Pergamon

International Journal of Law and Psychiatry, Vol. 22, No. 2, pp. 133–142, 1999

0160-2527/99 $–see front matter

PII S0160-2527(98)00038-7

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

II. A Case Vignette Study of Competency Judgements

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Introduction

No medical treatment or procedure should be initiated without the consent of the patient involved. However, consent can be regarded as valid only when given by a mentally sound individual. The term *mentally sound* can be regarded as equivalent to *competent.* If a patient is incompetent to give informed consent to a treatment, his/her decision will be substituted with that of a legally authorized proxy so as to protect the patient's best interest. Thus, it is the

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The present study was partly supported by a second 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 Drs. G. J. Bean and B. A. Martin for providing their 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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level of the patients competency that determines whether his/her autonomous decision can and should be accepted. Although the presumption of competence should generally stand, an attending physician should be cautious before concluding that the patient's consent is valid, because he/she may agree to whatever treatment (or no treatment) has been proposed, even though incompetent to do so. Treating the consent or refusal given by an incompetent patient as valid (and thus commencing or withdrawing a treatment) may violate his/her right to be protected through legal procedures (Marquett Law Review, 1990). However, treating the consent or refusal given by a competent patient as invalid (and again commencing or withdrawing a treatment) may violate his/her autonomous decision (e.g., Plotkin, 1978; Saks, 1991; Wolff, 1990). The British Medical Association and The Law Society (1995) have jointly stated:

> Doctors and lawyers have common responsibilities to ensure the protection of people who are incapable of deciding matters for themselves and to promote the choices of those who can and should regulate their own lives. (p. 1)

Although competency is a legal concept, it is usually the physician's "global" judgement that determines whether a patient is regarded as competent or incompetent. Although the current system has been criticized on the ground of courts' inadequacy to decide competency (Perlin, 1990), no empirical research has been initiated to address the concordance between psychiatrists' and lawyers' judgements of such competency. Lack of such concordance is problematic in that it may give the general public the impression that psychiatrists either force treatments on competent patients or neglect their duty to protect incompetent patients.

In the first part of this series of papers, we reported that (a) the image of psychiatric patients' competency to give informed consent held by Japanese mental health professionals (MHPs), lawyers, and medical and law students was multidimensional; and (b) Japanese MHPs laid significantly heavier emphasis on patients' Insight and Best Interest and Recovery. This led us to speculate that Japanese MHPs were more likely to judge incompetent those patients who would be judged as competent by lawyers and students. Because, in this study, participants were asked to rate the importance of 15 questions to tap patients' competency, the results may differ from the pattern of the subjects' assessment of competency in actual cases. Accordingly, in this study we report the results of a study in which the four groups of participants were asked to judge the competency/incompetency of each of several case vignettes of different degree of competency. In all the case vignettes, patients had been recommended for electroconvulsive therapy (ECT). ECT was used as an index not because we were interested in patients' competency to give informed consent specific to ECT, but rather for reason of the uncomplicated nature of the treatment. Although our interest was in the judgement of competency among the lay public, educational differences might have resulted in different patterns of assessment of competency, and we, therefore, chose medical and law students as participants. These students had not been exposed to psychiatric cases as a matter of professional responsibility, but were more likely to

show concern in such cases. Furthermore, the case vignettes used here might have been too difficult to assess for lay people with less interest in the subject or a poorer educational background.

The aims of the second study of this series were to examine in a case vignette study: (a) whether MHPs, lawyers, and students of medical and legal backgrounds would judge a psychiatric patient's competency differently; (b) whether there would be discernible patterns of competency judgement; and (c) what would determine a judgement of competency.

Methods

The participants in this study were the same as those in our first report (Kitamura et al., 1999). Eight members of the Japanese Association of Neurology and Psychiatry, five members of the Japanese Bar Association, and one law student returned the questionnaire with this part incomplete and were thus excluded from further analyses in this part.

The questionnaire contained five interview transcriptions (Bean, Nishisato, Rector, & Glancy, 1996) selected from a pool of Competency Interview Schedule (CIS; Bean, Nishisato, Rector, & Glancy, 1994) cases. Due to the lack of explicit definitions of competency/incompetency, it is likely that every case will be judged as either competent or incompetent, but some are in either category beyond substantial doubt. Such cases are likely to provoke no dispute in clinical settings. Therefore, using clinical expertise of this kind, Bean et al. (1996) classified the above cases into three categories: clearly competent, clearly incompetent, and marginal. In this study, Case A was judged clearly competent, Case B was clearly incompetent and the remaining three cases (Cases C, D, and E) were marginal. In every case, a patient had been recommended for ECT. Each vignette made clear that the patient had been informed of the benefits and risks of ECT, as well as possible alternative treatments. For each case, participants were requested to judge whether the patient: (a) had sufficient information about the risks, benefits, and alternatives to ECT to make an informed treatment decision; (b) had made his/her treatment decision based on rational reasoning; (c) had insight into the nature and severity of his/her illness; (d) appreciated the need for treatment and the consequences of not having it at that time; and (e) was competent to make a treatment decision regarding ECT. Finally, participants were asked to judge their confidence in the final assessment on a 7-point scale.

Participants were also asked to judge, using a 4-point scale, the importance of 15 questions tapping a patient's competence to consent to ECT (Bean et al., 1994). We performed a factor analysis on these 15 questions in our companion paper (Kitamura et al., 1999). After varimax rotation, four factors were extracted. The factors were interpreted as follows. The first factor reflected Understanding of the Treatment (e.g., "What are the harmful effects or risks associated with ECT?" and "Are there any other available treatments for your illness that you know of?"). The second factor reflected Insight (e.g., "Do you feel that you have an emotional problem or psychiatric illness?" and "Do you feel you need some kind of help or treatment?"). The third reflected Autonomy and Coercion (e.g., "Do you want to make your own decision to accept or

refuse ECT?" and "Do you want someone else to decide for you?"). The fourth factor reflected Best Interest and Recovery ("Do you think that your doctor has your best interest in mind?" and "Do you want to get better?"). Four composite variables were constructed by adding scores of the questions with factor loading of 0.5 or more on each factor. Statistical analyses were carried out using SPSS-X (SPSS Inc., 1986).

Results

Incompetency Judgement

As expected, the rates of incompetency judgement by the four participant groups were low (Table 1) for Case A, which was categorized as "clearly competent" by the research team of Bean et al. (1996). Case B, which was categorized as "clearly incompetent," was judged incompetent by most of the participants. Although the rates of incompetency judgement were very high among the four groups, the highest rate was that among the MHPs ($\chi^2 = 6.2$, $df = 3$, NS). For the remaining three case transcriptions, which were rated as "marginal" according to the classification of Bean et al. (1996), the rates of incompetency were between those of Case A and those of Case B. It is of note that the rates of incompetency judgement made by the MHPs were significantly higher than those by the student populations across these three cases (Case C, $\chi^2 = 11.5$, $df = 3$, $p < .01$; Case D, $\chi^2 = 11.5$, $df = 3$, $p < .01$; Case E, $\chi^2 = 14.2$, $df = 3$, $p <. 01$).

We then examined the rate of incompetency judgement of four subquestions tapping the components of competency of each case transcription. The level of statistical significance was set at $p = .0025$ [$.05/(4 \times 5)$] because there were four subquestions and five case vignettes. The rates of unfavorable assessment of patient competency (i.e., who answered "no") for the subquestion regarding appreciation of the need for treatment and the consequences of not having treatment in Case A were 63% among the medical students, 52% among the law students, 37% among the MHPs, and 55% among the lawyers ($\chi^2 = 18.8$, $p < .001$). The corresponding figures for the subquestion regarding

TABLE 1
Rates of Incompetence Judgement of Five Cases by Participants of Different Discipline

Bean, Nishisato, Rector, and Glancy's (1996) research team	Case A– Clearly competent (%)	Case B– Clearly incompetent (%)	Case C– Marginal (%)	Case D– Marginal (%)	Case E– Marginal (%)
Medical students ($n = 82$)	27	90	68	65	70
Law students ($n = 74$)	32	89	66	74	55
MHP ($n = 174$)	24	97	82	81	79
Lawyers ($n = 76$)	37	92	67	65	67

Note: Read, for example, that 27% of the medical students judged Case A as incompetent.
MHP = mental health professionals.

insight into the nature and severity of Case E were 71, 68, 91, and 79%, respectively (χ^2 =24.6, p <.0001). There were no differences between competency assessment for the other subquestions of the five case vignettes.

The mean numbers of cases judged as incompetent by the four participant groups were 3.20 (SD = 1.14), 3.18 (SD = 1.14), 3.26 (SD = 1.00), and 3.28 (SD = 1.08) for the medical students, law students, MHPs, and lawyers, respectively. There appeared significant differences [one-way analysis of variance (ANOVA), $F(3, 402) = 4.9, p < .01$)], and Scheffé's post-hoc comparison showed that the number of cases judged as incompetent was higher for the MHPs than for the medical and law students.

The judgement confidence of the four groups showed significance differences, and the MHPs always gave the highest scores (Table 2).

Patterns of Incompetency Judgement

Because we were interested in patterns of judgement of competency among the participants, we performed cluster analysis using judgements of competency/incompetency for the five case transcriptions to measure the "distance" between participants. The SPSS-X's QUICK CLUSTER was adopted; this command has an algorithm equivalent to McQueen's k-means clustering method, and the distances between cases are measured by the squared Euclidean distance (SPSS Inc., 1986). Interpretable results were obtained when the number of clusters was set at 4 (Table 3). Cluster 1 consisted of 242 participants who judged Case A competent but all the other cases incompetent. This cluster contained the majority of the participants, and was thus interpreted as the Standard cluster. Cluster 2 consisted of 65 participants who judged Cases D and E competent, but Cases A, B, and C incompetent. Because this result was quite opposite our expectation, this cluster was designated Questionable cluster. Cluster 3 consisted of 71 participants who judged all the five cases to be incompetent.

TABLE 2
Confidence in Judgement of Five Cases by Participants of Different Disciplines

Discipline	Case A	Case B	Case C	Case D	Case E
MS (n = 82)	3.7	4.2	3.8	3.5	3.5
	(1.2)	(1.2)	(1.2)	(1.1)	(1.3)
LS (n = 74)	4.0	4.4	3.9	3.9	3.4
	(1.0)	(1.4)	(1.3)	(1.3)	(1.3)
MHP (n = 174)	4.5	4.8	4.3	4.1	4.3
	(1.0)	(1.1)	(1.1)	(1.2)	(1.2)
LY (n = 76)	4.0	4.2	3.9	3.8	4.0
	(1.0)	(1.3)	(1.2)	(1.2)	(1.1)
Difference	<.0000	<.001	<.01	<.01	<.0000
	MS, LS, LY < MHP	MS, LY < MHP	MS < MHP	MS < MHP	MS, LS < MHP

LS = law students; LY = lawyers; MHP = mental health professionals; MS = medical students.

TABLE 3
Rates of Incompetency Judgement of Five Cases by Four Groups of Participants by Cluster Analysis

Clusters	Case A (%)	Case B (%)	Case C (%)	Case D (%)	Case E (%)
1 (n = 242)	0	98	74	84	79
2 (n = 65)	65	100	85	25	28
3 (n = 71)	100	97	83	100	99
4 (n = 28)	7	29	21	25	25

Note: Read, for example, that none of the participants belonging to Cluster 1 judged Case A as incompetent.

Cluster 4 consisted of 28 participants who judged all the five cases to be competent. Thus, Cluster 3 was deemed Conservative, Cluster 4, Liberal; and Clusters 1 and 2, intermediate.

Of the three participant groups, the MHPs seemed to be overrepresented among Cluster 1 and underrepresented among Cluster 4 ($\chi^2 = 18.7$, $df = 9$, $p = .05$). When pairs of clusters were compared separately, significant differences were observed between Clusters 1 and 2 [χ^2 (3) = 10.4, $p < .05$] and between Clusters 1 and 4 [χ^2 (3) = 8.5, $p < .05$].

More women were found more among Cluster 4, though this difference failed to reach statistical significance [χ^2 (3) = 7.17, $p = .67$]. The mean age was highest among Cluster 3 and lowest among Cluster 4, but again, these differences were not significant (Table 4).

Components of Competency

We then compared the four participant groups in terms of the rate of incompetency judgement for the four subquestions of the component of competency of the five case vignettes (Table not shown). Type I error was adjusted

TABLE 4
Characteristics of the Four Clusters

	Cluster 1 (%)	Cluster 2 (%)	Cluster 3 (%)	Cluster 4 (%)	p
Medical students (n = 82)	57	17	16	10	
Law students (n = 74)	54	20	14	12	
MHP (n = 174)	67	10	19	3	<.05
Lawyers (n = 76)	50	24	20	7	
Males (n = 308)	62	15	18	6	NS
Females (n = 94)	53	19	16	12	
Mean age—years (SD)	38.4 (16.8)	35.8 (15.5)	40.4 (17.4)	33.1 (15.2)	NS

Note: Read, for example, that 57% of medical students belonged to Cluster 1.
MHP = mental health professionals; NS = not significant.

by the Bonferroni method setting the alpha value at .0025 [0.05/(4 × 5)] because there were four subquestions for each of the five case vignettes. None of the 20 comparisons showed significant differences.

It is of interest that all the members of Cluster 1 judged Case A competent, but that 31% of cluster members considered that the patient had insufficient information about the risks, benefits, and alternatives to the treatment; 23% considered that the patient had not made his/her treatment decision based on rational reasons; 24% considered that the patient had no insight into the nature and severity of his/her illness; and 34% considered that the need for the treatment and the consequences of not having it. Since these findings were curious, we further inspected the response patterns of the participants in the four subquestions. It was observed that, for each case vignette, some participants in each of the four clusters denied the competency of the patient along all four subquestions, but nevertheless gave their judgement of the patient as "competent." In these cases, therefore, the participants did not reach their final judgement through the assessment of any of the competency components. The rates of this "incompetent-in-components-but-competent-as-a-whole" judgement was significantly different among Cases B, C, and E; it was highest among Cluster 4, but uniformly low among the other clusters (Table 5).

Importance of Competency Questions

Before being presented with the five case transcriptions, the participants were asked to judge the importance of 15 questions to tap the competency of a patient to give informed consent to a treatment. These questions were those used in the CIS. To examine whether the participants belonging to the four clusters had laid different emphasis on these questions, the scores of importance of the 15 questions and four composite variables were compared among the four clusters. Type I error was adjusted by the Bonferroni method; the alpha value was set at 0.003 (0.05 divided by 15) for the 15 questions and 0.013 (0.05/4) for the four composite variables. No significant differences were found between the four clusters.

TABLE 5
Rates of "Incompetent-in-Component-but-Competent-as-a-Whole" Judgement of Five Cases in the Four Clusters

	Cluster 1 (%) (n = 242)	Cluster 2 (%) (n = 65)	Cluster 3 (%) (n = 71)	Cluster 4 (%) (n = 28)	p
Case A	6	5	0	4	NS
Case B	1	0	1	29	<.000
Case C	3	3	3	7	<.01
Case D	3	3	0	7	NS
Case E	4	9	0	21	<.001

NS = not significant.

Discussion

This study showed that the rate of incompetency judgement differed between those individuals who were in psychiatric practice and the others. The first part of this series of papers showed that Japanese MHPs viewed patients' awareness of their illness and desire to get well as significantly more important than did lawyers and students. This is consistent with the present findings from the case vignette study, which showed that, although Japanese MHPs did not differ from the other groups of participants in their competency judgement in those cases that were either clearly competent or clearly incompetent, they did differ in cases where competency might be in a "gray zone."

Japanese psychiatric services have been sometimes criticized as overcoercive. The title of a popular Japanese paperback, *Japan: Archipelago of Detention* (Totsuka & Hirota, 1984) succinctly expresses the public fear of psychiatric asylums. If the present results can be replicated, it might be speculated that the public's criticism of psychiatric services is partly derived from a difference in assessment of patient competency. Although it should be emphasized that there is no empirical evidence that Japanese psychiatrists underestimate competency, the difference between the public's assessment of the competency/incompetency boundary and the same assessment by mental health professionals should be a matter of great concern. If there is a misunderstanding on the part of lay people of the level of competency of psychiatric patients, then this misunderstanding should be corrected through education of some type. But if this is not the case, then psychiatrists themselves should reconsider the definition of competency and its accurate assessment.

In the first part of this two-part series, we hypothesized that MHPs would view as important a patient's awareness of psychiatric illness (i.e., insight) and understanding of proposed treatment, whereas legal professionals would view as important a patient's autonomous determination and lack of undue pressure from others. Therefore, it was expected that MHPs would be more likely to judge cases as incompetent and that legal professionals would be more likely to judge cases as competent. Student assessment was expected to be located between those of the two professional groups. In actuality, MHPs judged more cases as incompetent, but Japanese lawyers were no more "liberal" than the medical and law students. This is again consistent with the results of Part I, which indicated that the lawyers laid no more importance on the autonomy and lack of coercion of patients than did the other three groups of participants.

The diversity of competency verdicts for the five case transcriptions was summarized by cluster analysis, revealing four patterns of competency verdicts. Cluster 1 consisted of those who judged the clearly competent case (Case A) competent, and the other four cases incompetent; this cluster contained the majority of the participants. Cluster 2 was difficult to interpret because those belonging to it judged both the clearly competent case (Case A) and the clearly incompetent case (Case B) to be incompetent, while they judged two of the three marginal cases to be competent. Cluster 3 members judged all the cases incompetent, and Cluster 4 members judged all the cases competent. These patterns may mean that in different people, competency judgement is reached through different pathways.

One such pathway may be through the occupational attributes of the participants. Thus, the MHPs were least likely to belong to Cluster 4, whose members judged all the cases competent. Neither gender nor age was associated with the pattern of clusters. Cluster 4 contained a substantial proportion of the individuals who rated incompetent all the components of competency, and yet finally decided to judge the case competent. These participants may maintain a theoretical belief that psychiatric patients should be treated as competent, irrespective of mental state, or they may use processes of judgement other than those we assumed. The finding that there was no difference among the four clusters in assessment of the importance of questions tapping the competency of a patient may favor the former hypothesis. This result was unexpected, because we thought that differences in importance placed on competency questions might explain, to some degree, the differences in the final judgement about the competency of the cases. For example, in Part I, we found four factors emerging from the 15 competency questions, and MHPs placed significantly more importance on the patient's insight and desire to recover. We, therefore, expected that these two factor scores would be positively associated with Cluster 3 and negatively associated with Cluster 4. However, this was not the case. Thus, at least among Japanese professionals and students, there appeared to be no obvious link between the importance of competency questions and components and the final judgement of cases. This may be consistent with the disagreement of competency judgement even among professionals.

Although legal and medical arguments thus far seem to regard competency/incompetency as dichotomous, recent commentators have emphasized its continuous nature. For example, Martin and Bean (1992) noted that the level of competency might vary along a continuum of the cognitive capacity of patients. Different cut-off points on the cognitive function may produce different verdicts of the patient's competency. This may also explain the differences among professions in judgement of competency.

Some limitations of this study should be noted. Firstly, this was a questionnaire study and the competency judgements rendered might be different than those given in actual interviews. Case transcriptions can convey only verbal information, whereas in interviews, the participants may be able to notice nonverbal signs of the competency of a patient, such as nodding, hesitation to answer, and eye contact. In such a setting, the participants would also be able to ask questions that they deemed appropriate.

Secondly, different probe questions may lead to different patient responses, and thus to different verdicts on patient competency. Researchers and clinicians have not yet agreed as to the set of probe questions needed to investigate different aspects of competency. Further studies should clarify the concept and elements of competency to give informed consent so that a standard interview guide can be developed.

In conclusion, the MHPs were most likely among all groups included in the study to judge psychiatric patients as incompetent. This may raise a concern as to the validity of the professional assessment of the competency of psychiatric patients to give informed consent. Given the notion that competency lies on a continuum, medical professionals, legal professionals, and the general public have not yet agreed on a cut-off point between competency and incompe-

tency. Idiosyncratic variations of this cut-off point may cause serious misunderstanding between different populations.

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