

ORIGINAL ARTICLE

Clinical ethics problems in psychiatry and the need for clinical ethics consultation in Japan: A cross-sectional study

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Abstract

Aim: Psychiatrists often encounter ethical dilemmas in their daily clinical practice. Clinical ethics consultations (CECs) have been recently increasing, especially in general hospitals. However, the current situation in the psychiatric field is unclear. This study clarifies clinical ethics problems in psychiatry and determines the need for CECs.

Methods: We conducted an anonymous self-administered questionnaire survey in February 2022, which targeted directors and supervisors of psychiatric specialty training programs at 1224 psychiatry facilities.

Results: Responses were received from 311 facilities (response rate: 25.4%). CEC systems existed in 223 (72.2%) facilities, and medical safety committees were the most common. Clinical ethics problems occurred at 248 (80.3%) facilities; the most common method for managing the problems was discussions at case conferences without using CECs. The top four reasons for psychiatrists to solicit advice were conflicts with patients' relatives, treating a patient with cognitive impairment, discontinuation of treatment, and suicide/attempted suicide. Most respondents (89.9%) considered CECs necessary.

Conclusion: Although CECs exist in psychiatry, they may not meet the needs of clients. Future studies are needed to investigate client satisfaction and CEC evaluation methods in facilities where psychiatric CECs are provided.

KEYWORDS

clinical ethics consultations, ethical challenges, ethics support, psychiatry, quantitative research

INTRODUCTION

Clinical ethics consultation (CEC) is a service provided by an individual or a group to help patients, families, surrogates, healthcare providers, or other involved parties address uncertainty or conflict regarding value-laden issues that emerge in healthcare.¹ CECs can be based on a committee, individual, or team model.^{2,3}

In psychiatry, CECs focus on various issues, including compulsory hospitalization, dementia, living donors for transplantation, assisted reproductive technology, genetic counseling, and palliative care.⁴

Cross-departmental collaboration is often required. Unlike other departments, psychiatry sometimes requires treatment against a patient's wishes; hence, a hospital advisory lawyer or medical safety management department may be involved. Although psychiatrists often encounter various ethical dilemmas in their daily clinical practice, only a few studies have focused on such dilemmas faced by them and the current situation of CECs (e.g., studies from Germany and other Western countries).⁵⁻⁹

Regarding clinical ethics problems addressed by psychiatric CECs, a German study identified the following three types of ethical issues for

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which psychiatrists consult ethical support services: dyadic problems based on the relationship between patients and professionals, triangular problems involving and influenced by a third party, and intersystem problems.⁵ In a 3-year survey of ethics consultations at the University of Basel in Switzerland, the most common request was related to coercion.⁶ Coercion is frequent in psychiatric clinical practice, and psychiatrists must balance the patient's best interests with patient autonomy. A survey in northern Germany revealed that 92% of acute psychiatric hospitals and 29% of forensic psychiatric hospitals have ethics consultation services. However, 85% of medical institutions noted that they only handled 0–5 cases per year, and ethical issues were discussed through external ethics consultations.⁷ In Switzerland, 59% of hospitals have ethics consultation services, and 69% of these services are provided by clinical ethics committees.⁸ Ethics consultations develop slower in psychiatry compared with other departments.⁹

Understanding the current situations of CECs in psychiatry is essential owing to the field's unique ethical issues. In particular, Japan has more psychiatric care beds per 1000 inhabitants compared with other Organization for Economic Cooperation and Development countries.¹⁰ This study is the first in Japan to clarify the current clinical ethics issues and CECs in psychiatry; in addition, the study discusses the need for CECs.

METHODS

Questionnaire survey

All facilities participating in psychiatric specialty training programs in Japan were targeted by this survey ($n = 1234$). Each psychiatry specialty training program has one core facility and several affiliated facilities that participate in the training program. In February 2022, an anonymous self-administered postal questionnaire survey was sent to the program directors of 230 core facilities and program supervisors of 1004 affiliated facilities. The 230 training programs were listed on the website of the Japanese Society of Psychiatry and Neurology.¹¹ The questionnaire was created after referring to previous studies^{6,12–19} and modified according to expert opinions provided by three psychiatrists with over 15 years of clinical experience, including the above program directors. Two types of return envelopes were used to distinguish between core and affiliated facilities.

In addition to facility and respondent demographics, the questionnaire asked whether the facility had a system for CECs, and if so, what specific organizations were in the facilities. The items were derived from a survey conducted among all resident-teaching hospitals in Japan¹⁶ and a study that referred to medical teams involving psychiatrists.²⁰ Next, respondents were asked about their experiences with clinical ethics problems, whether they had experienced any ethics problems, and if so, the number of clinical ethics cases per year, how they handled them, and the issues for which the respondents would like to receive advice. The items were obtained from a survey conducted among resident-teaching hospitals¹⁶ with the addition of the organizations where CEC is conducted at the facility of the

respondent in the previous question. The issues for which they solicited advice referred to issues from a survey conducted in all psychiatric hospitals in Germany.¹³ Respondents were also asked whether they collaborated with other facilities, whether they had a clinical ethics education program, and whether they needed CECs. If there was a need, they were asked about the reasons for the need; the reasons were obtained from a previous study.¹⁶ Finally, the respondents were asked about their most preferred CEC system.

Clinical ethics issues were defined as broadly related to ethics, such as dilemmas arising from diverse values in social support and not limited to medical care. CEC was defined as a service provided by an individual or a group to help patients, families, surrogates, healthcare providers, or other involved parties address uncertainty or conflict regarding value-laden issues that emerge in healthcare.¹

Analysis methods

First, a simple tabulation was conducted separately for the core and affiliated facilities, including facility and respondent characteristics, systems for providing CEC, experience with clinical ethics problems, number of ethics problems experienced per year, methods of managing ethics problems, issues necessitating advice, consultation with other facilities, education programs for clinical ethics, and the need for CECs. One facility responded that it had 215 full-time psychiatrists. We believe that no hospital in Japan has 215 psychiatrists; in fact, upon searching the Hospital Intelligence Agency website for a hospital with this or a higher number of psychiatrists,²¹ no hospital was found. Therefore, we excluded the response of the number of full-time psychiatrists at this facility from the analysis.

Next, a comparison was made between the core and affiliated facilities to understand differences in managing clinical ethics issues. Comparisons were performed using Fisher's exact tests with Bonferroni correction for multiple testing.

Finally, a multiple logistic regression analysis was conducted using facility attributes, CECs, experience of clinical ethics problems, consultation with other facilities, and education program for clinical ethics as explanatory variables and the need for CEC as the objective variable.

All analyses were performed using SPSS Version 28 (IBM Corp., Armonk, NY, USA). A value of $p < 0.05$ was considered statistically significant. This study was approved by the Research Ethics Committee of the Faculty of Medicine of the University of Tokyo (review No. 2021302NI).

RESULTS

Response rate

Of the 1234 letters sent, 311 facilities responded (response rate: 25.4%) and 10 letters were returned as undeliverable. The respondents included 80 core facilities (response rate: 34.8%) and 231 affiliated facilities (response rate: 23.2%).



TABLE 1 Characteristics of respondents and facilities (n = 311).

	Core facilities n (%)	Affiliated facilities n (%)	Total n (%)
Sex			
Male	74 (93.7)	192 (83.5)	266 (86.1)
Female	5 (6.3)	38 (16.5)	43 (13.9)
Age (years)			
<40	2 (2.5)	11 (4.8)	13 (4.2)
40–49	25 (31.3)	62 (26.8)	87 (28.0)
50–59	33 (41.3)	96 (41.6)	129 (41.5)
60–69	18 (22.5)	54 (23.4)	72 (23.2)
>70	2 (2.5)	8 (3.5)	10 (3.2)
Years of clinical experience			
<20	11 (13.9)	35 (15.2)	46 (14.8)
20–29	36 (45.6)	107 (46.3)	143 (46.1)
30–39	28 (35.4)	72 (31.2)	100 (32.3)
>40	4 (5.1)	17 (7.4)	21 (6.8)
Workplace			
University hospital	38 (47.5)	5 (2.2)	43 (13.8)
General hospital	17 (21.3)	91 (39.4)	108 (34.7)
Psychiatric hospital	25 (31.1)	102 (44.2)	127 (40.8)
Clinic	0 (0.0)	18 (7.8)	18 (5.8)
Others	0 (0.0)	15 (6.5)	15 (4.8)
Number of beds (mean)			
	144 (0–780)	133 (0–785)	136 (0–785)
Number of full-time psychiatrists (mean)			
	14.1 (4–34)	5.1 (1–20)	7.4 (1–34)
Clinical ethics consultation			
Yes	74 (92.5)	149 (65.1)	223 (72.2)
No	6 (7.5)	80 (34.9)	86 (27.8)
Experience of ethical problem			
Yes	73 (91.3)	175 (76.4)	248 (80.3)
No	7 (8.8)	54 (23.6)	61 (19.7)
Number of cases per 1 year (mean)			
	5.5 (0–50)	3.7 (0–100)	4.2 (0–100)
Education program for clinical ethics			
Yes	39 (53.4)	66 (30.1)	105 (36.0)
No	34 (46.6)	153 (69.9)	187 (64.0)

TABLE 1 (Continued)

	Core facilities n (%)	Affiliated facilities n (%)	Total n (%)
Consultation with other facilities			
Yes	27 (34.2)	65 (28.8)	92 (30.2)
No	52 (65.8)	161 (71.2)	213 (69.8)
Clinical ethics consultation is necessary			
Yes	78 (97.5)	199 (87.3)	277 (89.9)
No	2 (2.5)	29 (12.7)	31 (10.1)

Note: Number of beds, number of psychiatrists, and number of the cases per 1 year are presented as a mean (range); other items are shown as number (%). The total number may not always match the number of study participants, as there were missing responses for some items. One affiliated facility that had 215 full-time psychiatrists was excluded from the analysis of mean number of full-time psychiatrists.

Simple tabulation

Table 1 shows the characteristics of the respondents and their facilities separately for the core and affiliated facilities. The largest age group was 50–59 years (41.5%), and 86.1% respondents were male. The workplaces included 43 (13.8%) university hospitals, 108 (34.7%) general hospitals, 127 (40.8%) psychiatric hospitals, 18 (5.8%) clinics, and 15 (4.8%) others, including six mental health welfare centers. The average number of beds per facility was 136, and the average number of full-time psychiatrists was 7.4. More than half of all facilities (64.0%) and 34 (46.6%) core facilities did not have clinical ethics education programs. In terms of consultations with other facilities, 92 (30.2%) facilities sought external consultations; of those, 58 (63.0%) consulted with lawyers, 39 (42.4%) consulted with government agencies, and two (2.2%) consulted with third-party independent CECs.

Systems for CECs

CEC systems existed in 223 (72.2%) facilities, including 74 (92.5%) core facilities and 149 (65.1%) affiliated facilities. The CECs included 173 (77.6%) medical safety management committees, 139 (62.3%) research ethics committees, 126 (56.5%) clinical ethics committees, and 28 (12.6%) CEC teams (Table 2).

Experience with a clinical ethics problem

Clinical ethics problems were encountered by 248 (80.3%) facilities, with an average of 4.2 problems per year. Table 3 shows how ethical issues were managed. The most common method was “discussed at a case

conference” in 153 (61.7%) facilities, followed by “judgment by a physician at the supervisory level like a department head” in 117 (47.2%) facilities. Significantly more respondents from core facilities stated that “discussed at a medical committee meeting” and “consulted with the organization you chose in the previous question” were used to manage ethical issues compared to respondents from affiliated facilities.

When respondents who had experienced ethical problems were asked if they would like to seek advice, 230 (92.7%) of them answered yes. The top four common issues for which respondents wanted advice were “conflicts with patients’ relatives,” “dealing with cognitively challenged patients,” “treatment discontinuation,” and “suicide and attempted suicide” (Table 4).

Need for CEC

Regarding the need for CECs, 277 (89.9%) respondents answered that CECs were necessary. The top four reasons provided were

TABLE 2 Systems for clinical ethics consultations (multiple responses) ($n = 223$).

	<i>n</i>	(%)
Medical safety management committee	173	(77.6)
Research ethics committee	139	(62.3)
Clinical ethics committee	126	(56.5)
Palliative care team	90	(40.4)
Patient consultation center	76	(34.1)
Dementia care team	73	(32.7)
Abuse prevention committee	69	(30.9)
Psychiatric liaison team	60	(26.9)
Clinical ethics consultation team	28	(12.6)
Others	17	(7.6)

TABLE 3 Methods to manage clinical ethics issues (multiple responses) ($n = 248$).

	Total <i>n</i> (%)	Facilities		Fisher's exact test
		Core facilities <i>n</i> (%)	Affiliated facilities <i>n</i> (%)	
Entrusting the problem to the attending physician	97 (39.1)	20 (27.4)	77 (44.0)	NS
Judgment by a physician in the supervisory level, like the department head	117 (47.2)	33 (45.2)	84 (48.0)	NS
Decided by the head of the facility	99 (39.9)	22 (30.1)	77 (44.0)	NS
Discussed at a medical committee meeting	110 (44.4)	44 (60.3)	66 (37.7)	**
Discussed at a case conference	153 (61.7)	53 (72.6)	100 (57.1)	NS
Discussed at the facility executive committee meeting	89 (35.9)	25 (34.2)	64 (36.6)	NS
Consulted with the organization you chose in the previous question	87 (35.1)	37 (50.7)	50 (28.6)	**
Others	16 (6.5)	6 (8.2)	10 (5.7)	-

Note: Comparisons of each item between the core facilities and the affiliated facilities were performed using Fisher's exact test. A Bonferroni correction was applied to adjust for multiple comparisons (NS: $p \geq 0.05$).

** $p < 0.01$. Bold represents statistical significance.

as follows: “to objectively analyze the problem and sort out the issues by a third party,” “to prevent medical lawsuits,” “to coordinate communication between physicians and patients/families,” and “to reduce distrust of medical care” (Table 5). Multiple logistic regression analysis was performed with the need for CEC as the objective variable and facility attributes, CECs, clinical ethics problems, consultation with other facilities, and education program for clinical ethics as explanatory variables. The results revealed significant associations between the need for CEC and facility category and experience of clinical ethics problems (Table 6). For reference, the simple logistic regression analysis results are presented in the appendix (Supporting Information: Table A).

DISCUSSION

Current situation of CECs

According to the results of this study, 72.2% of facilities participating in psychiatric specialty training programs in Japan had a system for CECs (92.5% core facilities). The medical safety management committee responded most frequently, followed by the ethics committees. CEC teams were less common. In the US, a survey showed that 86.3% of general hospitals had an ethics consultation service (ECS).²² In Switzerland, 59% of general and psychiatric hospitals had an ECS, and 69% of these ECSs were clinical ethics committees.⁸ In Germany, ethics counseling was available in 57% of psychiatric hospitals in one study²³ and in 88% psychiatric hospitals in another German psychiatric hospital survey.⁷ In a survey of hospitals accredited by the Japan Council for Quality Health Care, 83.5% of hospitals had ethics committees.²⁴ Although the percentages of CECs in prior studies varied, the results of this survey are within the range of the percentages in these studies.

TABLE 4 Issues needing advice (multiple responses) (*n* = 230).

	<i>n</i>	(%)
Conflicts with patients' relatives	118	(51.3)
Dealing with cognitively challenged patients	95	(41.3)
Treatment discontinuation	93	(40.4)
Suicide and attempted suicide	74	(32.2)
Conflicts between patients and staff	73	(31.7)
Physical restraint	70	(30.4)
Coercive medication	68	(29.6)
Indication for surgery	56	(24.3)
Confidentiality	53	(23.0)
Conflicting values within team	50	(21.7)
Artificial nutrition	47	(20.4)
Seclusion	46	(20.0)
Data protection	35	(15.2)
Conflicts between staff	33	(14.3)
Diagnostic assessment	30	(13.0)
Risk assessment	28	(12.2)
Emergencies	23	(10.0)
Economic interests	21	(9.1)
Research with patients and their data	17	(7.4)
Intercultural issues	14	(6.1)
Lawful and professional behavior	13	(5.7)
Advance directives	10	(4.3)
Wish-fulfilling medicine	10	(4.3)
Pregnancy discontinuation	9	(3.9)
Others	23	(10.0)

TABLE 5 Reasons for requiring clinical ethics consultation (multiple responses) (*n* = 277).

	<i>n</i>	(%)
To objectively analyze the problem and sort out the issues by a third party	210	(75.8)
To prevent medical lawsuits	178	(62.8)
To coordinate communication between physicians and patients/families	122	(44.0)
To reduce distrust of medical care	118	(42.6)
To take moral responsibility together	83	(30.0)
To assure that our (physicians') judgment is correct	78	(28.2)
To avoid conflicts of opinion between physicians and non-physician healthcare providers	65	(23.5)
Others	16	(5.8)

TABLE 6 Factors related to the need for clinical ethics consultation (multiple logistic regression analysis).

	OR	95% CI	<i>p</i> value
Facilities [Ref: Affiliated facilities]			
Core facilities	40.987	1.336-1257.256	0.034
Workplace [Ref: University hospital]			
General hospital	9.620	0.680-136.023	0.094
Psychiatric hospital	1.169	0.067-20.436	0.915
Clinic	1.158	0.076-17.694	0.916
Number of beds	1.005	0.998-1.012	0.132
Number of full-time psychiatrists	0.882	0.760-1.023	0.097
Clinical ethics consultation [Ref: No]			
Yes	2.664	0.862-8.233	0.089
Experience of clinical ethics problems [Ref: No]			
Yes	7.880	2.970-20.905	<0.001
Consultation with other facilities [Ref: No]			
Yes	1.660	0.426-6.469	0.465
Education program for clinical ethics [Ref: No]			
Yes	0.602	0.163-2.223	0.446

Note: 261 who provided responses to all items were included in this analysis. Bold represents statistical significance.

Abbreviations: CI, confidence interval; OR, odds ratio.

The fact that medical safety management committees are the most widely used as CEC system is a characteristic feature of Japan. A survey of medical and legal professionals found that 63.1% of hospitals designated for clinical training and 54.9% of medical institutions with 200 or fewer beds had medical safety divisions in Japan²⁵ because Japanese Medical Care Law requires that measures be taken to ensure medical safety at facilities. Benefits in hospital evaluations and medical fees are associated with medical safety measures. Furthermore, many hospitals have established palliative care teams, dementia care teams, and psychiatric liaison teams because of the "team addition" in medical fees. However, CEC teams are not yet subject to such addition, which may be one of the reasons for the low number of CEC teams.

Managing ethical issues

Of the facilities that responded to this survey, 80.3% experienced clinical ethics problems. Ethical issues were commonly managed using case conferences. Although the use of CECs was significantly

higher at core facilities than at affiliated facilities, overall, 35.1% (50.7% at core facilities) of facilities used CECs. In other words, although CEC systems are in place, they are not fully utilized as a solution to ethical problems. Similarly, some studies have highlighted the low number of CECs in psychiatry despite the high number of ethical problems^{3,9} and the need for quality improvement even though CECs are already in place.^{7,23}

The lack of CEC use may be attributable to client needs that are not met owing to psychiatrist and CEC resource shortages. Reasons on the part of psychiatrists include underestimation of ethical issues,⁹ skeptical views of CECs and lack of willingness to actively collaborate,⁷ and psychiatrists' high communication and professional problem-solving skills.^{3,9} Psychiatrists sometimes interview patients/families who are challenging to deal with and learn how to deal with them over time. Therefore, when ethical issues arise, they tend to underestimate problems and try to solve them themselves.

CEC resource shortages include structural shortages, such as CEC operating funds and full-time clinical ethicists.^{3,9,26} Much of the ethics consultation work is voluntary and a collateral duty at many facilities; therefore, the availability of trained consultants is limited.²⁷ In addition, the service quality may not be up to standard to meet the client needs. In this survey, "conflicts with patients' relatives" was the most common reason for seeking advice. Japan has a hospitalization system based on family consent called "hospitalization for medical care and protection." Unlike in Western countries where individualism prevails, family intentions influence treatment in Japan. Therefore, psychiatric and legal assessments are more important than physical medicine. The psychiatrist may want a CEC to communicate with the patient's family or perform ethical analysis, but the quality of CECs is unsuitable to fulfill that desire.

Clinical ethics education

Of all facilities in the study, 60.1% did not have a clinical ethics education program (46.6% core facilities did not have one), whereas 83.0% of facilities considered an education program to be necessary. The Code of Ethics for Psychiatrists of the Japanese Society of Psychiatry and Neurology states that "psychiatrists shall cooperate with other specialists, as well as the public in general, in providing psychiatric treatment and comprehensive support that give priority to the best interests of individuals with mental illness."²⁸ The Society's training program for psychiatric specialists also describes "medical ethics" as a method wherein "residents should inspect their conduct and discuss it with their specialty training supervisors by observing the clinical attitudes of the supervisors."²⁹ Currently, guidelines dictate that physicians should be educated in research ethics, but there is no standard regarding education in clinical ethics.

Clinical ethics education is important in psychiatry because psychiatry has more ethical problems than other departments, including involuntary hospitalization.^{12,18} In a survey of ethics and professionalism curricula for US child and adolescent psychiatry residency programs, reading seminars and lectures were the most

common teaching formats.³⁰ The present study also indicated the need to create a systematic clinical ethics education program in Japan. Furthermore, Japanese psychiatric professionals may not realize that the problems they experience are ethical issues. What is not named (e.g., attention deficit hyperactivity disorder) becomes easier to understand when grouped and given a name. Ethical issues that have been considered problems in case conferences may become easier to understand and solve when clinicians are aware that they are ethical issues. These problems can be easily solved using an ethics consultation approach and by comparing and contrasting values.

External ethics consultation

In terms of consultation with other facilities, 92 (30.2%) of facilities had the experience of external consultation, of which 58 (63.0%) consulted with lawyers, 39 (42.4%) consulted with government agencies, and two (2.2%) consulted with third-party independent CECs. These results suggest that psychiatrists in clinical practice are concerned about the legal aspects of ethical issues. The advantages of consulting with outside organizations include access to lawyers or government agencies in highly specialized and technical cases. However, the use of external independent CECs was rarely observed. Establishing a highly specialized CEC is difficult for psychiatric hospitals given the limited human resources; appointing an external CEC is effective in this regard. Using external ethics consultation may also lower costs. In a Swiss study, the authors presumed that small rural hospitals opted for external ethics consultations due to the cost-effectiveness.⁸ In Germany, 74% of acute psychiatric hospitals in North Rhine-Westphalia are supervised by an external agency,⁷ and out-of-hospital ethics consultation services are increasing with the organization of a web-based public registry of healthcare ethics services.⁸ Considering the large number of psychiatric hospitals in Japan, out-of-hospital ethics consultation services may be more effective than establishing an in-house CEC, especially for smaller hospitals.

Need for CECs

Regarding the need for CECs, psychiatrists at 277 (89.9%) institutions stated that CECs were necessary. Fox et al. have suggested that legitimate alternatives to ethics consultation in the US are more realistic and better serve the needs of small, non-teaching, and rural hospitals.³¹ In Japan²⁵ and Germany,^{7,13} different clinical ethics support systems have been established depending on the characteristics and size of the medical institutions. In other words, all patients, families, and healthcare providers should have access to CEC services, even if CEC methods vary according to the size and type of hospital. However, establishing the same standard of CECs in all hospitals is not economically feasible.

Based on the results of the multivariate logistic regression analysis, the need for CECs was higher at core facilities and facilities

with more ethics problems. Thus, enhancing CEC services at core facilities and creating a system whereby collaborating hospitals can consult with CEC services at core hospitals would be meaningful. However, setting up a CEC is insufficient; the CECs should be functional. The results of this study show that the major reasons for needing CECs were “to objectively analyze the problem and sort out the issues,” “to prevent medical lawsuits,” and “to coordinate communication between physicians and patients/families.” Coordinating communication between physicians and patients/families was a top-ranked issue. Issues such as “conflict with patients’ relatives” require professional advice but may not be handled by an existing CEC. A proper CEC can convey the knowledge and application of professional standards and ethical principles in specific clinical cases and provide the communication and interpersonal skills needed to successfully implement them.²⁷

There are three models of CECs,^{1,2} namely, committee, individual, and team, to support “coordinating communication between physicians and patients/families.” In this survey, CEC was most frequently provided by medical safety management committees and ethics committees.

One disadvantage of medical safety committees dealing with ethical issues is that they tend to be law-oriented and focused on not causing problems.³² This causes physicians to refrain from advanced medical intervention.^{33,34} In terms of the four principles of medical ethics (respect for autonomy, nonmaleficence, beneficence, and justice),³⁵ nonmaleficence tends to be more valued than beneficence. When considering the best interests of the patient, the ethical aspects should be taken into account during discussion rather than the legal aspects.

Sometimes, such committees can be viewed as authoritative, which may lead to hesitancy among psychiatrists in approaching them for ethics consultation.³ In this study, “coordinating communication between physicians and patients/families” was one of the needs for which CECs are required. The operational method of committees is too formal and sometimes bureaucratic,^{3,36} which is not considered effective for improving communication. Conversely, mobility is a characteristic of ethics consultation in the team model.^{3,36} The mobility provided by the team model enhances the quality of communication between the physician and the patient/family. For example, in the team model, individuals can visit the site of medical care and attend the meeting together. Therefore, the team model is more likely to meet the psychiatrists’ needs.

For an ideal CEC to be realized, the lack of resources must be addressed. Structural shortages include funding for CEC operations and a lack of full-time clinical ethicists.^{3,9,26} Hopefully, CEC teams will be included in hospital evaluations and medical fees to educate and recruit personnel.

Finally, only a few studies in Europe and the United States have focused on CECs in psychiatry. This study provides a broad perspective on the current situation in Japan. In the future, investigations into client satisfaction and CEC evaluation methods at facilities where psychiatric CEC services are available are needed. Furthermore, qualitative research, such as semi-structured interviews with physicians who have clinical ethics problems, is needed.

Limitations

There are several limitations to this study. First, the response rate was 25.4%. The respondents were likely to be more interested in clinical ethics issues than the nonrespondents. Thus, CEC retention rates and the number of clinical ethics issues may have been overestimated. This limitation is also consistent with the fact that the response rates for core and affiliated facilities were 34.8% and 23.2%, respectively, and affiliated facilities had lower CEC retention rates and fewer clinical ethics issues than core facilities. Second, the differences in ethical issues based on the type of hospitalization are unknown because we did not inquire about the type of hospitalization that each facility has, such as mandatory hospitalization. Third, the responses to some questions, such as the question about the number of clinical ethics problems per year, were obtained by recalling past experiences, which may have introduced recall bias. Fourth, the survey was only conducted with physicians, so patients’ needs for CECs are unknown.

CONCLUSIONS

We identified clinical ethics issues that psychiatrists face in Japan and the current situation of CECs at psychiatric specialty training facilities. Most personnel in charge of psychiatric specialty training programs believed that CECs and clinical ethics education were necessary. Although there have been previous studies in Europe and the United States, we believe that understanding the current situation in a different culture is important. The results of this study contribute to the establishment of CECs and the development of clinical ethics education in psychiatric specialty training programs, which will lead to a reduction in ethical dilemmas for psychiatrists.

AUTHOR CONTRIBUTIONS

Hiroyuki Sato designed, collected, and analyzed the data, and wrote the first draft of the manuscript. Yoshiyuki Takimoto provided advice on the results and the composition of the manuscript. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The datasets analyzed in the current study are available from the corresponding author upon reasonable request.

ETHICS APPROVAL STATEMENT

This study received approval from the Research Ethics Committee of the Faculty of Medicine of the University of Tokyo (review No. 2021302NI).

PATIENT CONSENT STATEMENT

All participants were provided with an explanation about the aim as well as the procedure of this survey. They were regarded as agreeing to participate by responding to the questionnaire. Written informed consent is not necessary for this type of study.

CLINICAL TRIAL REGISTRATION

N/A.

REFERENCES

- Aulisio MP. Ethics committees and ethics consultation. In: Post SG, editor. *Encyclopedia of bioethics*. 3rd ed. New York, NY: Macmillan; 2004. p. 841–7.
- Chris H, Micah H. Introduction: What should an HEC look and act like? In: Hester DM, editor. *Ethics by committee: A textbook on consultation, organization, and education for Hospital Ethics Committees*. Lanham, MD: Rowman & Littlefield Publishers; 2008. p. 1–19.
- Vollmann J. Clinical ethics committees and ethics consultation in psychiatry. In: Helmchen H, Sartorius N, editors. *Ethics in psychiatry*. Netherlands, Dordrecht: Springer; 2010. p. 109–25. https://doi.org/10.1007/978-90-481-8721-8_7
- Nishimura K. Clinical ethics consultation in healthcare: introduction to the special issue. *Japanese J Psychiatr Treat*. 2020;35(3):229.
- Haltaufderheide J, Gather J, Juckel G, Schildmann J, Vollmann J. Types of ethical problems and expertise in clinical ethics consultation in psychiatry –insights from a qualitative empirical ethics study. *Front Psychiatry*. 2021;12:558795. <https://doi.org/10.3389/fpsy.2021.558795>
- Reiter-Theil S, Schürmann J. The “Big Five” in 100 clinical ethics consultation cases. *Bioethica Forum*. 2016;9(2):60–70. <https://doi.org/10.24894/BF.2016.09013>
- Gather J, Kaufmann S, Otte I, Juckel G, Schildmann J, Vollmann J. Level of development of clinical ethics consultation in psychiatry—results of a survey among psychiatric acute clinics and forensic psychiatric hospitals. *Psychiatr Prax*. 2019;46(2):e1. <https://doi.org/10.1055/a-0839-8938>
- Jox RJ, Porz RC. View across the pond: insights from a national survey on clinical ethics services in Switzerland. *Am J Bioeth*. 2022;22(4):50–2. <https://doi.org/10.1080/15265161.2022.2044564>
- Reiter-Theil S, Schürmann J, Schmeck K. Clinical ethics in psychiatry: state of the art. *Psychiatr Prax*. 2014;41(7):355–63. <https://doi.org/10.1055/s-0034-1370058>
- OECD. Hospital beds (indicator). <https://doi.org/10.1787/0191328e-en>. 2023. Available from: <https://data.oecd.org/pinboard/4xwG>
- The Japanese Society of Psychiatry and Neurology. Certified Psychiatrist of the Japanese Board of Psychiatry. 2021. Available from: <https://www.jspn.or.jp/modules/program/>
- Bruun H, Lystbaek SG, Stenager E, Huniche L, Pedersen R. Ethical challenges assessed in the clinical ethics Committee of Psychiatry in the region of Southern Denmark in 2010–2015: a qualitative content analyses. *BMC Med Ethics*. 2018;19(1):62. <https://doi.org/10.1186/s12910-018-0308-z>
- Franke I, Speiser O, Dudeck M, Streb J. Clinical ethics support services are not as well-established in forensic psychiatry as in general psychiatry. *Front Psychiatry*. 2020;11:186. <https://doi.org/10.3389/fpsy.2020.00186>
- Michall FK, Abira R, Meni K, Ora N, Shai K. Psychiatric hospital ethics committee discussions over a span of nearly three decades. *HEC Forum*. 2021;35:55–71. <https://doi.org/10.1007/s10730-021-09454-8>
- Milliken A, Courtwright A, Grace P, Eagan-Bengston E, Visser M, Jurchak M. Ethics consultations at a major academic medical center: a retrospective, longitudinal analysis. *AJOB Empirical Bioethics*. 2020;11(4):275–86. <https://doi.org/10.1080/23294515.2020.1818879>
- Nagao N, Takimoto Y, Akabayashi A. A survey on the current state of hospital ethics consultation in Japan. *J Japan Bioethics Assoc*. 2005;15(1):101–6. https://doi.org/10.20593/jabedit.15.1_101
- Reiter-Theil S. Initiating and maintaining clinical ethics support in psychiatry. Ten tasks and challenges—and how to meet them. *Clin Ethics*. 2016;11(2–3):45–53. <https://doi.org/10.1177/1477750916649119>
- Syse I, Førde R, Pedersen R. Clinical ethics committees—also for mental health care? The Norwegian experience. *Clin Ethics*. 2016;11(2–3):81–6. <https://doi.org/10.1177/1477750916657656>
- Fox E, Myers S, Pearlman RA. Ethics consultation in United States hospitals: a national survey. *Am J Bioeth*. 2007;7(2):13–25. <https://doi.org/10.1080/15265160601109085>
- Yamamoto K. Multi-disciplinary collaboration at general hospitals. *Psychiatria et neurologia Japonica*. 2018;120(4):328–35.
- Hospital Intelligence Agency. Hospital search. Available from: <https://hospi.jp/hoslist>
- Fox E, Danis M, Tarzian AJ, Duke CC. Ethics consultation in U.S. hospitals: a national follow-up study. *Am J Bioeth*. 2022;22(4):5–18. <https://doi.org/10.1080/15265161.2021.1893547>
- Wollenburg LM, Claus S, Kieser C, Pollmächer T. The state of application of clinical ethics consultation in German psychiatric hospitals. *Psychiatr Prax*. 2020;47(8):446–51. <https://doi.org/10.1055/a-1179-4314>
- Dowa Y, Takimoto Y, Kawai M, Shiihara T. Hospital ethics committees in Japan: current status from an exploratory survey 2012–2015. *Am J Prevent Med Public Health*. 2022;8(5):1–6. <https://doi.org/10.21203/rs.3.rs-1407045/v1>
- Iijima Y. The ethics of blood transfusion refusal in clinical practice among legal and medical professions in Japan. *Nagoya J Med Sci*. 2020;82(2):193–204. <https://doi.org/10.18999/nagjms.82.2.193>
- Rabenschlag F, Steinauer R, Heimann R, Reiter-Theil S. Perception of ethical aspects in psychiatric patient care: a pilot study. *Psychiatr Prax*. 2014;41(7):376–8. <https://doi.org/10.1055/s-0034-1370210>
- Geppert CMA, Shelton WN. A comparison of general medical and clinical ethics consultations: what can we learn from each other? *Mayo Clin Proc*. 2012;87(4):381–9. <https://doi.org/10.1016/j.mayocp.2011.10.010>
- The Japanese Society of Psychiatry and Neurology. Code of Ethics for Psychiatrists. 2014. Available from: https://www.jspn.or.jp/uploads/uploads/files/about/Code%20of%20Ethics%20for%20Psychiatrists_2015.pdf
- The Japanese Society of Psychiatry and Neurology. Detailed enforcement regulations for enforcement of the rules for the Psychiatric Specialty Program. 2018. Available from: https://www.jspn.or.jp/uploads/uploads/files/specialist/senmoni_kisokusaisoku_20180317.pdf
- Dingle AD, Kolli V. Ethics in child and adolescent psychiatry training: what and how are we teaching? *Academic Psychiatry*. 2020;44(2):168–78. <https://doi.org/10.1007/s40596-019-01149-0>
- Fox E, Tarzian AJ, Danis M, Duke CC. Ethics consultation in U.S. hospitals: opinions of ethics practitioners. *Am J Bioeth*. 2022;22(4):19–30. <https://doi.org/10.1080/15265161.2021.1893550>
- Tsuboi E. Patient safety issues—challenge of the JMA to protect patient safety. *JMAJ*. 2001;44(9):382–4.
- Studdert DM, Mello MM, Sage WM, DesRoches CM, Peugh J, Zapert K, et al. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. *JAMA*. 2005;293(21):2609–17. <https://doi.org/10.1001/jama.293.21.2609>
- Yahata S. A study of defensive medicine in Japan. Center for Applied Ethics and Philosophy (ed.). In: *Applied ethics: old wine in new bottles?* Sapporo: Center for Applied Ethics and Philosophy Hokkaido University; 2011. p. 175–85
- Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 7th ed. New York, NY: Oxford University Press; 2013.

36. National Center for Ethics in Health Care. Ethics consultation: responding to ethics questions in health care. 2nd ed. Washington, DC: U.S. Department of Veterans Affairs; 2015.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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