or "capacities of self-governance, such as understanding, reasoning, deliberating, and independent choosing."[9] In general, we are to recognize that respect for autonomous agents involves acknowledging "their right to hold views, to make choices, and to take actions based on personal values and beliefs."[10] Therefore, in medical practice, the principle of respect for autonomy requires us to accept "the value and decision-making rights and enabling [patients] to act autonomously."[11]

From the principle of respect for patient autonomy flow some practical rules for medical practice, including the injunctions "to tell the truth," "to respect the privacy of others," "to protect confidential information," "to obtain consent for intervention with patients," and "when asked, to help others make important decisions."[12] Today, such rules have become imperatives in ensuring ethical practices in medicine. In general, the medical community in the West recognizes these rules and is guided by the principle of respect for patient autonomy as a general guideline that supports patient-centered medical practices.

In Japan, too, the medical community and the general public have, since the 1980s, recognized the principle of respect for patient autonomy and its accompanying rules. The third and fifth editions of *Principles of Biomedical Ethics* were translated into Japanese[13], so medical professionals and members of patients' families in Japan can currently read this textbook in their own language.

There is no evidence on the effect that the translated editions of this work may have had on the issue of autonomy in Japan's medical culture. But a slight change in that culture is detectable, whatever its cause, since over the past decade Japanese physicians have come to take patient autonomy more seriously. The Ministry of Health, Labor and Welfare of Japan has conducted national surveys on end-of-life care every five years for the past two decades, and these have included questions to medical professionals asking them, in cases where a patient is suffering from an incurable condition, to whom they explain this. The responses revealed that the rate of those explaining the situation directly to patients increased from 3.4% in 1998 to 8.7% in 2008. The proportion of physicians who considered explaining to the situation directly to patients depending on their condition also increased, from 35.6% in 1998 to 56.5% in 2008. On the other hand, the proportion of those who explain directly to patients' families decreased from 58.8% in 1998 to 33.6% in 2008[14]. These figures suggest that many Japanese physicians might now be considering patients rather than their families as the primary decision makers in questions of medical treatment.

In addition, the 2008 national survey showed that over 93% of the general public and over 98% of physicians and nurses wanted to receive some form of information about their medical condition from their own physicians even if they were suffering from an incurable condition[15]. So a vast majority of people in Japan, including medical professionals themselves, clearly want such information.

(2) The Japanese Way of Telling the Truth to a Patient

However, in actual Japanese medical practice, the physician's style of communication sometimes violates the principle of respect for patient autonomy and the rule of “telling the patient the truth” when the members of a patient's family wish to take the initiative in the decision-making process. This is a marked difference between the U.S. and Japanese cultures of medical practice, so I will focus here on these circumstances as a way of clarifying a unique aspect of Japanese medical culture.

It will be helpful to cite the following typical Japanese case regarding the disclosure of a cancer diagnosis:

> A 62-year-old Japanese woman [was admitted] to a Tokyo hospital with a fever and severe back pain. Diagnostic work-up included [a] serological tumor marker testing and abdominal computed tomography. This revealed advanced gall bladder cancer

> metastatic to the liver and back. Since her expected survival was less than three months and she was not a candidate for surgery or chemotherapy, a regimen of comfort measures and pain control was needed.
>
> The diagnosis was first revealed to her family members, namely her husband and her son, separately from the patient. The husband and son discussed it with the daughter, and together the family requested that the patient not be told. The family explained that while still healthy the patient had mentioned to them her wish not to be told if she developed cancer…
>
> After initial treatment for pain and fever, the patient stabilized and was competent to participate in decision making, though she was a little withdrawn and dependent. The treating physician and family met with the patient and in the family's presence, the treating physician told her: "You don't have any cancer yet, but if we don't treat you, it will progress to a cancer." In response, the patient [did not ask…] further details. An aggressive pain control regimen was continued and though she was intermittently drowsy, she died four months later without apparent suffering from physical pain. The physician never explicitly discussed the diagnosis with her.[16]

In this case, the patient's preference was not to be told if and when her disease became serious. But the opposite situation, where people prefer to be told their diagnosis or prognosis regarding their illness can also occur in Japan. So the question that needs to be answered is whether a doctor in Japan should honor such a request. This probably needs serious discussion among medical professionals in Japan.

1) The Family's Involvement in the Process

Such cases can illustrate the common consultation process and disclosure pattern of a diagnosis of terminal disease in Japan. We notice first that the family has an influential role in the decision-making process. The physician often discusses a serious diagnosis, such as that of a cancer in its terminal stage, with the family prior to communicating it to the patient.[17] Family members generally believe they know the personality of patients best and can best gauge their ability to manage information about a fatal diagnosis. Family members and physicians all fear that patients will be shocked by being told the diagnosis of a terminal disease and will lose hope for the future, even if they had previously expressed a wish to be told. Even when the patient is competent to make decisions, physicians think that it best to ask the family's consent, prior to disclosing a diagnosis to the patient. Because they think it is the patient's family that is most concerned with the patient, physicians often share a diagnosis, especially a serious one, with the family not with the patient first. This Japanese consultation process indicates the significance of the family's wishes and their influence on medical decision-making for the patient.[18] In other words, this pattern shows that family members can easily override patient autonomy, and thus physicians take the family's decision more seriously than that of the patient, even though a physician's primary duty should be to the patient.

Tomoaki Tsuchida views the power of the family in clinical decision-making as a reflection of its role in Japanese society in general. Comparing the method of disclosure of a serious diagnosis in Japan and the U.S., he writes:

> For the American, [receiving a diagnosis] is not only a right to exercise control over one's own destiny, but also one's duty. Death and life are one's own private concern. The Japanese, in contrast, have lived for centuries in a highly integrated and contextualized society where even life and death have to be seen as a family affair—if not the affair of the community as a whole—as much as the affair of the particular individual. Without the consent of the family, a doctor is not expected to inform a patient of a fatal illness or even to undertake serious surgery, much less organ transplants.[19]

This Japanese cultural tradition means that family members see death not as an isolated process affecting one person but as a shared process involving the entire family.

Yoshihiko Komatsu calls the dying process as a “resonating death.”[20] One’s death resonates with other family members and is shared with them as if one’s death is also their death. Given these cultural values regarding death and dying, the family members of a patient in Japan tend to be closely involved in medical decision-making for patients. Since this role in medical decision-making is important in Japan, family members there frequently overturn the patient’s decision about treatment. This can lead Japanese people unconsciously to discount the patient’s autonomous will or decision. They may not recognize that overemphasizing the family’s role may violate the patient’s right to autonomy.

2) The Unique Japanese Pattern of Communication

The case just cited also involves another unique factor: the Japanese physician’s way of communicating, for this communication pattern reflects Japanese cultural values that can lead to violations of patient autonomy and the rule of “truth-telling,” even though Japanese physicians advance a different interpretation to try to justify their behavior.

We have seen in this case how the physician initially communicated the cancer diagnosis to the family, and then gave the patient inaccurate information about her condition, saying “You don’t have any cancer yet, but if we don’t treat you, it will progress to cancer.” But cancer was not only already present, but was also incurable and at a terminal stage.

Some would object that giving incorrect information to a patient does not amount to disclosure. However, in the context of Japanese language and culture, I think that there was much more being communicated here than appears to be contained in the literal words. The physician’s use of the word “cancer” in fact sends an implicit message to the patient that there is a very serious problem. Japanese listeners would know intuitively that the patient would sense that she might have cancer because the physician actually uses the word.[21] So the physician is equivocally disclosing the truth, at least in part.

In addition, Japanese people could interpret the message from the way it was presented to the patient in more than one way. The literal interpretation is that the patient was affected by a pre-malignant condition. A second interpretation, though, is that she indeed had cancer, but that her physician, in accordance with the family's request, did not want to shock her with an unambiguous disclosure of the diagnosis, and wished to leave her with hope. In this way, the patient had the option of interpreting the statement either positively (she had a pre-malignant condition which was treatable) or negatively (she did, in fact, have cancer but her physician was trying to be sensitive to the fact that she had an incurable condition and did not want to force her to confront her true condition). Thus, the physician was taking into consideration the family's preference by communicating in a way whereby the patient was never explicitly told that she had cancer.[22]

The pattern of communication in this case embodies ambiguity, and many Japanese people are accustomed to -- and commonly prefer -- such a method of understanding. The Japanese generally think that there is no need to be direct about such a delicate matter and, in fact, view being too direct as insensitive and cruel behavior. Although it appears that the physician actively deceived the patient, it could also be argued that what was in fact conveyed was an offer to tell her the details of her case, but in a culturally sensitive way.[23] The physician's ambiguous message to the patient may therefore represent a specifically Japanese form of "offering accurate information to the patient."[24]

This method might be said to demonstrate "respect for patient autonomy" from a Japanese perspective, though some might assert that the process of ambiguous disclosure is not consistent with the meaning of this phrase. The disclosure process in this case did not include a frank dialogue between the physician and the patient, which is necessary in most contemporary definitions of autonomy. However, one cannot claim that the physician did not consider this patient's wishes at all in this case. Through ambiguous disclosure, the patient was given the opportunity to interpret the physician's message as one that disclosed that she indeed had cancer. From a Japanese viewpoint, those involved may have been largely satisfied with this method of disclosure since it did respect the patient's preference in terms of learning of the diagnosis.

Additionally, at the time of disclosure, the patient did have the chance to ask questions and obtain further details about her condition, if she so desired. Thus, in the context of Japanese society, the physician could justify the method used to convey the information as one that displayed respect for patient autonomy.[25]

Some might argue that the problem here lies with culturally different definitions of the term "autonomy." The Japanese do not think of autonomy in an individualistic, Western sense, but understand it in the context of the individual being a member of a group, such as a family unit. On the subject of the Japanese sense of autonomy, Rihito Kimura points out that "[The] unique character [of autonomy] can be interpreted in the framework of 'related autonomy' or the making of autonomous decisions in relationships striving for harmony with other people..."[26] This interpretation might justify the doctor's behavior in conveying the diagnosis not to the patient directly but to her family first.

The case also illustrates how the Japanese view a patient in the final stages of a terminal disease as being fragile or vulnerable. While many Japanese people with serious diseases are in fact able to make decisions about their treatment, Japanese doctors and family members often treat very seriously ill patients as if they are non-autonomous persons with no capacity for decision-making at all. So they might feel that not telling patients their diagnosis is a better way of caring for them, as is allowing others to make decisions about treatment regardless patient preferences. As a result, the two parties, medical doctors and family members, cooperate in becoming paternalistic decision-makers.

3. *Wit* and Japanese Medical Professionals

As previously noted, "truth-telling" as practiced in the U.S. can run into conflict with Japanese medical culture, something we can see in the very first scene in *Wit* when Dr. Kelekian tells bluntly Vivian, "You have cancer." Nevertheless, *Wit* can still effectively teach Japanese physicians about various medical practices in the U.S., help them to reflect on Japanese medical practice, and recognize ethical issues in their own practice. They can learn that their approach to patient care sometimes differs from that in the U.S., and might consider which aspects of medical practices are valuable in terms of providing proper medical care for patients, while also recognizing that their practices might be considered unethical from a different perspective.

In *Wit*, the scene in which the physician informs Vivian of her condition can speak directly to Japanese medical doctors and health professionals, especially as a reminder that aspects of common medical practice in Japan might be viewed as unethical in the light of the principle of patient autonomy and the rules of privacy and confidentiality, so that they might be missing opportunities to provide patients with humane care. The scene can help them to recognize that telling patients even a very negative diagnosis honestly can be a medical practice that helps maintain patient privacy, reinforcing the physician's responsibility to keep patient information confidential. It can also remind them that a patient's medical information belongs only to the patient, and not to family members; providing patient information to family members without the patient's permission thus means violating patient confidentiality. In addition, they need to consider that if the doctor had not told Vivian of her diagnosis, she could not have made a decision about her own death, the most private and serious matter for a human being. In general, the behavior of not telling the truth can be seen as depriving patients of an opportunity to make important decisions about their end of life. Having given consideration to these factors, Japanese physicians might come to consider that their common practice of sharing a patient's diagnosis with the family first violates patient privacy, as well as undermining the autonomous decision-making capacity of the patient.

Japanese physicians could also consider other medical practices that may lead to better patient care. In failing to inform patients of their diagnosis, doctors can miss opportunities to provide the patient with humane care. If the physician in *Wit* had failed to tell Vivian the correct diagnosis, Susie, as her primary nurse, could not have talked about the imminent and upcoming decisions regarding life and death choices with Vivian nor have taken such intense care of her. I think the clinical practice of giving the patient a true diagnosis is not a simple matter, but it is a very important consideration for medical professionals in taking care of patients humanely and having a positive relationship with them.

I believe that familiarizing Japanese medical professionals with other medical cultures can help them to understand and reflect on their own medical practices objectively, so that they can come to understand their own medical culture in greater depth. If they are liberated from some fixed, traditional perspectives, it is quite possible that their practice might improve. For this reason, using Western medical educational resources such as films like *Wit* can help those training Japanese or non-Western medical professionals to make the medical practice of these future doctors more humane.

Concluding Remarks

Western medical resources can, then, be useful in non-Western educational contexts in two ways: first by helping aspiring medical professionals understand important issues that transcend cultures; and secondly in allowing them to recognize culture-specific points of importance in medical practice. Regarding the first of these, Japanese medical professionals can learn about the patient's point of view, how a serious disease plays a role in the patient's life, and how the patient faces difficult conditions in a hospital. They also can learn how they take care of patients humanely from *Wit*. With regard to the second point, they can learn how Western medical professionals take care of patients in different ways, reflect on Japanese medical practices, and recognize that these might be considered unethical from a Western perspective.

In comparing the medical practices of different countries, I have specifically examined the issue of patient autonomy and truth-telling as an example of a potential conflict in medical culture and values between Western countries and Japan. In the medical educational context, I believe that non-Western educators should not ignore such conflicts, but rather view them as good opportunities to reflect that their own medical culture is not universally accepted, and so create chances to improve patient care. Non-Western physicians can be provoked into such reflections by Western educational resources such as *Wit*, which are therefore valuable in promoting the cause of humane practice among medical professionals.

Notes

[1] Although the terms "the West" and "Western" are usually employed to refer to people from a variety of ethnic or cultural backgrounds, in this paper their use is confined to those of an Anglo-Saxon one, since in the film *Wit*, many characters (including the main one, Vivian, and most of the medical professionals, with the exception of the nurse, Susie) are Caucasian or "white."

[2] My personal experience of this film began when I watched it twice as part of my course in the medical humanities program at Drew University/ Raritan Bay Medical Center. I saw it again when it was shown at the annual meeting of the American Society of Bioethics and Humanities in 2002 to demonstrate the use of a film in medical humanities education. Details of the 'Wit Film Project' can be found at http://www.growthhouse.org/witfilmproject/index.html (accessed 14 March 2013).

[3] Margaret Edson, *Wit: A Play* (New York: Straus and Giroux, 1993). The book of Japanese translation was translated into Japanese; *Wit* trans. Sayuri Suzuki (Tokyo: Hakusui-sha, 2001).

[4] Full code is the permission patients give to allow a doctor to utilize every kind of treatment to save their life.

[5] John D. Skykes, Jr., "Wit, Pride and the Resurrection: Margaret Edson's Play and John Donne's Poetry," *Renascence* 55.2 (2003): 163-174.

[6] Ellen A. Foster, "A Rigorous Mind Meets Her Yielding Body: Intellectual Life and Meaning-Making in *Wit*," *Annals of Internal Medicine* 147.5 (2007): 353-356.

[7] The development of the bioethical framework of these four principles has been retrospectively described by the two authors in the following articles: Tom L. Beauchamp, "The Origins, Goals, and Core Commitments of *The Belmont Report*

and Principles of Biomedical Ethics," and James F. Childress, "*Principles of Biomedical Ethics*: Reflections on a Work in Progress," in *The Story of Bioethics: From Seminal Works to Contemporary Explorations*, eds. Jennifer K. Walter and Eran P. Klein (Washington, DC: Georgetown University Press, 2003).

[8] The 7th and latest edition of this book was published in 2012. The first edition used the phrase, "the principle of autonomy," but the authors replaced this with "the principle of respect for autonomy" in the third edition. The quotations here are from *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2009), 13.

[9] Ibid., 100.

[10] Ibid., 103.

[11] Ibid.

[12] Beauchamp and Childress, *Principles of Biomedical Ethics*, 4th ed., 127.

[13] *Seimei-igakurinnri* 3rd edition translated by Yukimasa Nagayasu and Norio Tachiki (Tokyo: Seibunndo, 1997) and its 5th edition translated by Norio Tachiki and Toshitaka Adachi (Kashiwa: Reitaku University Press, 2009).

[14] Shumatsuki-iryo no arikata ni kansuru kondankai [A Conference on End-of Life Care], *Shumatsuki-iryo ni kansuru chousa-kekka* [*The Results of a National Survey on End-of-Life Care*] http://www.mhlw.go.jp/bunya/iryou/zaitaku/dl/07.pdf (Accessed on August 28, 2013.)

[15] Ibid.

[16] Akira Akabayashi, Michael D. Fetters and Todd S. Elwyn, "Family Consent, Communication, and Advance Directives for Cancer Disclosure: a Japanese Case and Discussion," *Journal of Medical Ethics* 25.4 (1999): 296-301.

[17] Susan O. Long, and Bruce D. Long, "Curable Cancers and Fatal Ulcers, Attitudes toward Cancer in Japan," *Social Science and Medicine* 16 (1982): 2101-2108.

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