



Discussions on Present Japanese Psychocultural-Social Tendencies as Obstacles to Clinical Shared Decision-Making in Japan

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Abstract

In Japan, where a prominent gap exists in what is considered a patient's best interest between the medical and patient sides, appropriate decision-making can be difficult to achieve. In Japanese clinical settings, decision-making is considered an act of choice-making from multiple potential options. With many ethical dilemmas still remaining, establishing an appropriate decision-making process is an urgent task in modern Japanese healthcare. This paper examines ethical issues related to shared decision-making (SDM) in clinical settings in modern Japan from the psychocultural-social perspective and discusses the ideal decision-making process in present Japan. Specifically, we discuss how five psychocultural-social tendencies – “surmise (*Sontaku*),” “self-restraint (*Jishuku*),” “air (atmosphere or mood, *Kuuki*),” “peer pressure (or tuning pressure, *Docho-Atsuryoku*),” and “community (*Seken*)”—which have often been referred to as characteristics of present-day Japanese people, may affect the ideal practice of SDM in Japanese clinical settings. We conclude that health care professionals must be aware of the possible adverse effects of the above Japanese psychocultural-social tendencies on the implementation of SDM and attempt to promote autonomous decision-making, thereby allowing patients to make treatment choices that sufficiently reflect their individual and personal views of life, experiences, goals, preferences, and values.

Keywords Shared decision-making · Japan · Clinical ethics · Autonomy

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Introduction: Existing Ethical Issues and Major Decision-Making Models in Japanese Healthcare

One prominent ethical issue that has emerged as a major social topic concerning modern medical practice in Japan has been that of decision-making related to the treatment of serious illnesses. Decision-making is an act of choosing from multiple potential options. In 2018, a female patient in her 40s with chronic kidney disease died as a result of a decision to withhold the introduction of hemodialysis. One issue with this case was that the attending physician had initially recommended the withholding of hemodialysis as a treatment option, to which the patient originally consented. Later, the patient expressed her desire to rescind her consent, but the physician ignored this as her condition worsened (Kawami 2020). We would argue that, in this particular case, it was unlikely that an appropriate patient-physician relationship had been established and that decision-making based on authentic patient preference had taken place.

In 2019, two physicians were arrested after administering a lethal injection to a woman in her 50s who was suffering from amyotrophic lateral sclerosis as physician-assisted death. The fact that they were not her regular physicians and that they received money from her for this are considered highly problematic, not to mention the act of euthanasia itself (Chabot 2021). This case brought to the forefront the discussion of whether the absence of a continuous patient-physician relationship is a serious problem in the decision-making process. As for the former case, accusations against the physician developed into a civil lawsuit. The latter, investigated as a criminal case that ended with the arrest of the two physicians for commissioned murder, appears to have had a greater social impact, and arguably, more serious ethical implications.

Some dialogue has progressed concerning ethical issues in cases involving treatment refusals, such as life-saving intensive care for a seriously ill baby, blood transfusions for patients who are Jehovah's Witnesses, and removal of an implantable cardioverter-defibrillator (Ogawa et al. 2019; Yamaguchi et al. 2020; Iijima 2020). In Japan, a prominent gap remains in what is considered the patient's best interest as defined by the medical side versus the patients and appropriate decision-making processes are difficult to establish in clinical settings. Many ethical dilemmas remain in modern Japanese healthcare, and establishing an appropriate decision-making process is an urgent task.

There are three main decision-making models: "paternalism," "patient-informed choice (decision-making)," and "shared decision-making (SDM)" (Nakayama 2019; Hansson and Froding 2020). The "paternalism" model fails to provide sufficient information to patients and thus fails to respect their self-determination. Meanwhile, the "patient-informed choice" model does not adequately address patient comprehension of medical information, places an excessive burden on patients to make decisions themselves, and ignores changes in patient values. Because of these shortcomings, the former two models are considered less ideal, and the SDM model has been recommended as a better alternative (Childress and Childress 2020).

There are, however, some advantages to the paternalism and patient-informed choice models that deserve to be highlighted. The former (e.g., a physician overrides a competent patient's choice for the good of the patient) enables physicians to provide the best, purely medical intervention to patients regardless of their wishes, thereby preventing harm that might arise when patients refuse a potentially beneficial treatment based on their idiosyncratic preferences. This process also saves time for physicians to explain treatment alternatives. Another advantage is that it provides satisfaction to patients who want to leave all crucial decisions to physicians. With regard to the latter model, its advantages include that the intentions of patients who have strong and fixed values are respected, that medical professions exert no influence on patients, and that autonomous decision-making is ensured for patients who strongly wish to make decisions on their own without any interventions. Patients who wish to remain free from interference would prefer the patient-informed consent model for the above advantages.

Against this backdrop, this paper examines ethical issues related to decision-making in clinical settings in modern Japan from the psychocultural-social perspective and discusses the ideal decision-making process in present Japan. First, we discuss problems concerning major decision-making models with a focus on SDM, the latter of which has attracted attention in recent years. SDM has been actively introduced in Japan to improve a patient's ability to make autonomous decisions, so that patients can make treatment choices that sufficiently reflect their individual and personal views of life, experiences, goals, preferences, and values (Tejima 2011; Coulter and Collins 2011; James and Quirk 2017; ACOG Committee on Ethics 2021; Noro et al. 2015; Nakayama 2019; Aoki and Watanabe 2020). Next, we discuss psychocultural-social tendencies that have often been referred to as characteristics of present-day Japanese people – “surmise (*sontaku*),” “self-restraint (*jishuku*),” “air (atmosphere, *kuuki*),” “peer pressure (*Docho-Atsuryoku*),” and “community (*seken*).” (Kokami 2013; Enomoto 2017; Katada 2017; Mochizuki et al. 2019; Ikeda 2020; Monoe 2020; Kokami and Sato 2020; Ohta 2021; Wada 2021; Oimatsu 2021). Finally, we conclude that health care professionals should be aware of the possible adverse effects of psychocultural-social tendencies present in Japan on the implementation of SDM.

Before we begin our discussion, let us clarify that, while this paper explores the purpose, concept, and problems of SDM, decision-making support or aid for patients is outside the scope of the present discussion. This is because our primary goal is to illustrate the negative impact of Japanese psychocultural-social tendencies, which are often used to describe present-day Japanese people, on the ideal implementation of SDM. In this regard, we aim to alert medical professionals on related issues but not discuss the need for, or lack thereof, support or aid for SDM.

Introduction of Shared Decision-Making

According to Brown and Salmon (2019), SDM was developed to resolve the tension between patients, who are entitled to make health care decisions and medical practitioners, whose responsibility is to protect the patient's best interest. SDM

theory ensures that decisions are evidence-based and that they align with patient interests. Proponents of SDM, who implicitly assume patient willingness and capability to make appropriate decisions for themselves, suggest that patients and medical practitioners negotiate decisions. This SDM approach based on the negotiation between patients and medical practitioners currently dominates the literature on how to achieve patient participation (Brown and Salmon 2019). SDM is often positioned between the paternalistic approach and the autonomy-based approach: it recognizes both physician beneficence and patient autonomy and respects, protects, and supports patient autonomous choices (Childress and Childress 2020). There is also the idea that being able to make self-determined choices is happiness as a natural nature of human beings. Furthermore, people live interdependently, in relationships with one another. The concept of supporting patient self-determination and autonomy has developed as an ethical extension of the informed consent concept. That said, the provision of information alone does not ensure that patients make decisions that suit their preferences and intentions (Nakayama 2019).

SDM is characterized as a complex intervention in which patients and clinicians form a partnership, making decisions together using the best available evidence. Medical decision-making is approached as a shared process with shared responsibilities: clinicians present the various treatment options, benefits, harms, and probabilities, and patients weigh the pros and cons and gradually arrive at their preferred decision (Stiggelbout et al. 2012; Olthuis et al. 2014; Elwyn et al. 2017). The fundamental goal of SDM is to improve the patient's ability to make autonomous decisions, allowing them to make treatment choices that sufficiently reflect their individual and personal views of life, experiences, goals, preferences, and values (Tejima 2011; Coulter and Collins 2011; James and Quirk 2017; ACOG Committee on Ethics 2021).

Indeed, SDM has been recommended with increasing advocacy in Japanese clinical settings (Nakayama 2019; Nakayama et al. 2020; Komatsu 2021; Osaka 2021; Goto 2021; Goto et al. 2021). In 2017, the Japan Medical Association General Policy Research Organization conducted a "Japanese Medical Awareness Survey" targeting Japanese citizens. Four thousand adults from all over the country were randomly selected, and an attitude survey on healthcare was conducted through individual interviews. In total, 1200 responses were obtained, with a valid response rate of 30% (Japan Medical Association 2017). When asked who would be the appropriate decision-maker and what decision-making style they would choose if they suffered from a serious illness, 50.9% of participants responded, "decide by myself after consulting with a doctor," 24.5% responded "listen to the doctor's explanation and then agree with it," 19.7% responded "listen to the doctor's explanation and leave the final decision to the doctor," and 1.1% responded "leave everything to the doctor without listening to his/her explanation" (Japan Medical Association 2017).

The Working Paper of the Japan Medical Association General Policy Research Institute interpreted these results as the indication of the strength of Japanese people's independence in terms of healthcare choices, although there were age-based differences (Japan Medical Association 2017). According to Nakayama (2019), these results indicate that 50% of respondents prefer the SDM model, suggesting that they are aware of the importance of self-determination in healthcare. He also

pointed out that 40% of those aged ≥ 70 years chose the SDM model, and that only 1.1% of respondents chose the paternalistic model (“leave everything to the doctor without listening to his or her explanation”). If the above results truly reflect the opinions of the general population, they suggest that Japanese people have become more independent than they were in the past and wish to participate in SDM for healthcare decisions. Findings from research studies and clinical practice in Japan also suggest that SDM as a decision-making method has become widespread, with increasingly more active patient participation in decision-making (Noro et al. 2015; Komatsu 2021). In addition, patient participation in SDM has been suggested to help reduce decision-making conflicts in patients, expand their treatment options, and improve long-term treatment satisfaction (Watanabe and Kamakura 2014; Osaka and Nakayama 2017; Yoshihara and Kaneko 2020). Japanese healthcare professionals also recommend the use of SDM with decision aids (Komatsu 2021; Osaka 2021; Goto 2021).

Problems Concerning Shared Decision-Making

Recent reports have described several theoretical and practical problems concerning SDM. First, the definition of SDM is not clearly established, and there is disagreement about what SDM really is. Indeed, according to some studies, there are at least nine different definitions of SDM (Makoul and Clayman 2006; Kon 2010; Landry 2021). Second, there has not been enough time to implement appropriate SDM, and competing clinical demands exist in clinical settings (Wiener et al. 2018; Pieterse and Finset 2019). Third, levels of education and health literacy (i.e., ability to understand health information such as risks, and use of medical care services) affect attitudes toward decision-making participation, with a decreasing trend in intention to participate with decreasing levels of education and health literacy. For example, the most common factors for patients favoring SDM are female gender, higher education, and younger age (Shinkunas et al. 2020). On the other hand, low levels of health literacy negatively affect patient understanding of relevant medical information. However, some claim that patients should be asked what role they want to play in the decision-making process, and that various strategies, such as literacy-appropriate communication (e.g., use of pictographs or tape recorders, writing down information) should be utilized. (Blumenthal-Barby 2016; King et al. 2018; Covey et al. 2019). Fourth, according to the latest review on the benefits of SDM, although there are some data indicating that SDM improves patient satisfaction (e.g., better affective-cognitive outcomes, lower decisional conflict), no evidence suggests its influence on actual clinical outcomes (Shay and Lafata 2015). Fifth, studies have found that poor communication by physicians impairs SDM, physician recommendations may be biased, and that a substantial proportion of physicians have a negative attitude toward SDM and disregard it in their practice (Joseph-Williams et al. 2017; Elwyn et al. 2017; Paton et al. 2020). Sixth, in SDM, patients and physicians should be equal when discussing treatment options to make final decisions. Inappropriate interventions lacking medical evidence are more likely to be selected by patients than physicians, including options that are harmful to third parties, such

as the overuse of antibiotics (Hansson and Froding 2020). Finally, some argue that differences in patient abilities to make decisions and the amount of support they receive to do so are the causes of inequality in the decision-making process (Hansson and Froding 2020).

The situation is complicated further by differences in the various understanding of personal autonomy, which may be considered the eighth issue. At least two kinds of autonomy are at play—individualistic autonomy and relational autonomy. A highly individualistic view of autonomy regards patient preferences as clear, firmly established, and enduring (Entwistle and Watt 2016; Childress and Childress 2020). On the other hand, a less individualistic view assumes that patient preferences are often unclear, unstable, variable, and dependent on the context and individual relationships, i.e., similar to relational autonomy (Sherwin 1998; Childress and Childress 2020). Proponents of relational autonomy claim that all self-determination occurs in a context that is embedded within the society, rather than being self-determined on an individual basis, and that self-determination is influenced by the beliefs of society; this concept has been used in questioning the tendency to overemphasize nonintervention against self-determination (Morita et al. 2020).

As mentioned above, the fundamental aim of SDM is to improve patient ability to make autonomous decisions, so that their treatment choices might fully reflect their individual and personal views on life, experiences, goals, preferences, and values (Tejima 2011; Coulter and Collins 2011; James and Quirk 2017; ACOG Committee on Ethics 2021). However, in addition to the lack of clear understanding of what SDM really is, if there were serious discrepancies in the understanding of fundamental concepts such as autonomy, value, and preference, how and to what end SDM should be carried out would remain undetermined and controversial. In addition, distrust among stakeholders and irreconcilable differences in values would make SDM more difficult and sometimes impossible to achieve (Jonsen et al. 2015).

It has also been pointed out that some ethical issues exist regarding SDM processes. For example, patients may fear being labeled a difficult patient if they explicitly express their desire to participate in SDM (Frosh et al. 2014). Other issues include an unequal power balance between patients and physicians (Paton et al. 2020), inappropriate family interventions (Laryionava 2020), physicians having a strong influence on patient decisions (Mendel et al. 2012), decisional burden, patient's changing values, biased and irrational decisions by stakeholders, and involuntary consent (Asai et al. 2021).

Psychological, Cultural, and Social Tendencies in Modern Japan

We are concerned that the abovementioned issues surrounding SDM, which are difficult to solve, would also become serious obstacles in practicing SDM in Japanese clinical settings. In addition, when considering the ideal SDM in modern Japanese society, it becomes important to gauge the impact of psychocultural-social tendencies on its implementation. In light of this, the following section explores some of the issues we consider to be important from the psychocultural-social perspectives.

Psychocultural-social tendencies have been used by many critics in Japan to describe Japanese people today. Those include “surmise (*Sontaku*),” “self-restraint (*Jishuku*),” “air (atmosphere, *Kuuki*),” “peer pressure (*Docho-Atsuryoku*),” and “community (*Seiken*)” (Yamamoto 1983; Kokami 2013; Enomoto 2017; Katada 2017; Mochizuki et al. 2019; Ikeda 2020; Monoe 2020; Kokami and Sato 2020; Oimatsu 2021; Ohta 2021; Wada 2021). It is very important to discuss how these tendencies may affect the ideal practice of SDM in Japanese clinical settings and for Japanese health care professionals to be aware of the adverse effects that these tendencies might have on SDM.

“Surmise,” “self-restraint,” “air,” and “peer pressure” are often brought up in the context of recent political scandals in Japanese society, as well as being predominant public behaviors amid the COVID-19 pandemic. We argue that these tendencies associated with social characteristics could have non-negligible impacts on medical practice. “Community” (hereafter used to refer to *seiken*, unless otherwise noted) can be regarded as a platform where people behave according to these tendencies. Potential ethical implications of all five tendencies, especially their negative impacts on SDM, need to be thoroughly examined. Definitions and brief explanations of the five tendencies are provided in Table 1.

These five tendencies, as summarized in Table 1, are interrelated, overlapping, and are not mutually exclusive. For instance, Kokami claims that “air” is a fluidized version of “community” (Kokami 2013). Some also consider “air” to be the cause of “surmise” (Enomoto 2017; Katada 2017). People who are good at reading the “air” are subject to “peer pressure” (Monoe 2020), while those who ignore the “air” are regarded as individuals who do not “surmise” (Katada 2017). Also, “peer pressure” may be completely external or internalized, and in the latter case, the individual unconsciously “surmises” or refrains from doing what they truly want to do. “Surmise” is an action and “self-restraint” is an omission; however, it is a person’s actions based on their common consideration for both others and heteronomy. “Peer pressure” is an intervention by “community” upon individuals, and “air” can be the content, which peer pressure imposes on people. “Community” appears to generate a certain “air” with normative power, and this “air” forces people to act in a certain manner through “peer pressure;” individuals read the “air” and practice self-restraint, or “surmise.” Some say that “surmise,” “self-restraint,” and “peer pressure,” as well as behaviors to read the “air,” all result from one’s consideration for how others might evaluate them, and that all are deeply linked to the mental structure of Japanese people. Although these five tendencies have yet to be established as academic terms (Ikeda 2020), what they all have in common is that they do not use clear and explicit words for communication. There is also a view that it is the Japanese spirit to be concerned about the emotional reactions of others around them (Itakura 2021).

Despite their similarities and close associations, each of these five words has independently and separately been in Japanese society. It should also be noted that an increasing number of reports have mentioned these psycho-cultural-social tendencies in the last 5 years (Enomoto 2017; Katada 2017; Shimotomai et al. 2017; Mochizuki et al. 2019; Aoki and Watanabe 2020; Ikeda 2020; Monoe 2020; Kokami and Sato 2020; Matsushita et al. 2020; Oimatsu 2021; Ohta 2021; Wada

Table 1 Definitions and brief explanations of five tendencies

Surmise (*sontaku*): reading the “air” (atmosphere), recognizing the superior’s intentions in advance, and deciding one’s actions accordingly. There is a system in Japan in which people excessively surmise the wishes of one’s boss (Kokami and Sato 2020). Surmising can occur in any organization in Japan, and this is due to the psychology of self-protection, desire for approval, fear of being hated by or upsetting others, and the effort to avoid being excluded from one’s organization. Some claim that “surmise” is based on one’s consideration for others, as the Japanese are always half-unconsciously taking note of other people’s moods and feelings (Katada 2017). Behaviors according to “surmise” are speculative and have no rational basis (Kokami and Sato 2020). Originally, the word *sontaku* was used to mean “guessing the hearts of others” (Niimura 2018), but in recent Japan, it has been used to refer to a set of actions that one takes to read the mind of one’s superior and regarding the superior’s wishes as rules to obey (Monoe 2020).

Self-restraint (*jishuku*): “self-restraint,” or self-regulation, is the voluntary refraining from doing things when one wishes to do them (Niimura 2018). It is argued that Japanese people would quietly and gently refrain from engaging in a certain behavior even if refraining is optional and lacks coercion or penalties, simply as a result of “reading the air” (Kokami and Sato 2020). Japanese people do not say “no” easily (Ohta 2021). In the culture of “I don’t want to bother people around me,” one tends to be hesitant about exercising self-determination (Miyashita 2019). It also seems that modern Japanese people tend to refrain from expressing their own true hopes. From the beginning of their lives, many Japanese people are consistently told at home that they should not bother others (Kokami and Sato 2020).

Air (atmosphere, *kuuki*): an invisible force that keeps people from doing what they want to do; a very powerful and almost absolute criterion of judgment concerning one’s actions. A community with a strong “air” tends to exclude socially those who resist the “air” as heretics (Yamamoto 1983). “Air” is a vague, difficult-to-control rule for which no person is in charge or is a decision-maker but for which sanctions will be issued to those who disobey or ignore. However, it is often ambiguous as to who is given the order or what kind of rules they are expected to obey (Monoe 2020).

Peer pressure (tuning pressure, *Docho-Atsuryoku*): the power that implicitly forces a minority or dissident to act like a majority. The pressure that “everyone must be the same.” An order to obey the “air” of a majority or mainstream group. While Japan is reportedly a country with outstandingly high peer pressure (Kokami and Sato 2020), it is also argued that peer pressure is a ubiquitous force worldwide (Monoe 2020). It is also argued that peer pressure is increased by the closedness of Japanese society, a homogenization norm, the undifferentiated nature of individuals (i.e., no clear differentiation between self and others), and the small size of the community (Ohta 2021). Even the attitude of “it is a voluntary activity, but everyone must participate in it” is accepted in a Japanese community (Ohta 2021). In Japan, people tend to be accused of both making individual decisions and taking unique actions. Some say that brainwashing is being carried out in the field of education, establishing firmly in the mind of children that obedience is a good thing (“peer pressure”) (Mochizuki et al. 2019). That said, there are also young people who do not give in to such pressure (Mochizuki et al. 2019).

Community (*seken*): “*seken*” refers to a community formed only by people who are related to each other, now and in the future (stakeholders). Examples are companies, schools, and neighbors. Some argue that “community” is the dynamic that often occurs when Japanese people form a group. In such a group, there are specific rules including gift/reciprocity (“return-rule”), the class system in the order of seniority, absence of individualism, groupism, exclusion of foreigners (the distinction between homogeneous inside/outside and ostracizing those who disobey community rules, traditions, or “air”), equality, common-time consciousness (all people live in a group in a common time frame and share the common past/present/future), which are obeyed due to peer pressure (Kokami 2013; Kokami and Sato 2020). It is said that Japanese people have historically been bound by “community” for more than 1000 years (Kokami 2013; Kokami and Sato 2020). Some also point out that “community” is regarded by its members as the reference group against which each individual judges their decisions or actions (Inoue 2007). The eyes of others become the code of conduct (Enomoto 2017). Individuals are concerned about others’ evaluation within their “community,” worried about being locked out of it, and are aware that they are required to be in tune with or obey community rules (Nakamura 2011).

2021; Itakura 2021). In this paper, we use “surmise” and “self-restraint” as independent concepts because of the following differences. “Surmise” is an act of both self-defense and self-benefit, such as promotion, and there is no “surmise police,” as in the case of “self-restraint” (i.e., “self-restraint police” represent angry people who attack and blame others for not practicing self-restraint) (Ikeda 2020). “Surmise” is an action, whereas “self-restraint” is an omission. In some situations, this difference could ethically lead to different personal responsibilities for the consequence in these situations. The norm of not causing trouble to their community may mainly lead to people’s “self-restraint.”

The power of “air” has frequently been mentioned as the cause of the Japanese Navy’s defeat in World War II (Yamamoto 1983; Katada 2017; Kokami and Sato 2020). “Air,” which refers to the normative content of “peer pressure,” is the term from which the buzzword “KY” (an acronym of *kuuki-yomenai*, meaning, “can’t read the atmosphere/air”) has been derived. The content of “air” may vary, but the presence of “peer pressure” is persistent in Japan. “Community” (*seken*) appears in the *waka* (classical Japanese poetry) read by the famous poet Okura Yananoue over 1000 years ago (Kokami and Sato 2020). In Japan, “community” is sometimes called “*seken-sama*” with the honorific title “*sama*,” and is regarded as an entity having a kind of superior personality.

Ohta (2021) claims that Japan has “Japanese-made communitarianism”. A community in a general sense is a form of human communal life based on blood-related, territorial, or emotional connections, and it is a group in which mutual aids and mutual regulations exist due to communality (Niimura 2018). Communitarianism, in general, is a value system that considers the community as desirable both emotionally and ideologically and actively maintains and strengthens its existence. Some argue that the “Japanese-made community” is one that is characterized by strong closedness, a homogeneity norm, and the undifferentiated nature of individuals (i.e., no clear differentiation between self and others). Therefore, it tends to aim for a situation in which all members are united and solidarity is regarded as a golden rule. In other words, the ultimate goal of the community is a complete union of its members (Ohta 2021). In this sense, “Japanese-made communitarianism” can be regarded as “*seken*.”

Communitarianism generally emphasizes common social customs and cultural traditions. The common good is considered a substantive concept of a good way of life, which defines the way people live in the community (Kymlicka 2005). The common good of the “Japanese-made community” may be that all people live in the same way as a group in a common time frame, sharing the common past, present, and future. In other words, harmony, solidarity, and homogeneity (equality) are the most important values, or “goodness.” In such a community, members are required to act, or not act, according to “surmise,” “self-restraint,” “air,” and “peer pressure.” Moreover, the members of this community follow the homogeneity norm so that they can be accepted and respected by other members (Miller 2003; Ohta 2021). They may exist in other groupist cultures similar to Japan (Monoe 2020). At any rate, in terms of how these trends affect SDM in Japanese healthcare as discussed in the next section, it is less important whether

or not these trends are unique to Japan; instead, what matters most is the possibility of them having adverse effects on SDM in contemporary Japan.

In the following, we will briefly describe the relationship between the above-mentioned five tendencies (Table 1) and Japanese cultural characteristics previously discussed in the literature. The tendency to “surmise” may be attributed to respect for, or obedience to, authority (e.g., recognizing the superior’s intentions in advance and deciding one’s actions accordingly) (Tamura 2006). Both “surmise” and “self-restraint” could be the product of heteronomy (Matsuda 2010). “Air” is a vague, difficult-to-control rule for which no person is in charge or is a decision-maker. Ambiguity has long been regarded as a dominant Japanese cultural character, and “air” clearly is a form of ambiguity, in that no explicit order or suggestion is implied by it (Asai 2012). “Peer pressure,” which implicitly forces a minority or dissident to act like a majority, orders “everyone to be the same” and easily achieves the state of harmony, no matter what people want. In the “community,” the eyes of others become one’s code of conduct (Enomoto 2017); it forms “the other-oriented tendency,” in which one regards both the members of the community as well as the community itself as collective guidelines against which one judges one’s own actions (Wakazuma 1987). Finally, it is the Japanese spirit of caring for and worrying about the emotional reactions of others (Itakura 2021) that makes Japanese people cooperative or willing to avoid conflict. “Community” in this sense has clearly evolved on the basis of family-/group-oriented approaches (Sasaki and Yamaguchi 2010).

Notably, those five tendencies do not appear to include explicitly the elements of dependence (*amae*: the Japanese tendency to expect others to consider what they need and unconsciously require others to act in their best interest) (Doi 1995) and entrusting (*omakase*: an individual’s tendency to be willing to leave judgment to others and expect that the others will choose the best for him/her) (Slingsby 2004). However, according to these tendencies, person A could expect that person B would not do anything against A’s interests, just as A could surmise B’s wishes and interests. This may be referred to as “reverse surmise” or “mutual surmise.” In this context, we argue that surmising and dependence/entrusting are quite similar. As pointed out by Japanese psychiatrist Wada, in relation to the COVID-19 pandemic, Japanese “peer pressure” is so strong that Japanese people cannot express individual opinions out of fear of criticism; they have no real appreciation of the importance of freedom and gently obey the government policies, while also believing what the mass media reports without any doubts (Wada 2021).

In summary, while it may seem that Japanese psychocultural-social tendencies are incompatible with the idea that independent individuals decide what is most important for them and live freely without the influence of others or community traditions, it can also be said that a clear, direct, and low-context communication method is not generally appreciated and has not been adopted in Japanese society. Moreover, the position that individuals should be able to make the best decisions for themselves based on their own personal values has not been popular.

Notably, however, some claim that the myth that “Japanese are collectivist and Westerners are individualist” has no scientific basis and is a bad cultural stereotype, and such a notion has been denied in various psychological studies (Takano 2019). This claim is based on the results of several empirical studies, which primarily

conducted psychological experiments and laboratory analyses in subjects who were mostly university students in Japan and the USA. Those studies, however, aimed to compare general groupism and individualism traits between Japan and the USA and did not address patient attitudes, actions, or decisions in clinical settings. Moreover, no studies have looked into the effects of “surmise,” “self-restraint,” “air,” and “community” as *seken*—tendencies that concern us. According to Takano (2019), some experiments have been conducted on “tuning” (*Docho*), but “peer pressure” was not directly investigated or clarified. Based on these facts, although those studies are very valuable in the field of academic psychology, their results are unlikely to be generally applicable to Japanese clinical settings. To clarify, the aim of this paper is to highlight the cultural tendencies that may negatively impact the practice of SDM; to this end, we do not question how many people actually have these tendencies.

We think that dividing the East (e.g., Japan) from the West (e.g., the USA) for cultural categorization would be too simplistic. Within any country, differences exist among individuals, generations, families, and regions, even within the same culture. Some aspects may change over time, while others remain constant; certain aspects may also be shared across different cultures. At the individual level as well, personal and cultural perspectives can significantly change during one’s lifetime (Masaki et al. 2014).

Speculative Arguments concerning Potential Adverse Effects of Modern Japanese Psychocultural-Social Tendencies on Shared Decision-Making

The aforementioned psychocultural-social tendencies (i.e., “surmise,” “self-restraint,” “air,” “peer pressure,” and “community”) could have a strong influence on the practice of SDM in Japanese healthcare. Thus far, however, no empirical studies have tested this assumption, and no academic papers exist on this matter. Therefore, in the following section, we will consider how SDM might be affected by the five psychocultural-social tendencies in clinical settings, in relation to the previously described Japanese social characteristics.

The arguments that follow, although clearly lacking in scientific evidence, present our purely speculative claims—our doubts, concerns, and worries about what might happen in Japanese clinical settings—from the perspective of bioethicists and clinicians facing Japanese patients in clinical practice. This paper is not one that reports descriptive ethics work with objective data; rather, our points are based on ethical arguments that we believe to be important for those working in clinical settings, as well as being ethically important from the standpoint of a “precautionary principle.”

Generally speaking, the core elements of the SDM process—regardless of the multiple definitions and varying implications—could be summarized as follows: both the patient and physician participate as a team in making the best choice for the patient; both are equal partners in their relationship; the physician should provide information and recommend reliable options in an easy-to-understand manner; the patient, or patient and family, weigh the benefits and disadvantages of options

while also knowing that they are in a situation with no single best option; the patient makes a healthcare decision based on their own values and concerns; the physician should examine the patient's understanding and expectations; and the patient and physician should negotiate and make a shared decision (Simon et al. 2006; Makoul and Clayman 2006; Olthuis et al. 2014; Elwyn et al. 2017; Nakayama 2019).

In the discussions that follow, we simplify our points by assuming that SDM takes place among the patient, family, and physician, and present our concerns, doubts, and questions regarding the ongoing and future practice of SDM in Japanese clinical settings from an ethical perspective. Again, we are aware that individual differences exist even within the same culture or group and emphasize that we have no intention to argue that the following applies to all Japanese people.

First, is it even possible for relevant parties in Japanese clinical practice to establish an equal partnership among themselves, forming the basis of SDM? “Japanese-made communitarianism/community” is highly authoritarian. The physician may be perceived as an authoritative figure by the patient. There is also no guarantee that all family members have equal say in these matters or that the patient is immune to strong opinions or intentions of influential members, such as an older male or main provider. It may also be difficult for stakeholders to form an equal partnership as independent individuals, as it has been pointed out that individuality is not valued in Japan (Ohta 2021). Rather, the physician would develop a relationship with the patient not as an independent individual but as one of the family members. This makes it difficult for the patient and physician to exchange opinions freely as equal, independent partners.

Second, would the patient willingly reveal their true opinions and intentions to the physician? Japanese people usually find it difficult to say “no” to others, especially to their superiors whom they perceive as an authority (Ohta 2021). The patient may try to surmise the physician's thoughts and express their wishes while taking into consideration what the physician might want. The patient may also refrain from expressing their preferences due to the “self-restraint” tendency. At the same time, given their high-context cultural background and the psychological tendencies of “dependence” and “entrusting,” they may tend to think that what they want to say or do can be communicated and understood without words. Thus, the patient may hesitate to tell the physician that they have doubts, or disagree with the physician's recommendations. The patient may even refrain from asking questions, even if they do not understand what the physician is saying. Because of the desire to avoid confrontation and keep a harmonious patient-physician relationship, the patient may leave their real opinions ambiguous or unspoken.

Third, would the patient carefully and willingly weigh the benefits and risks of each treatment option on their own? Heteronomous, other-oriented, and dependent tendencies of the patient may lead them to leave crucial decisions to the physician and family. Alternatively, the “air” created by others may lead them to make treatment decisions rather than through well-founded rational balancing of merits and drawbacks concerning treatment choices. It is also necessary for the patient and family to pay attention to the cognitive bias of all stakeholders involved, especially that of the physician (Asai et al. 2021). Moreover, it is doubtful that

family members could calmly and carefully consider the merits and demerits of options and the future situation due to emotional instability and burdens.

Fourth, we are very concerned about the kind of decision-sharing that might take place in the SDM process in Japanese clinical settings, where a real equal partnership is unlikely to be achieved. We fear that proper decision-sharing would not happen in situations where the patient “surmises” the physician’s intentions and refrains from expressing their wishes to the physician and family members, reads the “air” created by people involved and feels coerced to follow it, or receives “peer pressure” indicating that “an ordinary patient usually listens to the physician’s opinions and accepts them in any way.” SDM would also not work for the patient’s autonomy and best interest if the “community’s” idea, i.e., “a patient in a certain condition usually chooses a certain treatment and never disagrees with their physician,” has been internalized.

If the patient “surmises” the physician’s intent, refrains from expressing their wishes and involuntarily accepts what the “air” expects them to do in the first place, it is unlikely that the patient willingly participates in SDM and collaborates with the physician to make shared decisions on an equal footing, as they might consider their participation meaningless or a waste of time. The patient’s attitude toward participation in decision-making also depends on their personality and emotional state, as well as their relationships with the physician and family members (Asai et al. 2021). Therefore, no one can tell what is going on in the decision-sharing phase from the outside due to the complicated psychocultural-social tendencies and high-context communication style prevalent among the Japanese. Collaborative processes under the norm that everyone should be united and homogenized would be far from an approach that considers the patient an individual with personal values and beliefs. Even the physician and family members may exert pressure on the patient to obey the “air” if the patient is unwilling to follow.

Fifth, would the patient make the final decision for themselves? Some people may not want to make decisions based on their other-oriented tendency, while others may give up making their own decisions when confronted by physicians or family members (i.e., “external pressure”). The “air” that carries stakeholder opinions may generate the final decision in the absence of the final decision-maker. Some may care more about what others want them to do than what they really want to do (i.e., the “surmise” tendency), or expect physicians to decide for them (i.e., dependency and entrusting). Yoichi Miyashita, a Japanese journalist who has worked overseas for a long time, wrote that he was against the legislation of voluntary active euthanasia in Japan given the ambiguity of society. He argued that Japanese family relationships are under the influence of the social climate, and people are supposed to “read the air” in given situations and feel compelled to respect harmony with others. He was concerned that some patients may decide to end their lives by physician-assisted suicide just so they could avoid bothering their family in the process of medical and nursing care, even if they want to live longer (Miyashita 2019). Family members with unclear boundaries between self and others may impose certain principles. For some patients, the family serves as the reference group against which they make judgments about right and wrong.

Finally, what does mutual agreement in SDM really mean in circumstances dominated by “surmise,” “self-restraint,” “air,” “peer pressure,” and “community” in which harmony, solidarity, and homogeneity are valued? Is the agreement a true agreement when all people concerned want to avoid being considered the disturber of harmony or a difficult patient? Would not the wishes of vulnerable patients be ignored in the name of unanimity? Would not the final agreement itself become the ultimate goal, justifying manipulation? With much concern and doubt, it is possible that the patient’s final consent is not purely voluntary but rather represents the involuntary or reluctant agreement made in line with the intentions of those in a stronger position (Kokubun 2017; Kokubun and Kumagai 2020). Moreover, what is regarded as good in the community may differ from what the individual patient considers to be good for themselves. Hence, the potential adverse effects of psychocultural-social tendencies in modern Japan on SDM are very worrisome, and we cannot afford to ignore them.

Conclusions

This paper discusses the certain risk of SDM being adversely affected by Japanese psychocultural-social tendencies and argues that SDM in Japanese clinical settings might fail to achieve its goal. Although SDM is a good model in and of itself and is necessary for improving decision-making processes in Japanese clinical practice, we are concerned that SDM requires a closer relationship among stakeholders and more frequent communication, which may increase the influence of health care professionals (e.g., physicians) on patient psychology and the likelihood that the Japanese psychocultural-social tendencies become too marked. Close relationships and frequent communication are undoubtedly preferable, but the shared nature of SDM can make authentic patient decision-making difficult to ensure.

Healthcare professionals including physicians should try to identify patients’ authentic preferences free from “surmise,” “self-restraint,” “air,” “peer pressure,” and “community.” This task may be quite difficult and time-consuming and will require building a patient-physician relationship with openness and mutual trust. It goes without saying that in order for the SDM model to work well in reflecting patient understanding and values, health care professionals need to be supportive of and sensitive to the individual preferences and needs of patients during SDM processes because the decisional burden is heavy and patient values are not fixed (Asai et al. 2021).

Finally, in present Japan, health care professionals should be aware of the influences of “surmise,” “self-restraint,” “air,” “peer pressure,” and “community” on patients, even in situations where they tend to the patient alone. Japanese healthcare professionals should also be aware of the fact that they, too, may be falling subject to the unwanted influences of the Japanese psycho-cultural-social tendencies. In conclusion, we emphasize that there is a possibility that the abovementioned psychocultural-social tendencies present in Japan could strongly influence the practice of SDM in Japanese healthcare. We argue that efforts should be made to eliminate these negative impacts on SDM, and furthermore, to conduct rigorous empirical

research to establish trustworthy evidence in the future. Only with such efforts can we make more plausible arguments and claims based on convincing psycho-scientific data.

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Declarations

Competing Interests The authors declare no competing interests.

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