

Human Rights and Bioethics within Psychiatric Hospitals in Japan

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Abstract

Looking inside the walls of private psychiatric institutions in Japan, this paper explores bioethical concerns for autonomy in a high context culture, amongst people diagnosed with severe mental illness. The objective is to identify contextual components of control in Japanese clinical ethics that affect well-being, including the controversial extended use of bed restraints, and to recommend the need for future research and discussion of culture-specific values in accommodating respect for autonomy. This paper explores how and why these controlling factors need to be exposed, and considered, in any agenda focused on re-conceptualizing autonomy as a human right for people in psychiatric care. The paper sets out why these issues are issues of international human rights and seeks to open the dialogue through exploration of cultural, normative ethics of hospital conduct and psychiatric health care in situational context within Japan. Central to the paper is exploration of respect for autonomy and what this means for a population of people whose voice is seldom heard, always questioned, and who are vulnerable to being second-guessed and abused. This paper calls into focus the roles that sociocultural constructs, history, politics, and cultural values play in a health care system for people with psychosis and aims to contribute inquiry into a global social justice within a culture-bound domain of morals and ethics. In the conclusion and throughout this paper suggestions of careful and culturally sensitive international intervention are put forward as key strategies toward a humane solution for the serious human rights issue of respect for autonomy and agency on behalf of psychiatric patients in Japan.

Keywords: bioethics, culture-bound, human rights, psychiatric, medical anthropology

Introduction

On April 30th, 2017 a young man named Kelly from New Zealand was admitted to Yamato psychiatric hospital in Kanagawa prefecture, Japan. Following a manic outburst, he was restrained to a bed at the wrists, ankles and waist with large and heavy clamp machines for a period of ten days. On the tenth consecutive day of full body restraints, the man in his twenties passed away with an autopsy revealing he had almost certainly died of massive heart failure following deep vein thrombosis of his immobile legs (Takanaka, 2017). The practice of bed restraint in a small padded wall room (*zashiki-rou*) is common practice in Japan, and 30 days of restraint is not uncommon (Brown, 2017). Kelly's case brought to global attention the practice of full body restraint of the mentally ill in Japan and the glaringly absent reforms in favor of psychiatric patient's human rights. The United Nations Committee against Torture, reported in 2013 that solitary confinement, forced medication and use of bed restraints constitutes inhumane and degrading treatment, (United Nations, 2013) but these treatments still routinely and prolifically exist.

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The practice of bed restraints for patients considered dangerous either to themselves or others including hospital staff, has been in practice since the 17th century in Japan when the government ordained the mentally ill to be out of sight and restrained in private domestic cells of a relative's homes up until 1944 (Totsuka, 1990, Kanata, 2016, Ishikawa, 1990). Legend and folk traditions describe how older mentally ill people were abandoned in the mountains and left to die perpetuating the idea that mentally ill persons are shameful and a disgrace to their relatives and society (Totsuka, 1990, Kanata, 2016). The principle of social defense situates ethics with a priority on society as a large social unit (Matsumoto, 2003), even if this security comes at the cost of autonomy and unmitigated role loss for a disadvantaged minority. Kleinman discusses "social contributions to mental illness" (1988, p.56) and the influence social structure has on well-being. Autonomy, in its already diminished state for severely disabled persons may mean contextual interventions that promote better feelings of well-being and respect for personhood. Excessive control and extended use of bed restraints constitutes a disrespect for autonomy and is inhumane. Forced restraint is particularly concerning in mental illness because attributions of blame and punishment fall on an already damaged sense of self. For people with psychosis and severe mental disorders, positive images of self and identity may well be intrinsic to protection from severity and duration of disease remission. Psychosis features eddying disturbance of self, and people with psychosis are extra vulnerable to control abuse that might take away the small amount of agency they are able at any given time to retain. Sue Estroff in discussing chronicity in schizophrenia points out that people with psychosis and severe mental illness are judged "more offensive to moral convention regarding individual restraint and responsibility" (Lindenbaum & Lock, 1993, p.257). This moral convention is based on purity and contamination theory in eugenics (Ruger, 2006). "The Eugenics Protection Law was in operation in Japan between 1948 and up till as late as 1996" (Kanata, 2106, p.482). It still operates indiscriminately throughout psychiatric care in Japan as a silent principle undiscussed but culturally assumed. This assumption is perpetuated within the social construct of psychiatric care which the government selected for exclusive privatization in Japan in the 1960's and is accordingly run by business owners as a profit driven industry with limited supervision by the Ministry of Health (1966). As an age-hierarchy socially structured country Japan's institutions are managed exclusively by older men (and a few women) who grew up with the Eugenics Protection Law taught to them in school and pervasive through communal upbringing.

In the 1960's, the government encouraged use of de-populated land offering construction loans at very low interest for private ownership of mental health facilities out of town (Kanata, 2016). Today most private psychiatric institutions (80% of the total number of institutions) are located in the middle of the countryside with limited access via road and none via train. Typically, visitors can expect a bus to take one-and-a-half hours to arrive and will need to wait for a return bus to the nearest city, possibly with as few as one to three buses traveling to and from institutions daily. This is a concern because distance and inconvenience serve as considerable utilitarian barriers for loved ones wishing to visit, further isolating patients. Wards are locked 24 hours a day and patients cannot go outside in the fresh air. Wards typically have a bad smell, small barred windows, and old, tattered and uncomfortable wooden furniture with narrow iron beds. Access to telephones and other means of communicating with the outside world are severely restricted. Patients must hand in their phones to nurses on admittance and do not have them returned until they are discharged. "Day to day, says Dr Fujisawa, patients are totally controlled" (In the dark ages, 2001). Patients are not allowed personal belongings except one box of clothes. Every visitor entering a facility must have their bags and pockets checked much like a TSA check and without informed consent. There is no Wi-Fi or access to computers. A television stays on from 6am to 8pm in the living area and this is the only sound apart from the patient's voices and comings and goings of staff.

People who suffer from severe psychosis, are hospitalized via administrative proxy consent and routinely confined to their bed with restraints for observation for the first week. There is a process of levels to rehabilitation that are non-negotiable and apply to a wide variety of psychiatric disorders. Recently there has been a shift in some regions toward a more community style layered system of integration back to society on discharge, however, stigma of patients is so strong that patients will not be able to work again except with the handicapped status that permits lower wage pay than the legal minimum. This social infrastructure negates the third condition principle of non-control in Beauchamp and Childress' theory of autonomy (2013). It is a violation of human rights and an example of how structural violence manipulates the lives of marginalized people to keep them isolated and excluded.

The pattern of admission in private, rural, psychiatric hospitals in Japan occurs as follows: patients who have experienced level 3 relapse (or first episode psychosis) are taken to a psychiatric care unit where there are many procedures carried out, including electric shock treatment, full body restraint and 24-hour monitoring is in place. After a long period of evaluation and medication with the average length of stay of 300 days in a psychiatric institution (Kanata, 2016), and if the patient shows signs of improvement or remission, they are taken to unit 2 which is a slightly less restricted unit and patients can have visitors, immediate family members only. Following a period of time depending on improvement patients are then admitted to a much freer come and go "stress care unit" level where phones are allowed to be used between 9am and 5pm and next of kin can visit between these hours too. During this observation period of 3 regulated levels patients are continually being monitored and may return to level 3. At level 1 (stress care) patients gain back some autonomy and are introduced to a social worker who takes their case on and arranges for hospital release. Release however is no promise of return to self-governance with strict rules in place for a lifetime for any person socially tainted with a history of psychiatric institutionalization.

This institutionalization of psychiatric care is embedded in both cultural values and socio-economic norms. Empty beds (early discharge) means less economic revenue. De-institutionalization or reform toward a less hospitalized structure and earlier discharge for patients is complicated because more than 80% of Japan's psychiatric hospitals are privately

owned and run, rendering government interventions ineffective. Priority of economic growth over respect for self-governance and personhood takes precedence. This dynamic goes largely unquestioned because autonomy is constructed in a cultural setting prioritizing group consensus that duly gives respect and power to authority in dictating degrees of independence. Kleinman calls this social suffering of people with psychosis “moral death” and “social exclusion” begging for inquiry into what ground zero for mental health means and the “appalling ways in which people with psychosis are treated almost all over the world” (Kleinman, 2012, p.120).

In 1958 (Kanata, 2016) the Japanese government introduced *seishinka-tokurei* a law allowing psychiatric hospitals to operate legally with a much lower ratio of trained medical care workers than general hospitals. This created potential for employment of staff with little experience of working with patients suffering from psychosis and severe mental illness. There have been many cases of severe abuse including fatalities, and over 20,000 patients in private psychiatric hospitals a year die in care (Kanata, 2016). In 1984 an incident occurred in a psychiatric unit in Utsunomiya where two patients were beaten to death by hospital workers (Koboyashi, 1993). Investigation by the Asahi Shinbun newspaper further uncovered 222 suspicious fatalities at the same hospital.

In a high context country, a blink of an eye, a slight graze of touch in passing, or getting up and leaving the room can be powerful signals expressing disagreement or approval. This nuanced cultural norm is pertinent to care of people with psychosis because through illness of the mind, the ability is lost to decipher boundaries or to tread extra gently, to express subtly and to be understood with indirect communication. In severe mental illness linguistic cues within Japanese culture that foster social acceptance and inclusion are deactivated, eroding feelings of belonging. Communication is severely disturbed. This linguistic context is another feature of psychosis that determines isolation culturally and embeds marginalization as culture bound. A person who cannot read, perform and master the non-confrontational and confusionist traits of nonverbal linguistic cues is a person who does not fit well into social contexts in Japan. While emphasis is on harmony and subtlety in communication norms, peace, harmony and social order are paramount in society at large. Private psychiatric units have direct connections with the Japanese police, allowing private information to be released in cases where a patient may be implicated. Cases of forced confession in Japan have posed serious ethical concern (Onishi, 2007) and this is especially worrisome among vulnerable mind-disordered populations. Totsuka (1990) in his summary of mental health law in Japan, writes that Japan has no concept of voluntary hospitalization or rights with respect for autonomy for mentally ill patients and that Japan “has always considered that all mentally ill people are incompetent” (p.199) relegating decision making in entirety to authority. Many laws of informed consent are overridden in psychiatric care. Not only does the complete abdication of self-governance occur as soon as a patient enters the hospital but also the stamp of irrevocable loss of rights on a broad social scale as admission to a psychiatric unit negates the possibility of ever working a normal wage hour again. Patients with a psychiatric history are issued with a mental disability certificate and are thereafter ineligible to be paid minimum working wage per hour and instead must be paid the much lower “disabled” rate of around \$2-\$3. These are social issues of structural violence that the government needs to address to enable dignity and respect for autonomy and role in society. A “culturally informed bioethics examines the field itself, questioning bioethics’ actions in relation to broad social institutions” (Marshall & Koenig, 2004, p. 254). It is here we must begin.

Conclusion

The Japanese government has a responsibility to protect the vulnerable and reduce social suffering amongst people with mental illnesses. The international community has a responsibility to examine human rights within fragile and marginalized groups around the world. Protection begins by unpacking and defining the contributors that go towards oppression and excessive control of individual agency and autonomy. The world must see what is hidden in the countryside of rural Japan. Change begins with dismantling smaller and larger components of life for patients in psychiatric hospitals that impede well-being; the ubiquitous use of bed restraints, the appalling wages for any person holding an ‘impaired mental health’ card, the denial of personal telephone usage in psychiatric wards, and the denial of personal belongings that dehumanizes a bed area that may be a long term home for the patient, are to mention a basic few. Global social justice demands the system of privatization of psychiatric hospitals in Japan to be opened internationally for scrutiny. I believe that only with intervention from outside of the country, free from the binds of Japanese tight cultural contexts and rigid culturally fixed ethical codes, will change be successfully ordained for people with psychosis and severe mental illness here in Japan. Further research and an updated discussion of ethics with implementation of revised ethical laws is imperative for a group of people whose voices and lives are seldom seen or heard.

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References

- Beauchamp, T. L., & Childress, J. F. (2013). Autonomy. *Principles of biomedical ethics* (7th ed., pp. 99–148). New York: Oxford University Press.
- Ishikawa, N. (1990). People who suffer from mental illness. Tokyo: Iwanami shinsho press (in Japanese).
- In the dark ages. (2001, November 22). Hospitals for the mentally ill badly need to reform. *Economist*. Retrieved from <https://www.economist.com/asia/2001/11/22/in-the-dark-ages>
- Kanata, T. (2016). Japanese mental health care in historical context: why did Japan become a country with so many psychiatric care beds? *Social Work/Maatskaplike Werk* (eds.) 52(4), 471–489. <https://doi.org/10.15270/52-4-526>
- Kleinman, A. (1988). Rethinking psychiatry: from cultural category to personal experience. The Free Press. New York.
- Kleinman, A. (2012). Medical anthropology at the intersections: Histories, activisms, and futures. In M. Horn & E. Wentzell (eds.) *Chapter 5: Five questions for the next fifty years*, pp.116–128. Duke University Press. Durham and London.
- Koboyashi, N. (1993). Toddling advocacy in Japan. In J. Mandiberg (Ed.), *Innovations in Japanese mental health service*. San Fransisco: Jossey-Bass Publishers. CA.
- Lindenbaum, S., & Lock, M. (1993). Knowledge, power, and practice: The anthropology of medicine and everyday life. Berkeley and Los Angeles, CA. University of California Press.
- Marshall, P. & Koenig, B. (2004). Accounting for culture in a globalized bioethics: *Journal of Law, Medicine and Ethics*, 32(2), 25–266. <https://doi.org/10.1111/j.1748-720X.2004.tb00472.x>
- Matsumoto, S. (2003). The historical background of social hospitalization and the viewpoints of psychiatric social workers. *Japanese Journal of Psychiatric Social Work*, 34(1), 11–15 (in Japanese).
- Ministry of Health. (1966). *Mental Hygiene of our country*. Tokyo: Ministry of Health (in Japanese).
- Onishi, N. (2007). Pressed by police, even innocent confess in Japan. New York Times. Retrieved 2018.09.28: <https://www.nytimes.com/2007/05/11/world/asia/11japan.html>
- Ruger, J. P. (2006). Ethics and governance of global health inequalities. *Journal of Epidemiology & Community Health*, 60, 998–1003. <https://doi.org/0.1136/jech.2005.041947>
- Takanaka, K. (2017). New Zealander’s death puts mental patients’ restraint in Japan under spotlight. Reuters news. Retrieved from <https://www.reuters.com/article/us-japan-newzealand-death-idUSKBN1A41JV>
- Totsuka, E. (1990). The history of Japanese psychiatry and the rights of mental patients. *Psychiatric bulletin*, 14(4), 193-200. <https://doi.org/10.1192/pb.14.4.193>
- United Nations (2013) UN Committee against torture convention. Retrieved from https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&clang=_en

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