



Image of Psychiatric Patients' Competency to Give Informed Consent to Treatment in Japan

I. A Factor Analytic Study

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Introduction

The right of individuals to exercise control over matters related to their own body is manifest in the practice of informed consent in Western medicine (Appelbaum & Grisso, 1988; Miller, 1994; Weisbard, 1986). According to the doctrine of informed consent, competent individuals have the right to make right and “wrong” decisions within the framework of their own value system. Thus, no physician should commence a treatment (or other medical procedure) unless the patient gives consent. However, physicians cannot claim that they have obtained the valid consent of a patient unless: (a) necessary medical in-

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The present study was partly supported by a 2nd Health Culture Research Grant from Meiji Life Foundation of Health and Welfare (1994) and a grant from Pfizer Health Research Foundation (1994, 1998). We are grateful to Dr. G. J. Bean for providing his questionnaire and permitting us its translation into Japanese and use in the present research. We also thank all participants of the questionnaire survey.

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formation has been disclosed; (b) the patient has competent mental capacity; and (c) the patient's decision is voluntary, without any undue coercion (Appelbaum, Lidz, & Meisel, 1987; Brabbins, Butler, & Bentall, 1998). The decision made by a patient should not be regarded as valid if any of these three prerequisites is lacking. However, a dilemma arises in medical practice when one or more of these prerequisites appear nebulous. This is especially true of requirement (b), and thus psychiatrists and other mental health professionals (MHPs) face a particular challenge in cases where competency is difficult to assess. If, for example, a competent patient is erroneously assessed as incompetent, his/her right to give informed consent will be violated (Brakel, 1985). If, on the other hand, an incompetent patient is erroneously assessed as competent, his/her right to be protected by a legislation, such as mental health laws, will be violated (e.g., Royal College of Psychiatrists, 1989; Winick, 1991),¹ possibly resulting in deprivation of the right to be proper treatment. The Royal College of Psychiatrists' (1989) joint Working Group on the Consent of Non-Volitional Patients and De Facto Detention of Informal Patients, for example, expressed their concern that "nothing will have been achieved if, in the name of somewhat spurious autonomy, incompetent patients are deprived of the benefit of treatment to which they cannot consent but to which rational competent people would readily agree" (p. 2).

Although the pivotal importance of the assessment of patients' mental capacity has been acknowledged in anecdotal reports (e.g., Lippert & Stewart, 1988; Paul, 1996), and several guidelines and research instruments have been developed to do such work (Appelbaum & Grisso, 1995; Appelbaum, Mirkin, & Bateman, 1981; Bean, Nishisato, Rector, & Glancy, 1994; Grisso & Appelbaum, 1995a; Grisso, Appelbaum, Mulvey, & Fletcher, 1995; Janofsky, McCarthy, & Folstein, 1992; Roth, Meisel, & Lidz, 1977; Searight, 1992; Weithorn & Campbell, 1982), practitioners and lawyers have not yet reached consensus on a universally applicable means of assessing patients' competency to give informed consent (for review see Grisso, 1986). This failure might be expected to result not only in poor agreement among professionals on the assessment of competency in everyday practice, but also a difficulty in communication between different disciplines (e.g., Kaufmann, Roth, Lidz, & Meisel, 1981).

Clinicians, researchers, and lawyers have long argued that the concept of competency is homogeneous and dichotomous. For example, it is argued that competent patients can make their own decision about treatment, so that their right of privacy will be protected, whereas coerced (involuntary) treatment can be justified for incompetent patients under the state's *parens patriae* (e.g., Appelbaum & Grisso, 1988; Appelbaum & Roth, 1982; Bloom, Faulkner, Holm, & Rawlinson, 1984; Cichon, 1991, 1992; Harvard Law Review, 1974; Kaufmann et al., 1981; Marquett Law Review, 1990; Sullivan & Youngner, 1994).

A patient's competency does not usually become an issue of legal debate when the patient accepts a suggested treatment (Winick, 1991). Nevertheless, the U.S. Supreme Court held that admitting a psychotic patient without first

¹Zinermon v. Burch, 110 S.Ct. 975 (1990).

taking steps to ascertain his competency is a violation of his procedural due process rights.² In the case in question, Burch was found wandering along a Florida highway, and appeared to be injured and disoriented. On psychiatric evaluation he was hallucinating, confused, and psychotic, believing that he was "in heaven." Burch signed an admission form and was admitted as a *voluntary* patient. This later led to a civil rights action against the treatment facility, in which Burch alleged that employees at the state mental facility admitted him without first ascertaining his competency. The Supreme Court supported his allegation.

In *Rennie v. Klein*,³ in which a repeatedly admitted patient argued for his right to refuse psychiatric treatment, the District Court articulated that mental illness was not equivalent to incompetency and that the mentally ill had a right to refuse treatment for the reason of side effects in the absence of an emergency.

As seen in these cases, competency/incompetency has long been seen as black or white, clearly a bifurcated issue. And its assessment generally seems to determine the right of a patient to refuse treatment and to receive legal protection.

Competency is strictly categorical in this kind of argument. Recently, however, it has been acknowledged that competency is better represented as continuum between complete competency and complete incompetency, with a fairly wide "grey zone" in between (e.g., Grisso & Appelbaum, 1995b; Martin & Bean, 1992; Perlin, 1991; Saks, 1991). Because of this, Schwartz (1993) proposed abolishing the idea of competency completely. Even as long ago as 1941, Green (1941) warned that there were borderline competency cases, and that "injustice may be done by deciding erroneously that a particular individual belongs on one side of the line rather than the other."

Despite this danger, however, there have been no studies on the assumed single-dimensional nature of the psychiatric patient's competency to give informed consent. If competency was found to be psychometrically multidimensional, the proposal to measure competency on a single dimension might be seriously undermined. Although varying in their details and terminology, theorists of competency to give informed consent generally break the concept down into four constituent parameters (e.g., Appelbaum et al., 1987). These are (a) evidencing a choice (a patient can explicitly show his/her consent or refusal); (b) actual understanding (ability of a patient to understand treatment information, including benefits, risks, and alternatives); (c) rational manipulation of information (the patient's decision is not influenced by the psychopathology of disturbed reality testing); and (d) appreciation of the nature of the situation (ability of a patient to take into account the future orientation of his/her own decision-making) (for discussion, see F. Kitamura et al., 1998). Clearly, this categorization raises a serious question about the single dimensionality of competency.

There seem to be at least two avenues toward resolution of the above issue. One is to empirically examine the factor structure of different items reflecting

²*Id.*

³*Rennie v. Klein*, 462 F.Supp 1131 (D.N.J. 1978), modified, 476 F.Supp. 1294 (D.N.J. 1979), modified, 653 F.2d 836 (3rd Cir. 1981), vacated and remanded, 458 U.S. 1119 (1982), on remand, 720 F.2d 836 (3rd Cir. 1983).

the different aspects of competency of patients with mental illness. This approach is based on the assumption that competency is a psychologically and empirically testable *reality*. Another is to examine the same factor structure, but as subjectively understood by professionals and lay people. This is based on the assumption that competency is a legal or ethical *concept* shared by individuals. Thus, the former is a medical/psychological approach, and the latter a legal/ethical approach. In this study, we use the second approach to examine the discrete *images* of competency to give informed consent that are held by psychiatric and legal professionals and students.

The second aim of the present study is to examine whether the importance given to individual items of competency differs between different groups of individuals. We expected that medical/psychiatric professionals would emphasize the importance of the patient's awareness of illness—insight—and the patient's understanding of the proposed treatment, while legal professionals would emphasize the importance of the patient's autonomous decision-making and the absence of undue coercion. We also expected that the outlook of lay people would be located between those of medical/psychiatric and legal professionals, but that students of different specialities (medicine and law) would show a bias that was similar to, but less pronounced than, that of their corresponding specialists. Furthermore, we expected that professionals actually or potentially involved in the care and protection of the mentally ill would be more conservative, emphasizing the patient's awareness of the necessity and meaning of treatment, while lay people would be more liberal, emphasizing the rights of patients.

In this study, we requested the participation of professionals and students among four different populations: psychiatric professionals (mainly psychiatrists), lawyers, medical students, and law students. The latter two groups were selected as nearly representative of a population of lay people. Although students cannot perfectly represent the general public, we thought that our questionnaire might be too difficult for people without sufficient educational background and that medical and law students were particularly sensitive to the issue of informed consent and competency assessment.

The issue of competency assessment is particularly important in Japan because the current Japanese Mental Health and Welfare Law (MHWL) does not require the patient's incompetency for the purpose of involuntary treatment. The MHWL provides two involuntary admission systems—one for those mentally ill who are deemed to be a danger to themselves or others, and another for those mentally ill who need psychiatric treatment and care. There exists no formal method of competency assessment. Accordingly, an understanding of how medical and legal professionals and students view the issue of competency to give informed consent is essential for an understanding of the law and practice of Japanese psychiatry.

Methods

Eighty-two medical students, 75 law students, 182 mental health professionals, and 81 lawyers volunteered to participate in a survey by questionnaire. The medical students and law students were recruited from the Faculties of

Medicine and Law, Keio University, Tokyo. The mental health professionals were recruited by sending letters to 793 people randomly selected from the 7960 members of the Japanese Association of Psychiatry and Neurology. Among these 793 professionals, 1 was returned for a change of address while 248 agreed to participate in the study. Of these 248, 182 returned questionnaires. The lawyers were recruited by sending a letter to 464 people randomly selected from the 15,941 members of the Japanese Bar Association. Among the 464 lawyers, 2 were returned for changes of address while 99 agreed to participate in the study. Of these 99, 81 returned questionnaires. The questionnaires of three psychiatric professionals and two lawyers were later excluded from the analyses for being incomplete. The percentage of males was 73.2, 44.0, 88.1, and 86.8% among the medical students, law students, MHPs and lawyers, respectively. The mean (*SD*) ages were 20.7 (2.1), 24.1 (7.4), 45.9 (13.7), and 52.9 (10.9) years, respectively. The mean age differed significantly between the groups [$F(405, 3) = 193.6, p < .000$]. Post-hoc comparison by Scheffé's method showed that the lawyers were significantly older than the remaining three groups and the MHPs were older than the two student groups.

The questionnaire consisted of 15 questions designed to tap the capacity of a patient to give informed consent to electroconvulsive therapy (ECT) (Bean, Glancy, Nishisato, Rosatone, Rector, & Eastwood, 1992). The subjects were requested to rate the importance of each item on a 4-point scale (0 = cannot judge; 1 = not important; 2 = important; 3 = essential).

We performed a series of factor analyses (principle component solution) with varimax rotation among all the subjects combined and among subjects of each group separately. The number of factors was determined by the scree test (Cattell, 1966; Zwick & Velicer, 1982). Subscale scores were calculated by adding scores of question items with a factor loading of 0.5 or more on each factor. The mean scores of these subscales and each question were compared between the four groups by one-way analysis of variance (ANOVA). Post-hoc comparison of the means between the four groups was performed by using Scheffé's method. Because there were 4 subscales and 15 items to examine, we set the level of statistical significance at $p = .013 (.05/4)$ and $.003 (.05/15)$, respectively. For statistical analysis, the SPSS-X programme (SPSS Inc., 1986) was used.

Results

All the 15 question items of the questionnaire showed fairly wide deviation (Table 1) and none showed extremely high or extremely low base rates. Therefore, they were all entered into a factor analysis. Their eigen values were 26, 12, 9, and 7. Thereafter, eigen values showed less differences between them. Factor analysis revealed four factors (Table 1). The first factor was loaded by question items tapping the benefits and risks of ECT. It was also loaded by the outcome in the absence of the treatment. Thus, the first factor was interpreted as reflecting Understanding of the Treatment. The second factor was loaded by question items tapping the patient's insight into the illness and compliance with the treatment. The second factor was interpreted as reflecting Insight. The third factor was loaded by question items tapping the pa-

TABLE 1
Factor Analysis of Competency Questions Among All Subjects

Questions to tap patients' competency	Factors				Item mean (SD)
	I	II	III	IV	
Understanding of the treatment					
Are there any other available treatments for your illness that you know?	.82	-.02	-.00	.13	2.1 (0.9)
What are the harmful effects or risks associated with ECT?	.81	.01	.16	-.12	2.4 (0.9)
How could ECT benefit or help you?	.76	.09	.04	.12	2.2 (0.8)
What do you think will happen to you if you do not have ECT now?	.58	.28	-.02	.13	1.7 (0.9)
Why did you agree/refuse to have ECT?	.43	.23	.34	.13	2.2 (0.8)
Are you aware that you have been asked to make a decision regarding ECT?	.42	.41	.28	-.31	2.3 (0.8)
Insight					
Do you feel that you have an emotional problem or a psychiatric illness?	.18	.79	.07	.03	2.0 (0.9)
Do you feel that you need some kind of help or treatment?	.04	.75	.08	.20	2.1 (0.8)
Why do you think that the doctor feels that you should stay in hospital?	.08	.55	.07	.43	1.7 (0.9)
Autonomy and coercion					
Do you want to make your own decision to accept or refuse ECT?	.04	-.02	.70	-.10	2.1 (0.8)
Do you want someone else to decide for you?	-.02	.04	.66	.04	1.5 (0.8)
Do you feel that you have been pressured or coerced into making a decision?	.24	.26	.57	.16	2.0 (0.9)
Are you having trouble deciding whether or not to accept or refuse ECT?	.07	.02	.52	.49	1.8 (0.8)
Best interest and recovery					
Do you think that your doctor has your best interest in mind?	.28	.07	.19	.70	1.7 (0.9)
Do you want to get better?	-.03	.29	-.12	.61	1.7 (0.9)

ECT = electroconvulsive therapy.

tient's wish to decide on his/her own, lack of waiving of the decision, and lack of undue coercion. The third factor was interpreted as reflecting Autonomy and (Lack of) Coercion. The last factor was loaded by two items: the patient's perception that the attending physician had the patient's best interest in mind, and the patient's desire for recovery. Thus, this factor was interpreted as reflecting Best Interest and Recovery. The factor structures of these 15 questions were examined separately in the four subject groups and proved to be very similar (a table illustrating this is not shown here, but is available upon request to the first-names author).

When the four subscale scores were compared between the four groups, statistically significant differences emerged in the Insight and Best Interest and Recovery subscales (Table 2). Scheffé's post-hoc comparison showed that the

TABLE 2
Competency Question Subscale Scores by the Four Groups

	Subject groups				<i>p</i>	Differences
	MS (<i>n</i> = 82)	LS (<i>n</i> = 75)	MHP (<i>n</i> = 179)	LY (<i>n</i> = 79)		
Understanding of the treatment	8.1 (2.6)	8.4 (2.9)	8.6 (2.5)	8.2 (2.8)	NS	
Insight	4.9 (1.9)	5.5 (2.2)	6.3 (1.8)	5.3 (2.1)	<.000	MS, LS, LY < MHP
Autonomy and coercion	5.5 (1.6)	5.8 (2.0)	5.5 (1.8)	5.9 (1.5)	NS	
Best interest and recovery	3.0 (1.3)	3.6 (1.6)	3.7 (1.3)	3.0 (1.3)	<.000	MS, LY < MHP

MS = medical students; LS = law students; MHP = mental health professionals; LY = lawyers; NS = non-significant.

Standard deviations are in parentheses.

Insight score was higher in the MHPs than in the other three groups and that the Best Interest and Recovery score was higher in the MHPs than in the medical students and lawyers. In concordance with this finding, when the scores of individual items were compared among the four groups, it was found that the items “Do you feel that you have an emotional problem or a psychiatric illness?” ($p < .000$; medical student < mental health professional), “Why do you think that the doctor feels that you should stay in hospital?” ($p < .001$; medical student < mental health professional), and “Do you want to get better?” ($p < .000$; medical student, lawyer < mental health professional, law student) showed significant differences.

Discussion

The present study showed that the image of a psychiatric patient’s competence to give informed consent was multidimensional; factor analysis yielded four factors reflecting Understanding of the Treatment, Insight, Autonomy and Coercion, and Best Interest and Recovery. This means that both Japanese professionals and students tend to think of competency in terms of these four dimensions. The finding, in turn, suggests that these four dimensions of the image of competency are held in common by the Japanese population generally.

What are the implications of these results? For clinicians, the findings suggest that equal attention should be paid to all the aspects of competency when judging a patient’s capacity to give informed consent, particularly prior to involuntary admission. Otherwise, the assessment of competency may differ widely. For researchers, our study suggests that all the components of competency should be included when developing any new instrument to rate the competency of patients. We are currently developing an instrument of this kind to meet this requirement (Kitamura & Kitamura, 1993; Tomoda, Yasumiya, Sumiyama, Kitamura, & Kitamura, 1997). For lawyers, our results argue for a change in the paradigm of jurisprudence and theorization, from a homogeneous to a multifaceted view of competency. If competency is subdivided

into at least four parts, competency/incompetency should be assessed individually for each dimension. For legislators, future revisions of mental health laws should incorporate the multifaceted view of competency and, if possible, an explicit criterion of competency, using empirical data. These efforts should reduce any possibility of violating a patient's right of autonomy as well as a patient's right to be protected by due process in the case of involuntary care and treatment.

The second salient point of our findings is that Japanese MHPs laid more importance on the patient's insight into the condition and desire to recover. The importance laid on the other two dimensions of competency was similar between the four groups of subjects. This was in contradiction to our expectation that both MHPs and lawyers would put more importance on the patient's awareness of the necessity and content of treatment. The biases of medical and law students were expected to be located between those of the two professional groups, but were in fact closer to the viewpoint of the lawyers. This suggests that some patients (e.g., those with a good understanding of the contents of the proposed treatment but with less insight into their illness) may be judged as incompetent only by MHPs, but judged as competent by lawyers and students. Whether or not this would occur in a clinical situation should be empirically studied. In a companion paper (T. Kitamura et al., 1999), we will report a study in which case vignettes were presented to these subjects. The results of this companion paper are consistent with the above assumption that some patients are judged as incompetent only by MHPs, but judged as competent by lawyers and students.

Discrepancies in the importance assigned to different aspects of competency to give informed consent between MHPs and others raise a concern for several reasons. Firstly, there are two ways to consider competency—as a legal concept and as a clinical reality. Although, at least in theory, the question of whether or not a patient is competent should ultimately be decided in court, this is rarely the case in Japan (unlike some states in the U.S.). In reality, this matter is assessed by clinicians in everyday practice. Thus, the discrepancy between these two professions in terms of how they define competency might lead to serious difficulties. Secondly, psychiatry has always been a target of libertarians' criticism for its paternalistic intervention. The lack of ability of some patients to decide for themselves has been used as a theoretical basis to justify such coercion of treatment. If, however, MHPs have a substantially higher threshold of competency and, therefore, a wider definition of incompetency, as suggested by this study, an interdisciplinary debate on how to define competency in terms of conceptual frameworks and operational measurement should be initiated.

The emphasis placed by Japanese MHPs on a patient's insight and desire to get better may well be due to their graduate and postgraduate education geared at the "curing" of patients as well as to societal pressure to "protect" the public from danger caused by the mentally ill. However, MHPs in other countries are also likely to be in more-or-less the same situation. Therefore, a similar result might be obtained if this study were replicated in countries other than Japan. Cultural and social differences related to mental health services may be associated with differences in images of psychiatric patients' compe-

tency to give informed consent. The United Nations' Principles for the Protection of Persons with Mental Illness and for Improvement of Mental Health Care claims that competent mentally ill should have the right to refuse treatment. This notion should not be implemented differently in different countries. Therefore, differences in images (and hence operational definitions) of competency between countries might constitute a major threat to the civil rights of the mentally ill. An international comparative study may shed more light on this important issue in law and psychiatry.

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