表1　遺伝学的検査に関するガイドライン〔Ⅱ遺伝学的検査の実施より抜粋〕

3. 遺伝学的検査を実施する場合には，事前に担当医師が被検者から当該遺伝学的検査に関するインフォームド・コンセントを得なければならない．
（1）インフォームド・コンセントを得るための説明に際しては，検査の目的，方法，予想される検査結果，内容(想定される被検者の利益・不利益を含む)，精度(特に不可避な診断限界)，被検者のとり得る選択肢，実施にあたっての医療上の危険性などについての正確な情報を，遺漏なく，かつ被検者が十分に理解できるよう，わかりやすく説明しなければならない．説明は口頭に加えて，文書を用いて行わなければならない．
（2）遺伝学的検査を受けるか否かは，それを受ける者の自由意思に基づいて決定されなければならない．担当医師は，説明に当たって，被検者は検査を受けないという選択が可能であること，検査を受けても，途中で中止を申し出ることができること，検査後その情報開示を拒否することもできること，検査を受けないか又は中止を申し出ても，それによる不利益を被ることはないことを説明しなければならない．但し，その場合には遺伝学的検査の結果が得られないことによる医療上の不利益があり得ることについても正確に伝えられなければならない．医療者は被検者の決定を尊重し，それに沿って最善の医療が受けられるよう努力しなければならない．
（3）未成年者など，自由意思に基づいて決定を行うことが困難な場合には，本人に代わって検査の実施を承諾することのできる地位にある者の代諾を得なければならない．この場合，できる限り被検者本人の理解を得るために努力し，代諾の必要性についての判断は慎重になされるべきである．代諾は，親権者，後見人，成年後見人などの代諾者により行われ，代諾者は被検者の将来にわたる利益を最大限に保護するよう努めなければならない．
（4）インフォームド・コンセントを得る際の説明にあたって，遺伝についての基礎的事項を説明する中で，遺伝学的情報が血縁者間で一部共有されていることに言及し，得られた個人の遺伝学的情報が血縁者のために有用である可能性があるときは，積極的に血縁者への開示を行うべきであることについて，被検者の理解を得るよう，担当医師は努力しなければならない．

表2　遺伝学的検査に関するガイドライン

Ⅳ．遺伝学的検査と遺伝カウンセリング
1. 遺伝学的検査は，十分な遺伝カウンセリングを行った後に実施する．
2. 遺伝カウンセリングは，十分な遺伝医学的知識・経験をもち，遺伝カウンセリングに習熟した臨床遺伝専門医などにより被検者の心理状態をつねに把握しながら行われるべきである．遺伝カウンセリング担当者は，必要に応じて，精神科医，臨床心理専門職，遺伝看護師，ソーシャルワーカーなどの協力を求め，チームで行うことが望ましい．
3. 遺伝カウンセリング担当者はできる限り，正確で最新の関連情報を被検者に提供するように努めなければならない．これには疾患の頻度，自然歴，再発率(遺伝的予後)，さらに保因者検査，出生前検査，発症前検査，易罹患性検査などの遺伝学的検査の意味についての情報が含まれる．遺伝カウンセリング担当者は，遺伝性疾患が，同一疾患であっても，その遺伝子変異，臨床像，予後，治療効果などにおいて異質性に富むことが多いことについて，十分留意しなければならない．
4. 遺伝カウンセリング担当者は被検者が理解できる平易な言葉を用い，被検者が十分理解していることをつねに確認しながら遺伝カウンセリングを進めるべきである．被検者の依頼がある場合，又はその必要があると判断される場合は，被検者以外の人物の同席を考慮する．
5. 遺伝カウンセリングの内容は，一般診療録とは別の遺伝カウンセリング記録簿に記載し，一定期間保存する．
6. 被検者が望んだ場合，被検者が自由意思で決定できるように，遺伝カウンセリングは継続して行われなければならない．また必要に応じて，臨床心理的，社会的支援を含めた，医療・福祉面での対応について，情報が与えられるべきである．
7. 遺伝学的診断結果が，担当医師によって，被検者の血縁者にも開示されるような場合には，臨床遺伝専門医の紹介など，その血縁者が遺伝カウンセリングを受けられるように配慮する．
8. 遺伝カウンセリングは，遺伝学的検査の実施後も，必要に応じて行われるべきである．

（一部省略）

行為である．同ガイドラインにおける遺伝カウンセリング関する記載を表2に示す．

遺伝カウンセリングは遺伝医学的知識と経験をもった臨床遺伝専門医(日本人類遺伝学会と日本遺伝カウンセリング学会による「臨床遺伝専門医制度」により認定される)などによって行われ，必要に応じて精神科医，臨床心理専門職，遺伝看護師，ソーシャルワーカーなどとチームで対応することが求められている．遺伝学的検査は十分な遺伝カウンセリングを行った後に実施される．

遺伝学的検査の実施にあたって，担当医師は事前に検査に関するインフォームド・コンセントを得なければならない．インフォームド・コンセントで重要なことは，正確な情報を提示し，被検者

が自分自身の状況を理解したうえで納得して同意することである．担当医師は遺伝学的検査の精度・感度，検査を受けたときと受けなかったときに予想される状況をわかりやすく説明する必要がある．また検査を受けるかどうかは任意であること，検査を受けても途中で中止できること，検査を受けないまたは途中で中止しても不利益はないこと，検査後に意思が変わったときは結果を開示しないという選択も可能であることなどを正確に伝えなければならない．

おわりに

ガイドラインとは共通認識を持つための考え方の土台のようなものである．1つひとつのガイドラインは大変重要で，遺伝学的検査を行うものは熟知する必要がある．しかし，目の前の被検者は問題点も，重要と考える点もそれぞれ違っている．ガイドラインに従っていたらよいのではなく，ガイドラインを念頭に置いて，個々の被検者や血縁者・家族に合わせた対応が必要である．

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An analysis of patient rights violations in psychiatric hospitals in Japan after the enactment of the Mental Health Act of 1987

(Patient rights violations in psychiatric hospitals.)

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Abstract

The Mental Health Act in Japan was enacted in 1987. This study aims to determine whether the act has been effective in protecting patient rights by delineating the content and trends of patient rights violations at psychiatric hospitals through an analysis of newspaper reports. An analysis of 924 newspaper articles found 39 hospitals involved in patient rights violations. The results shows that violations of patient rights have continued to occur after the implementation of the Act, because of the for-profit policy of hospitals, a defective oversight system, and a lack of knowledge about the Act by medical staff.

The Mental Health Act in Japan was enacted in 1987 for the improvement of patient rights, as the previous acts had proven ineffective at preventing violations of patient rights. This study aims to determine whether the Mental Health Act has been effective in protecting patient rights by delineating the content and trends of patient rights violations at psychiatric hospitals through an analysis of newspaper reports. Findings will be used in the development of a system for preventing patient rights violations.

Background of the Mental Health Act

According to the textbook of Japanese psychiatric nursing (Toguchi, 2001), it is stated that prior to World War II, Japan had few psychiatric hospitals leaving many psychiatric patients confined to their homes. After WWII, the establishment of additional public psychiatric hospitals failed to occur. As a result, the laws were revised in 1954 stipulating that the establishment of private psychiatric hospitals would be subsidized by the state. Thereafter the number of psychiatric hospitals, including for-profit hospitals, rapidly increased. Nearly all patients were hospitalized involuntarily or forcibly in those days. Only five percent of inpatients were hospitalized voluntarily as of 1983 (Seishin hoken fukushi kenkyukai, 2004).

Utsunomiya Hospital was widely publicized for misconduct in 1984. Two patients hospitalized there were killed as a result of physical abuse inflicted by the nursing staff (The Asahi, 1984a). The hospital was extremely understaffed, where only two medical doctors including the hospital director treated approximately 950 inpatients (The Asahi, 1984a). The results of a formal investigation found that violence was common practice among the hospital staff, and that the hospital director had previously beaten several patients with a golf club (The Asahi, 1984b). Unqualified patients at times performed electroencephalograms and electrocardiograms on other patients (The Asahi,

1984c). Far from being only a domestic issue, this incident drew harsh criticism from the International Commission of Jurists and the International Commission of Health Professionals. This international criticism later led to legislative revisions and ultimately the enactment of the new Mental Health Act (The Act) in 1987 (Mino, Kodera, Bebbington, 1990).

Features of the Act and Characteristics of Japanese Psychiatry

The Act aimed to ensure appropriate psychiatric treatment protecting patient rights, and promote deinstitutionalization. For those purposes, centering on voluntary hospitalization, The Act required that patients be notified of their freedom to leave the hospital, freedom of communication, and their right to informed treatment in writing. Procedures of involuntary admission, which include protective hospitalization and compulsory hospitalization, were strictly regulated, but were/are not required to be legally reviewed. Regulations concerning social rehabilitation facilities were also newly enacted. Seclusion and restraint were to be administered only with the judgment of designated psychiatrists. In addition, the Psychiatric Review Board (PRB) was established to review the propriety of involuntary hospitalization, and to check whether the hospital may have violated patient rights when an inpatient complained about his/her treatment. Subsequently, the supervision of psychiatric hospitals has been enforced through a number of legal revisions and notifications. The most notable revisions were one ensuring the welfare of people with mental disorders in 1995, and another granting the PRB the right to perform onsite inspections of hospitals aimed at protecting admitted patients from human rights violations in 2000 (Hayama, 2004).

There are several unique characteristics of psychiatry in Japan due to its historical background. No less than 90.0% (n=1073) of psychiatric hospitals in

Japan are private with public hospitals accounting for a mere 10.0% of the total (Ministry of Health, Labor and Welfare in Japan [MHLW], 2005a). This, combined with a lack of social rehabilitation facilities in Japan, has resulted in an inefficient system and a remarkably high percentage of the population in psychiatric beds (Hayama, 2004); approximately 3.7 times that of US and approximately 4.9 times that of Great Britain (WHO, 2005). The Japanese system also tends to subject psychiatric patients to extremely long hospitalizations. More than 20% of in-patients are admitted for 6 months or longer, with the average length of stay for patients discharged after hospitalization for schizophrenia, schizotypal, or delusional disorders (ICD-10, F20-F29) being 609.5 days (MHLW, 2005b), this compares to three or four weeks in UK, or approximately 40 days in Finland (Hayama, 2004).

METHOD

Data Collection

Newspaper articles detailing patient rights abuses were used, as such incidents were significantly noteworthy as to break free of the "closed door" society which continues to exist in Japanese psychiatric hospitals, and enter the public spotlight. Only the newspaper articles, which met at least one of the following criteria, were used as data: (1) Patients rights violations were actually proven by audit, or government surveillance (not only nation but also prefecture), or human rights organizations. (2) Some staff of the hospital was/were arrested by police. (3) The hospital admitted having violated patient rights. The "newspaper and magazine article cross-search" internet search engine (Asahi Net, 2006) was used to search one news agency, four national newspapers, five national web news sites, and six local newspapers, which are known as reliable news sources in Japan. We excluded sports journals and tabloids. The keywords used for searching were "psychiatric hospital,"

"fraud," "illegal," "human rights violation," "assault + patient," "improvement order," and "suspicious death + patient." We searched for target articles of 19 years ranging from 1987, when the Act came into effect, to 2005, obtaining 924 articles. Two reports involving two hospitals were omitted, because the incident occurred prior to 1987. If the details of a particular incident were unclear, we used the name of that hospital as a keyword to further investigate for relevant articles.

Method of Analysis

We conducted a content analysis of newspaper articles according to the following criteria: (a) violation type, (b) mode of detection, (c) private or public hospital, and (d) hospital location.

A qualitative and inductive content analysis was taken assessing the substance of the incident, and the mode of detection. The first author examined reported articles and divided them into 14 violation categories, and six categories of detection method. The other authors then reviewed the categories to ensure their validity. An incident could consist of single or multiple categories of violation types.

The year of the report was recorded as the year in which each hospital was reported for its first violation. Administrative structures of hospital were categorized as either public or private, and hospital locations were categorized according to prefecture.

CONTINUING PATIENT RIGHTS VIOLATIONS

Violations of patient rights continued to occur on a widespread basis after the implementation of The Act. Thirty-nine hospitals were revealed to have violated The Act or other regulations for 19 years examined (see Table 1). The number of violation types per hospital ranged from 1-12. Of these hospitals,

28 were punished by the government, including 10 cases in which hospitals had their designation as an insured medical institution revoked. Hospital directors and nursing staff were arrested in eight cases.

Procedures regulated by The Act to protect patient rights were violated in many cases. Seven hospitals participated in the use of *illegal admission procedures*, such as forced hospitalization without examination by a psychiatrist, and forced hospitalization by putting a patient to sleep with an unexpected injection. Next, violations involving freedom of communication, that is *isolation from the outside world* occurred in 10 hospitals. Such violations consisted of preventing patients from making contact with the outside world, infringing upon patients' rights by not allowing patients to make telephone calls, censoring letters, not allowing voluntarily admitted patients to go outside, or preventing patients from meeting with their families and/or lawyers. Fifteen hospitals were involved in *illegal seclusion and restraint*, which included restraining or secluding patients without an examination by a designated psychiatrist. One such case involved tying a patient in a day room for ten years (The Yomiuri, 2002a). The patient had to do everything including sleeping, eating, and egesting into a portable latrine there, and was referred to as "Pochi", a common dog's name in Japan, by other patients (The Yomiuri, 2002a).

Some hospitals, almost all of which were private broke other laws, such as penal code laws, in addition to The Act. First, there were eight instances of physical *assault* by nurses and/or assistant nurses. Examples included punching, kicking, striking with a golf club, beating a patient's head against a wall, shooting a patient with an air gun, and hosing a naked patient with water in winter. Three patients died as a result of such assaults, the most recent of which occurred in 2002 (The Yomiuri, 2002b). Second, *uncompensated labor* cases, in which patients were forced to work with extremely little or no

compensation, occurred in seven hospitals. This category included various instances where patients cleaned rooms, and changed other patients' diapers, as well as cases where patients were sent to work under contracts that the hospital had made with outside companies, all for little or no money. Third, three hospitals were involved in *medical care by unqualified staff*. Such incidents included medical practices such as examinations being performed by nurses instead of qualified doctors, administration of intravenous drips by nursing assistants, and the issuance of death certificates by nurses (The Yomiuri, 1997a, 1998a).

Even if no violation of the law was involved in itself, some instances presented serious ethical problems: *unethical care*. Eight hospitals were involved in such cases, which often resulted in patient deaths. Examples included Yamatogawa Hospital where medical staff were not responding during emergencies, neglecting severe side-effects of treatment, withholding examinations, or prescribing the same medicine to all patients without examinations. This category also included cases of forcing patients who voice complaints to take large quantities of antipsychotic drugs (The Yomiuri, 1998a). Another case was that of Asakura Hospital, where three patients had cancer surgery performed in hospital rooms while other patients were present (The Asahi, 2000a), and the administering of intravenous hyperalimentation (IVH) on patients with appetites who could orally ingest food (The Asahi, 2000b). These hospitals had their medical institute insurance certifications revoked, and as a result had no choice but to close their doors, were not punished for these "medical procedures." These problems question the medical insurance system in Japan, where a greater application of medical practices such as medication, surgery, and so on generates increased medical fees for the hospital.

The hospitals involved in large scale scandals were reported not only in

newspapers but also in medical journals. After the Yamatogawa Hospital scandal was revealed, the state and local governments were blamed for neglecting their responsibility to supervise the hospital, and what should have been done to rectify the situation was outlined in several articles (Satomi, 1999, Nagasawa, 1999). But little was learned from the experience. Government negligence was also cited as a possible cause in the Asakura Hospital scandal (Kobayashi, 2004). In addition, the relationship between doctors and nurses in Japan, where nurses implicitly follow doctor's orders, was cited as one of the reasons why medically unnecessary IVH was administered to many patients (Ishii, 2001). Because of these practices nurses selected patients who should be administered IVH, and placed them in seven point restraints under doctors' direction. Although a much higher number of patients died in Asakura hospital than at other similar hospitals (The Asahi, 2000b), with the cause suspected of being as a result of infection of IVH or surgery, legal accusations were never brought. In Japan, as doctors have wide ranging discretionary powers, only doctors can decide what "medical procedures" should be administered to whom.

Takagi (1986) examined cases that had occurred before the Utsunomiya Hospital Incident in 1984 in academic journals, and showed 54 psychiatric hospitals had been involved in scandal during the 20-year period from 1965 to 1984. The incidents were nearly identical to those of this study, including illegal admission procedures, uncompensated labor, and other similar cases. The frequency of incidents, 54 in the 20 years before and 39 in 19 the years after the implementation of The Act, seems to have decreased. But the former contains seven cases of labor dispute, two cases of assault by patients, one case of multiple deaths resulting from a fire, and so on. So the frequency has largely remained the same. Yet, after the enactment of The Act, the number of hospitals reported for violations increased drastically from six hospitals in the

nine-year period before The Act was amended in July, 1995, to 33 hospitals in the 10-year period after The Act was revised. Although the PRB was granted the right to perform onsite inspections of hospitals in April, 2000, the number of reported incidents has remained roughly the same since then. Twenty-one hospitals were reported in the 13-year period prior 2000 April, and 18 hospitals were reported in the 6-year period to follow (see Figure 1).

VIOLATIONS AND PROFIT SEEKING

Violations such as *fraudulent claims for medical expenses*, *overstatement of staff*, *swindling money from patients*, *overcapacity*, or *unnecessary hospitalization* appear to have been motivated by hospitals seeking to increase profits by illegal or improper means. These deceptions necessitated the *falsifications of or inadequacy in medical records*. Fraudulent claims for medical expenses involved 20 hospitals, where patients were charged for treatments or examinations that were not performed, psychotherapy that consisted merely of visiting with the patient, and other similar expenses. Overstatement of staff occurred in 15 hospitals, where the number of physicians and/or nurses was overstated either to meet the minimum standards, or to increase claims for nursing expenses. In one case, 70% of the physicians and 90% of the nurses which were claimed to be on staff were non-existent, and as a result patients were poorly cared for (The Yomiuri, 1997b). There were eight hospitals convicted of swindling money from patients. Examples included diverting and misappropriating patients' funds, or not returning money entrusted to the hospital by the patients, illegally collecting fees as an "assistance fee" or "bathing fee," and forcing patients to purchase daily necessities from companies affiliated with the hospital at inflated prices. There were four hospitals found to have been overcapacity, where the number of patients hospitalized exceeded the capacity of the hospital or the ward.

Unnecessary hospitalization occurred in seven hospitals. Such incidents included the forced hospitalization of patients at the behest of the family, and not permitting voluntarily admitted patients to be discharged despite the patients' wish to leave. This category included one report which documented 12 patients being unnecessarily and involuntarily hospitalized, the longest of which was hospitalized for 31 years. (The Yomiuri, 2000a).

In situations where hospitals maintained inadequate numbers of medical staff in order to increase profits, other patient rights violations such as illegal seclusion and restraint, uncompensated labor, or unethical care were far more likely to occur. Even assault is said to have resulted from situations where extremely few staff have had to manage large numbers of patients (Takagi, 1986). Three hospitals involved in large scale scandal, two of which were described above, were all private, and all incidents in which patients were assaulted or killed occurred in private for-profit hospitals. This indicates that violations of this type are more likely to occur at private hospitals motivated by a desire to increase profits. This is also true in other countries. In the US a scandal involving psychiatric hospitals under the control of the large hospital chain National Medical Enterprises was uncovered in 1993 (Mohr, 1994). In this incident, former patients and their families witnessed various forms of wrongdoing such as excessive medication, questionable and potentially abusive therapies, exorbitant charges, isolation of patients from their families, falsifying diagnoses to match insurance benefits, and the unnecessary hospitalization of patients (Mohr, 1996).

Conversely, violations such as illegal seclusion and restraint are more likely to occur at public hospitals. Public hospitals accounted for 10.3% of total violations, which is almost same the percentage of public hospitals out of total psychiatric hospitals in Japan. Though the percentage of unethical care, falsification of or inadequacy in medical records and overcapacity at public

hospitals were also high, these violations were not caused by profit seeking, but by inadequate care related seclusion and restraint. In Saigata Hospital, a national psychiatric hospital, a female patient under restraint choked to death on her vomitus (The Yomiuri, 1998b). The fact was revealed that patients were often restrained without adequate prerequisites such as medical examinations, and properly recorded orders of restraint (The Yomiuri, 1998b). This incident was of interest among psychiatric staff in Japan, and discussed in a symposium held by the society of Japanese Hospital and Community Psychiatry, where the fact that many psychiatric patients were often restrained with four-points for more than several hours or days (Kato, 1999). After this incident nurses both at public and private hospitals began to conform to the procedures of The Act, but they emphasize "procedures" such as recording having restrained patients, and not reducing the use of restraint (Yoshihama, 2001). Better laws are necessary to protect patient rights, but it is more important to put into practice the idea and principles of the law, than to conform to the procedure of the law.

DEFECTIVE OVERSIGHT SYSTEM

Though The Act has mechanisms to protect patient rights, and prevent wrongdoing, they seem to be functioning ineffectively. First, the PRB has been established in each prefecture to assure quality of care, but hospitals reported for violations were unequally located in this study. There are 47 prefectures in Japan. Fukuoka Prefecture, whose population is less than half of Tokyo, was exceptional in its high number of incidents with a total of eight hospitals (20.5%) reported, no hospitals were reported in 24 other prefectures. Three hospitals were reported in two prefectures, two in five prefectures including Tokyo, and one in 15 others.

To examine the regional variability of the PRB for psychiatric hospitals,

we examined the population of each prefecture in 2004 (MHLW, 2005c) and the number of patients under protective hospitalization in each prefecture in 2004 (MHLW, 2004). We found that one prefecture had the fewest at 80.8 and another had the most at 239.8 patients per 100,000 people, which shows a threefold difference. Likewise, when examining the number of compulsorily hospitalized patients (MHLW, 2004) per 100,000 people, we found a substantial difference of approximately 70 times, ranging from 0.1 to 6.9 between the prefectures of least and most prevalence. Regional differences in the incidence of severely ill patients of this magnitude are extremely unlikely. These differences suggest that a discrepancy exists in the criteria for determining which involuntary hospitalizations are necessary or no longer necessary. This regional variation also suggests that there are discrepancies in the modality of administrative inspections of the PRB.

The PRB has the right not only to inspect and examine the propriety of involuntary hospitalization, but also has the right to review patients' requests for improved treatment and discharge. Despite these rights, a recent study (Yamazaki et al., 2004) indicates that reviews conducted by the PRB are inadequate, since the PRB conducts a documentary examination of a maximum of 675 cases per meeting, with an average of 156.8 per meeting. One reason why the PRB cannot frequently hold review meetings is that present members of the PRB include attorneys and physicians who are busy with their own work. It is therefore necessary for the board to make membership full time, and open membership to more nurses who know a great deal about the workings of psychiatric hospitals. In addition, Yamazaki et al. (2004) also stated there were only 1,347 requests for discharge out of approximately 100,000 patients who were involuntarily hospitalized in 2000. Given that fewer requests for discharge were from hospitals with limited medical staff, these findings suggest that such a limited number of requests is

not due to patients' satisfaction, but rather because patients' voices are not reaching the outside world. This highlights the present lack of an effective system to protect patient rights related to psychiatric care in Japan.

Second, there were only seven instances (17.9%) detected by governmental investigation or audit. These cases were found to be clearly against law, such as false or overstated claims for medical expenses, overstatement of staff, and swindling money from patients. This is due to governmental investigators reviewing various documents including medical records, attendance records and time cards, not actual hospital conditions. Yet, quite often in Japan, periodic government audits are performed only after hospitals have been notified of the time and day of the audit. This is done so that hospitals have time to prepare reports and other documents to ensure that the audit proceeds smoothly; however, it is possible that some hospitals use this opportunity to prepare their records in a way that does not expose any improprieties on their part. In fact, six hospitals (15.4%) including three hospitals involved in nationwide scandals were uncovered as a result of internal accusations. Overall, administrative investigations and audits contribute little to disclose cases of large-scale patient rights violations uncovered through internal accusations. It is therefore necessary to revise the way audits are performed by not giving hospitals prior notification.

Our findings were based on newspaper reports and thus may not necessarily indicate that the number of hospitals violating patient rights has actually increased. The increase in the number of hospitals reported may reflect an increase in public interest, or may show the fact that violations and irregularities have become more easily revealed since 1987, but we can also surmise that the reported hospitals are only a small fraction of the current state, as actual cases transpire behind the closed doors of psychiatric hospitals.

CONCLUSION

It can be clearly seen from the results of this study that violations of patient rights have continued to occur after the implementation of The Act. These violations occurred due to hospitals seeking profits, defects in the oversight system, and a lack of knowledge about the Act by medical staff.

To provide patient-centered psychiatric care in Japan that can respect the dignity of patients, Japanese professionals first need to improve the hospital surveillance system, disseminate the revised acts related to psychiatric care, and enhance the system by which patients can live in their communities. Nurses working in the field of psychiatry also need to be acutely aware of their role in defending the patient rights.

AFTERWORD

A patient hospitalized in a private psychiatric hospital in Japan was kicked to death by a male nurse in November, 2007. Psychiatric hospitals in Japan have changed. Many of them were rebuilt, wards which were dark, dirty, and packed with many patients have become cleaner, and offer more space to patients. But changes in the psychiatric system, and greater nurse awareness of patients are truly needed.

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