

精神医療における患者の権利：発表論文

北村俊則, 北村總子：精神医療における告知同意と判断能力について. 精神神経学雑誌, 95(4); 343-349, 1993.

北村俊則, 北村總子：精神科医療における治療同意の判断能力評価手法について. 精神科診断学, 5(2); 233-242, 1994.

告知同意の構成要素である (1) 医学情報の開示, (2) 判断能力, (3) 自発性のうち, 判断能力の評価のために開発された技法を比較した. これらは Competency Questionnaire, Two-part Consent Form, Measure of Competency to Render Informed Treatment Decision, Recognition fo Rights Violation in Counseling, Manual for understanding treatments disclosure, Hopkins Competency Assessment Test, Competency Interview Schedule の7つである. こうした尺度は, 判断能力の構成要素である同意不同意の選択の明示, 実際的理解, 情報処理の合理性, 状況の特性の把握, 選択結果の合理性, について評価するよう構成されているがいずれも広く臨床に用いるものになっていない. 新しい尺度の開発が必要と思われる.

北村總子, 北村俊則：精神科医療におけるインフォームド・コンセントと判断能力. こころの科学, 60; 8-13, 1995.

Tomoda, A., Yasumiya, R., Sumiyama, T., Tsukada, K., Hayakawa, T., Matsubara, K., Kitamura, F., and Kitamura, T.: Validity and reliability of structured interview for competency incompetency assessment testing and ranking inventory. : Journal of Clinical Psychology, 53; 443-450, 1997.

The Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory (SICIATRI) is a structured interview guide to assess the competency for giving informed consent to treatment among psychiatric and medical patients. The competency levels of 48 psychiatric and medical inpatients were assessed by SICIATRI. A relatively high interrater reliability of the SICIATRI items (over half of the items had kappa \geq .60) and concurrent validity (sensitivity = .83, specificity = .67 as measured against the global judgement of competency rating by the attending physician) were obtained. In addition to its brevity (it takes about 20 minutes to complete), these findings may warrant application of this instrument in a clinical setting.

Kitamura, F., Tomoda, A., Tsukada, K., Tanaka, M., Kawakami, I., Mishima, S., and Kitamura, T.: Method for assessment of competency to consent in the mentally ill: Rationale, development, and comparison with the medically ill. International Journal of Law and Psychiatry, 21; 223-244, 1998.

The doctrine of informed consent has been widely accepted and the patient's right to self-determination highly respected, particularly in Western countries. In Japan, the doctrine of informed consent was introduced quite recently. The necessity of doctor's disclosure of medical information has been discussed since the 1970s. The term "medical ethics" was introduced in the 1980s and the concept of informed consent was increasingly respected in Japan. In 1988, the Ministry of Health issued an interim report relating to the future medical practice in Japan. It said that in view of the introduction of the concept of informed consent, it is desirable to take into account that patients receive satisfactory medical information—purpose, expected effects, and alternative of the proposed treatment—beforehand and that they give consent to the treatment (Iwamori, 1991). It is, however, regrettable that psychiatric patients are exempted from the right to self-determination in medical decision making, by reason of being dangerous or being deemed incompetent. We argue herein the patient's right to self-determination in the medical sphere from a legal perspective. The review focuses mainly on the American literature and American cases. We claim that the examination of the patient's competency is a safeguard of due process. It is worthwhile reviewing the American literature and cases because Japanese legal theories have been much influenced by the American legal theories and jurisprudence, particularly since the 1950s. We also review the literature on instruments of competency testing, and we present the development of a new

clinical instrument to assess the patient's competency to give informed consent. We report data using this instrument and show that, unlike what has been implied by mental health laws in many countries, not all psychiatric patients are totally incompetent. Finally, we offer a justification of the use of such a competency assessment scale in order to protect patient's due process rights.

坂本真士, 杉浦朋子, 蓮井千恵子, 北村總子, 友田貴子, 田中江里子, 木島伸彦, 丹野義彦, 北村俊則: 精神疾患への偏見の形成に与る要因—社会心理学的手法によるアプローチ. 精神保健研究 44; 5-13, 1998.

友田貴子, 木島伸彦, 斎藤令衣, 北村總子, 住山孝寛, 安宮理恵, 塚田和美, 田中眞, 三島修一, 川上郁子, 北村俊則: 精神疾患と判断能力—内科患者との比較を通して. 精神保健研究, 44; 37-43, 1998

北村總子, 北村俊則: 精神疾患を有する者のための権利擁護者 (advocate) 制度—その歴史と役割—. 精神保健研究, 44; 45-60, 1998.

坂本真士, 北村俊則: 精神疾患と偏見. Psychiatry Today, 23; 1-4, 1998.

Kitamura, T., Kitamura, F., Mitsuhashi, T., Ito, A., Okazaki, Y., Okuda, N. and Kato, H.: Image of psychiatric patients' competency to give informed consent to treatment in Japan: I. A factor analytic study. International Journal of Law and Psychiatry, 22; 45-54, 1999.

Kitamura, T., Kitamura, F., Mitsuhashi, T., Ito, A., Okazaki, Y., Okuda, N. and Kato, H.: Image of psychiatric patients' competency to give informed consent to treatment in Japan: II. A case vignette study of competency judgement. International Journal of Law and Psychiatry, 22; 133-142, 1999.

蓮井千恵子, 坂本真士, 杉浦朋子, 友田貴子, 北村總子, 北村俊則: 精神疾患に対する否定的態度—情報と偏見に関する基礎的研究—. 精神科診断学, 10; 319-328, 1999.

精神疾患への否定的態度を検討するため, 都内某大学の 1, 2 年生 323 名を対象に, ① 家族・友達と精神病・精神病患者に関する会話, ② 精神病・精神科について聞いたうわさ, ③ 記憶にある精神疾患患者の事件報道, ④ 記憶にある精神疾患患者のドキュメント報道, ⑤ 周囲に精神病院に入院, 受診した人がいるかという 5 項目について自由記述をさせた. 内容は KJ 法で解析した. さらに Link (1989) のスティグマ尺度を用い, 精神疾患への否定的態度を測定した. 精神疾患に否定的な態度をもつ人は, 家族・友人との会話で否定的な内容を話題として取り上げ, 奇異な行動や妄想, 幻覚といった症状に目をむけ, 事件報道の欄に多く記述をしていた. 精神疾患患者との接触体験は精神疾患への肯定的態度と関連していた.

Kurihara, T., Kato, M., Sakamoto, S., Reverger, R. and Kitamura, T.: Public attitudes towards the mentally ill: A cross-cultural study between Bali and Tokyo. Psychiatry and Clinical Neurosciences, 54(5), 547-552, 2000.

The present study investigates the differences in public attitudes towards the mentally ill in Bali (Indonesia) and Tokyo (Jaoan), the former being a non-industrialized society and the latter an industrialized society in Asia. Seventy-seven residents of Bali and 66 residents from Tokyo were examined by a devaluation-discrimination measure and a self-assessment questionnaire to gauge their reactions to five imaginary case study vignettes consisting of three cases of schizophrenia, one case of a depressive episode, and one case of obsessive-compulsive disorder. Balinese respondents had significantly lower devaluation-discrimination measure scores, indicating a more favourable global attitude towards persons with a history of psychiatric treatment. In the two societies, attitudes towards patients with mental disorders varied with the kinds of mental disorders, with Balinese having a more positive attitude to schizophrenics but more negative to depressive and obsessive compulsive

patients.

Kitamura, T. and Kitamura, F.: Reliability of clinical judgement of patients' competency to give informed consent: A case vignette study. *Psychiatry and Clinical Neurosciences*, 54 (2); 245-247, 2000.

The competency of psychiatric patients to give informed consent is important in respecting patient's decisions as well as protecting patients from undue exploitation. A total of 176 members of the Japanese Society of Psychiatry and Neurology gave a clinical judgment in a questionnaire of competency in five case transcriptions. Their interrater reliability of competency judgement was slight (generalized Kappa 0.31). Clinicians' global judgment of patient' competency was not reliable, but it may be improved by the use of a structured interview.

Hasui, C., Hayashi, M., Tomoda, A., Kohro, M., Tanaka, K., Ageo, F. and Kitamura, T.: Patients' desire to participate in decision-making in psychiatry: A questionnaire survey in Japan. *Psychological Reports*, 86; 389-399, 2000.

Summary: Japanese national sentiment has been described as paternalistic, which has potentially wide-ranging implications for the manner in which psychiatric patients should participate in medical decision-making. To examine the extent and possible determinants of the desire to participate in medical decision-making among Japanese people, we distributed a packet of questionnaires to 747 (nonmedical) university students and 114 of their parents. The questionnaires included an imaginary case vignette of psychotic depression. The participants were asked whether they would want various types of medical information, i.e., diagnosis, aetiology, treatment outcomes, medical charts, etc., disclosed to them were they in such a psychiatric condition. Also included was the 1995 Scale for Independent and Interdependent Construal of the Self by Kiuchi. More than half of the participants who wanted all types of medical information disclosed to them (n = 413), as compared to those who did not want to know at least one type of information (n = 445), tended to be male and to have an educational background in psychiatry (9.7 % vs 5.4 %) as well as an assertive attitude as indicated by a higher score on Independence on the Scale for Independence and Interdependent Construal to the Self. These results suggest that the Japanese in this sample are more likely to want to make an autonomous contribution to the psychiatric decision-making process and that less desire for information can be predicted by some demographic and personality factors.

Hayashi, M., Hasui, C., Kitamura, F., Murakami, M., Takeuchi, M., Katoh, H., and Kitamura, T.: Respecting autonomy in difficult medical settings: A questionnaire study in Japan. *Ethics & Behavior*, 10; 51-63, 2000.

Some people in Japan are still comfortable with the paternalistic role of doctors, but others wish that their own decisions would receive a greater amount of respect. A total of 747 students of universities and colleges and 114 parents of these students participated in a questionnaire survey. Most of the participants thought that autonomy should be respected in situations involving death with dignity and euthanasia, whereas it should not be respected in attempted suicide and involuntary admission of individuals with mental illness. A cluster analysis revealed that the participants could be divided into the following groups: aid in dying advocates (n = 577), complete libertarians (n = 109), protectors of the mentally ill (n = 90), complete paternalists (n = 29), and questionables (n = 27). The assertion of independence score of the Scale for Independent and Interdependent Construal of the Self showed a significant difference among the 5 clusters. These findings suggest that the traditional paternalistic relationship between doctor and patient is undergoing a gradual transformation in Japan.

Hasui, C., Sakamoto, S., Sugiura, T., and Kitamura, T.: Stigmatization of mental illness in Japan: images and frequency of encounters with diagnostic categories of mental illness among medical and non-medical university students. *Journal of Psychiatry & Law*, 28; 253-266, 2000.

Psychiatric patients suffer from their diagnostic labels. In this study we examined the relationship between stigmatization and psychiatric diagnostic labels using 233 non-medical students and 104 medical students. Results showed that students who have negative attitudes to the mentally ill do not necessarily have a negative image of psychiatric labels per se. The frequency of encounter, however, was higher in

medical students than in non-medical students. There were no differences between medical students and non-medical students as regards images of psychiatric labels. The label of schizophrenia has the poorest image of all psychiatric diagnosis labels. The labels often used to disguise the diagnosis of schizophrenia (e.g., “neurasthenia”, “autonomic nervous system dysfunction”, “Psychosomatic disease” and “psychogenic reaction”) had a more favorable image.

Hasui, C., Hayashi, M., Tomoda, A., Kohro, M., Tanaka, K., Dekio, F., and Kitamura, T.: Patients’ desire to participate in decision-making in psychiatry: A questionnaire survey in Japan. *Psychological Reports* 86; 389-399, 2000.

Japanese national sentiment has been described as paternalistic, which has potentially wide-ranging implications for the manner in which psychiatric patients should participate in medical decision-making. To examine the extent and Japanese people, we distributed a packet of questionnaires to 747 (nonmedical) university students and 114 of their parents. The questionnaires included an imaginary case vignette of psychotic depression. The participants were asked whether they would want various types of medical information, i.e., diagnosis, aetiology, treatment, outcomes, medical charts, etc., disclosed to them were they in such a psychiatric condition. Also included was the 1995 Scale for Independent and Interdependent Construal of the Self by Kiuchi. More than half of the participants wanted all the types of medical information disclosed to them. Those participants who wanted to have all types of information disclosed to them (n = 413) as compared to those who did not want to know at least one type of information (n=445), tended to be male and to have an educational background in psychiatry (9.7 % vs 5.4 %) as well as an assertive as indicated by a higher score on Independence on the Scale for Independence and Interdependent Construal of the Self. These results suggest that the Japanese in this sample are more likely to want to make an autonomous contribution to the psychiatric decision-making process and that less desire for information can be predicted by some demographic and personality factors.

Sugiura, T., Sakamoto, S., Kijima, N., Kitamura, F., and Kitamura, T.: Stigmatizing perception of mental illness by Japanese students: Comparison of different psychiatric disorders. *Journal of Nervous and Mental Disease*. 188; 239-242, 2000.

北村總子, 北村俊則: 精神医学・医療における倫理とインフォームド・コンセントの歴史: 概観, 中根人允文, 松下正明 (編) 臨床精神医学講座, 第 12 卷精神医学・医療における倫理とインフォームド・コンセント, pp. 3-15, 中山書店, 2000.

Kitamura, T.: Assessment of psychiatric patients’ competency to give informed consent: Legal safeguard of civil right to autonomous decision-making. *Psychiatry and Clinical Neurosciences*, 54(5), 515-522, 2000.

The amendment of the Mental Health and Welfare Law in Japan will limit the admission for medical care and protection only for those individuals who are incapable to give consent to admission. This is the first in the history of the Japanese mental health legislation. Reviewing the law and psychiatric literature, I argue that (1) the informed consent is a legal transaction which embodies an idea of individual right to autonomous decision-making in medical settings; (2) health professionals have a duty to protect those individuals who cannot decide medical matters because of lack of capacity to do so; (3) some patients are marginally incompetent so that assessment of their competency is essential in protecting patients’ civil rights; (4) in order for a competency assessment to be reliable (and hence fair) the method should be psychometrically sound; (5) at the same time, in order for a competency assessment to be valid, the structure of a competency assessment should match to the patient’s psychological, cultural, and social background; and (6) because informed consent is a process rather than a cross-sectional event, a competency assessment had better be performed in everyday practice. A use of a brief and semi-structured interview to assess patients’ competency to give informed consent may meet all the requirements described above.

北村總子, 北村俊則: 精神科医療における患者の自己決定権と治療同意判断能力. 学芸社, 2000.

治療拒否権, 治療を受ける権利, 強制治療, 代行判断などについての法理論的考察ならびに治療同意判断能力評価用構造化面接作成の経緯とその詳細

北村總子, 北村俊則: 精神医学・医療における倫理とインフォームド・コンセントの歴史: 概観, 中根人允文, 松下正明 (編) 臨床精神医学講座, 第12巻精神医学・医療における倫理とインフォームド・コンセント, pp. 3-15, 中山書店, 2000.

林美紀, 北村俊則: 英国精神保健法 1983 改正の動き. 法と精神医療, 4; 1-11, 2001.

Sugiura, T., Sakamoto, S., Tanaka, E., Tomoda, A. and Kitamura, T.: Labeling effect of seishin-bunretsu-byo, the Japanese translation for schizophrenia: An argument for relabeling. *International Journal of Social Psychiatry*, 47; 43-51, 2001.

Stigma attached to individuals with schizophrenia may be derived from its diagnostic label. Two forms of a questionnaire were distributed to 189 Japanese university students. Each questionnaire contains case vignette of schizophrenia and major depression. In one form, the students were told at the close of each vignette the diagnostic label assigned to that case (the label group) whereas in another form, they were not done so (the control group). The students were also asked to rate negative image of the case in four items each. The label group was significantly higher than the control group in three of the four negative image items for the vignette of depression. This suggests that the label of schizophrenia (the Japanese translation Seishin-bunretsu-byo) has stigmatizing effect. We discussed these findings in the light of the implications of a relabeling, and argued for a change of name.

Hayashi, M. and Kitamura, T.: Euthanasia trials in Japan: Implications for legal and medical practice. *International Journal of Law and Psychiatry*, 25(6); 557-571, 2002.

In this paper, we have reviewed the court cases relating to euthanasia in Japan. The extremely small number of euthanasia trials does not mean that euthanasia is exceptional in Japan, but rather that it has been conducted discreetly. The details of these cases suggest that, (1) palliative care of the terminally ill is poor in terms of pain control and psychological care; (2) there is a lack of informed consent and respect for the patient's autonomous decision-making; (3) there is a lack of explicit ascertainment of the patient's wishes; (4) euthanasia is performed by family members who are distressed due to the burden of providing care; and (5) a strong paternalistic tradition hinders the growth of patient autonomy in Japanese medical care. However, recent changes in national sentiment and a transition away from the traditional value system may indicate that the Japanese people are now ready to discuss issues relating to euthanasia, and would welcome a review of the two existing sets of prerequisites for legal euthanasia handed down by the Courts.

城野匡, 高森薫生, 北村俊則: 精神保健福祉法における任意入院と患者の判断・同意能力. 臨床精神医学, 31(12); 1471-1476, 2002.

Sakamoto, S., Kurihara, T., Kato, M. and Kitamura, T.: Public attitudes toward persons with mental illness: A cross-cultural study using case vignettes between Bali and Japan. (submitted)

In the present study, we investigated public attitudes toward people with mental illness in Bali (Indonesia) and Japan. A questionnaire was administered to 168 residents in Bali and 145 residents in Tokyo. The questionnaire included five brief vignettes describing persons with mental disorders. Participants were asked to answer how they would feel toward the target persons in the vignettes. In general, Balinese people, as compared with Japanese respondents, perceived mental patients as less abnormal, felt less uncomfortable being with them, and estimated a higher possibility of suffering from the illness themselves. If respondents have mental patients in their family, Balinese were less likely to conceal them from the public. Balinese thought that the persons with mental illness were more likely to be able to return to their society. While the attitudes of Japanese toward psychotic cases were consistently more negative than those of Balinese, the attitudes of Japanese toward nonpsychotic cases were partly more positive than those of the Balinese counterparts. The effect of the public attitude

toward people with mental illness on the outcome of mental patients was discussed.

Kitamura, T., and Takahashi, N.: Ethical and conceptual aspects of capacity assessments in psychiatry. *Current Opinion in Psychiatry*, 20, 578-581, 2007.

Kitamura, T. and Kitamura, F. (2005). Competency Testing in Medical and Psychiatric Practice: Legal and Psychological Concepts and Dilemmas. in (Takahashi, T. ed.) *Taking Life and Death Seriously - Bioethics from Japan*. Amsterdam: Elsevier.

Health professionals have been in an ethical dilemma for some time. On the one hand, all the patients, be they medical or psychiatric, should be assumed as capable of understanding what is involved in their care and thus of making their own autonomous decisions. Forcing competent patients into treatment is a violation of human rights. On the other hand, mental health professionals are expected to protect those patients who are unable to make medical decisions in their own best interest. Respecting their refusal of treatment superficially is a violation of their right to be protected as well as the deprivation of legal due process. Yet one cannot determine a patient's incompetency without testing him/her. However, testing the patient in terms of competency (its hypothesis being that he/she is incompetent) is a violation of the assumption of competency. If such testing is performed only among psychiatric patients, it may be criticised as lacking equal protection between medical and psychiatric patients.

Even if a competency test is justified, health professionals find themselves in yet another dilemma. A patient's competency varies temporarily and informed consent should be sought for any new diagnostic and therapeutic procedures. Theoretically, this will lead to the administration of a competency test in every situation where anything new commences. This will be burdensome for both the professionals and the patients. It may also have detrimental effects on the therapist-patient relationship.

Taking into account these two dilemmas, we have proposed the two different types of purposes of test use (even the same test). The first purpose is to measure the appropriateness of information disclosed by professionals. The patients' competence should be assumed. A poor test result will require that the information be repeated in a more accessible manner. Because tests of this kind are short and informal, they may be used in everyday practice. The second purpose of test use is to measure the competency of the patients on occasions when they need to make major decisions. Because the patients' incompetency is hypothesised by definition, the tests should be formal and carefully performed by independent assessors who have been rigorously trained. The methods and contexts for use of these tests should be legislated. A poor test result will be followed by the designation of a proxy who will represent the patient's value system or best interest. Thus, incompetent patients can be protected. Because such occasions are infrequent, testing may not be burdensome.

Tests of the appropriateness of disclosed information are justifiable because the balance of power between professionals and patients is strongly skewed. This power imbalance is due to (a) excessive and rapidly growing medical information, (b) special conditions of patients such as anxiety, depression, and denial. Furthermore, we believe such procedures will render all the people involved in patient care (including, of course, the patients themselves) more aware of the importance of respect for the autonomous decisions made possible by a mutual exchange of opinions and information.

北村總子, 北村俊則, 塚田和美, 加藤元一郎: 日本の精神医療における情報開示: 実態と規定要因. 先端倫理研究. 1; 39-62, 2006

実際の精神科医療と(対照群として)内科医療において何がどれほど開示されているのかと, そのような開示内容を規定する要因について検討するため, 精神科入院患者 80 名と内科入院患者 23 名に対して, 主治医が入院直後に開示した内容を告知内容調査表 Disclosure Content Check List (DCCL) にて確認した. DCCL の 12 項目は因子分析から治療の危険, 恩恵的示唆, 診断と治療の正式名称, 法的決定権と命名できる 4 因子に分かれることが示された. 各因子に 0.5 以上の因子負荷量を有する DCCL 項目の得点とを DCCL の下位尺度得点とした. 治療の危険得点は他の 3 群の患者に比べ自由入院(一般病院精神科病棟)患者に有意に高かった. 診断と治療の正式名称得点は精神病性障害群に比べ身体疾患群と気分障害群に有意に高かった. 法的決定権得点は自由入院(一般病院精神科病棟), 医療法入院(内科病棟), 任意入院(精神科開放病棟), 医療保護入院(精神科閉鎖病棟)の順であった. 医療・法律情報の開示はインフォームド・コンセントの前提であるが, そ

れは医療の現場では必ずしも実行されてはいなく、その要因として入院形態や診断分類があることが示唆された。

北村俊則：EBMは医療を変えるか？ 上島国利，三村将，中込和幸，平島奈津子（編）EBM精神疾患の治療 2006-2007. 中外医学社, 2006.

北村總子, 北村俊則：日本の精神科医療の回顧と展望—精神疾患を有する者の医療における自己決定—。高橋隆雄，浅井篤（編）日本の生命倫理：回顧と展望. pp. 131-159. 九州大学出版会, 2007.

Kitamura, T., and Takahashi, N.: Ethical and conceptual aspects of capacity assessments in psychiatry. *Current Opinion in Psychiatry*, 20, 578-581, 2007.

Purpose of review: To search the literature on conceptual and assessment issues of patients' capacity. **Recent findings:** Current literature shows that many instruments have been developed in the last decade to measure patients' capacity. Although these measures provide a rank-ordered scale of capacity, they cannot categorise patients into competent and incompetent which rely heavily on the concept of authentic autonomy. However, the latter should be carefully examined after considering the patients' cultural and subcultural background and the quality of doctor's communication skills. **Summary:** Academic and clinical psychiatry are posed with such questions as to how to categorically classify capacity and incapacity as well as to evidence the admissibility of measuring instruments when used in a civil commitment.

北村俊則，北村總子：医療における自己決定論の盲点—精神科医療のなかで。高橋隆雄，八幡英幸（編）自己決定論のゆくえ：哲学・法学・医学の現場から. pp. 108-122, 九州大学出版会, 2008.

Sakamoto, S., Kurihara, T., Kato, M. and Kitamura, T.: Public attitudes toward persons with mental illness: A cross-cultural study using case vignettes between Bali and Japan. (submitted)

In the present study, we investigated public attitudes toward people with mental illness in Bali (Indonesia) and Japan. A questionnaire was administered to 168 residents in Bali and 145 residents in Tokyo. The questionnaire included five brief vignettes describing persons with mental disorders. Participants were asked to answer how they would feel toward the target persons in the vignettes. In general, Balinese people, as compared with Japanese respondents, perceived mental patients as less abnormal, felt less uncomfortable being with them, and estimated a higher possibility of suffering from the illness themselves. If respondents have mental patients in their family, Balinese were less likely to conceal them from the public. Balinese thought that the persons with mental illness were more likely to be able to return to their society. While the attitudes of Japanese toward psychotic cases were consistently more negative than those of Balinese, the attitudes of Japanese toward nonpsychotic cases were partly more positive than those of the Balinese counterparts. The effect of the public attitude toward people with mental illness on the outcome of mental patients was discussed.

北村俊則，森田敏子，坂梨京子：終末期医療に関する態度とパーソナリティ。高橋隆雄，桑和彦（編）生命という価値：その本質を問う. pp. 320-334., 九州大学出版会，福岡，2009.

治療を開始しない (withholding of treatment), いったん開始した治療を中止する (withdrawing of treatment), 安楽死 (euthanasia) を含む終末期医療において患者の死のスタイルに関する賛否の態度は, その者のパーソナリティで規定されるという仮説を検証すべく, 仮想の 12 事例を提示し, 上記 3 つの医療行為の可否を 5 件法で問うアンケート調査を 100 人の被検者に実施した。

予想通り, 患者の死を容認する意見 (「死亡容認態度」) は, euthanasia, withdrawing of treatment, withholding of treatment の順に上昇した。「死亡容認態度」は, 患者あるいは家族の希望がない事例より希望が表明されている事例において高かった。また, 非医療職のものより医療職の者は患者を死に導く行為に反対の態度を示していた。

パーソナリティのうち気質は遺伝的影響を受け発達の初期から認められる個体の行動特徴であり, 性格は周囲の環境との相互作用を経過して形成される特徴であり, 性格は自己概念の成熟とともに発展するといわれている。そこから, 自己志向が

強いほど患者の決定を尊重し、協調性が強いほど患者家族の希望に配慮する傾向が強く、自己超越が強いほど患者の死を誘導する行為に対し反対の態度を取ると想定した。しかし、年齢、性別、職業差、事例の特徴を統制した後、性格のうち自己志向性 (Self-Directedness) と気質の持続 (Persistence) が低いほど死亡容認態度が強かった。低い自己志向性と死亡容認態度の関連は安楽死事例で、また非医療職の者でより顕著であった。

終末期医療において患者の死を誘導する行為を容認する態度の背景には、僅かに一部にその者のパーソナリティ未熟さが存在することが推定できた。

Kitamura, T.: Do mental disorders really exist? Eubios Journal of Asian and International Bioethics, 20(3); 72-74, 2010.

北村俊則：精神に疾患は存在するか 高橋隆雄, 北村俊則 (編) 医療の本質と変容：伝統医療と先端医療のはざままで。pp. 286-300. 九州大学出版会, 福岡, 2011.

北村俊則：精神に疾患は存在するか (単行本として執筆中)