Psycho-Oncology in Japan: History, Current Problems and Future Aspect

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HISTORY

In North America and Europe, psycho-oncology is now recognized as a new subspecialty of oncology concerned with the psychological, sociological, behavioral and ethical aspects of cancer. In those countries, the medical and social environment for cancer patients changed dramatically in the 1960s and 1970s. The changes included advancements in cancer tests and treatment, truth-telling practice, the right to know, quality of life, and living wills. In addition, more humanistic and supportive care was introduced by the hospice movement.

In the 1970s, psycho-oncology research steadily led to a better understanding of the psychosocial effects of a broader range of cancers, despite the lack of appropriate instruments for assessing quality of life and the limited availability of researchers with knowledge of both clinical oncology and psychosocial research. Since Western countries have come to accept the standard of truth-telling in cancer care, most cancer centers and hospitals have employed psycho-oncology professionals who provide patient care and also more active psychiatric treatment for patients in severe distress, their families and the care staff.

Extensive research has been conducted on the following subjects: the psychosocial impacts of cancer; how patients can adapt their cancers; how often patients, their families and care staff suffer from psychiatric disorders; why patients delay the initial visit for cancer examination and treatment; the psychosocial and behavioral variables that contribute to cancer risk and survival; quality of life and cancer treatment; and psychotherapeutic and psychopharmacologic interventions and decision-making in oncology. More recently, genetic counseling, the neurobiology of smoking and psychiatric issues in palliative medicine have been addressed.

The International Psycho-Oncology Society (IPOS) was founded in 1984 and has provided opportunities for healthcare professionals from different countries to learn new clinical and research skills through meetings and through the Psycho-Oncology Journal. Jimmie C. Holland, MD, was the Founding President. With encouragement from IPOS, the Japan Psycho-Oncology Society (JPOS) was established in 1987. Dr Hiroomi Kawano is well known as a Founding President of JPOS; he also founded the Japanese Society for Research on Death and Dying in 1977. His active role has had a great impact around Japan in the development of the psychosocial aspects of cancer care, by increasing physicians’ and nurses’ awareness of the emotional needs of patients and their families.

After the 2nd International Congress of Psycho-Oncology, chaired by Dr Kawano in 1995 in Kobe, JPOS took a further step from its enlightenment phase towards its scientific phase, in collaboration with Kaoru Abe, MD, President of the National Cancer Center, Japan. Dr Abe recognized that both psycho-oncology and palliative medicine played important roles in cancer patient care, and that society members should learn about both. In 1997, he organized a first, joint meeting with the 2nd annual meeting of the Japanese Society for Palliative Medicine; more than 1000 participants made the meeting a great success. JPOS now has more than 500 members, consisting of nurses, physicians and a very small number of mental healthcare professionals.

TRUTH-TELLING PRACTICE IN JAPAN

Since the hospice movement was introduced to Japan in the late 1970s, cancer-care policy has been slowly changing. The movement was led mainly by nurses and a limited number of physicians. They were concerned with issues related to providing aggressive treatment for terminally ill patients who had not been informed of their diagnoses of cancer. This situation was resulting in impaired communication between the patients and their families, and poor symptom management of cancer patients in pain and distress.

In 1989, a Japanese Ministry of Health and Welfare (JMHW) task force recommended the practice of telling the truth to terminally ill patients. In 1995, the JMHW promoted the practice of obtaining patients’ informed consent before every medical procedure. A 1994 survey of bereaved family members showed that only 20.2% of cancer patients had been told their true diagnoses. Since April 1996, physicians have been permitted to charge a fee for giving patients information about their cancer treatment plans. The above reports did not recommend that obtaining patients’ informed consent or telling the truth to cancer patients should be made a legal requirement, because a balance has not yet been established in Japan between the patients’ desire for detailed information on their illnesses and the families’ and physicians’ beliefs that providing patients with such information is beneficial.

Kai et al. (4) studied patient-physician communication about terminal care in Japan and reported that the concordance between a patient’s preference and the physician’s estimation of it was close to the figure expected by chance alone. Japanese healthcare planners may prefer advances in truth-telling practice in cancer care to be slow, because they are uncertain about the psychological impact of the diagnosis of cancer on the patient, and wish to...
respect the family’s and physician’s decisions, as well as the patient’s preference. The present care policy, which does not make truth-telling practice in cancer care a legal requirement, needs to be examined further to determine whether it really helps patients and their families.

CURRENT PROBLEMS AND FUTURE ASPECT IN JAPAN

In Japan, as was once observed in Western countries, withholding the truth in cancer care limits patient care options, and also limits research and training possibilities in psycho-oncology. There are only a few cancer center hospitals that have psycho-oncology professionals on staff to provide care for patients to whom the truth has been given. Of course, there are quite a few institutions in the world with well-developed psycho-oncology programs incorporating research and training: for example, the Memorial Sloan-Kettering Cancer Center Hospital in the USA and the Royal Marsden Hospital in the UK. In most hospitals in Japan, psychosocial interventions are offered only when cancer patients who are not informed of their true diagnoses show abnormal behavior and/or severe distress (4). Such rare psychosocial consultations hardly encourage young psychiatric and psychosomatic physicians to maintain high standards of care, and may even be detrimental to the morale of these workers. To make matters worse, the participation of psychologists and social workers in cancer care is limited because the Japanese Government does not certify them.

A recent patient survey showed that 75% of 1215 cancer in-patients treated at 24 of the 26 cancer center hospitals in Japan had been informed of their diagnosis of cancer (5). This indicates that the practice of truth-telling has been introduced rapidly in recent years, even if only in the cancer center hospitals. There is a need to establish a mental-health service run by psycho-oncology professionals with the aim of supporting communication between medical professionals and cancer patients and their families after cancer disclosure. The cancer center hospitals are expected to provide a pre- and post-graduate program of psycho-oncology training, hopefully with training in palliative medicine, in cooperation with medical schools where such training in clinical oncology has not yet been established.

CONCLUSION

The progress made in psycho-oncology is closely linked to the development of cancer medicine and its social environment. Non-Western societies like Japan are more likely to have group-centered models of medical decision-making than the patient-autonomy model favored by most Western countries. Consequently, the move towards the practice of truth-telling in cancer care is advancing slowly in Japan. Withholding the truth in cancer care really does limit patient care, as well as the scope for training and research in psycho-oncology. If truth-telling in cancer care and the participation of psycho-oncology professionals were made a legal requirement, there would be significant benefits for patient care, as well as for research and training in psycho-oncology, and health care professionals would have an opportunity to understand the concept of human care as individuals caring for other individuals who are ill. Furthermore, if Western and non-Western societies were to participate in cross-cultural psycho-oncological studies, we would improve our understanding of the concept of quality of life, which crosses all cultural boundaries.

REFERENCES