had no money with her, the subject paid the business travel fare for both the younger staff and herself. However, the hospital refused to reimburse the expense because she paid the fare for the younger staff member without advance permission. She was furious at the injustice of the situation even though it was only a small sum of money, and stopped going to work from that day onwards. In turn, the hospital also terminated her wages prior to her last day of work. Upon her colleagues visiting her, she returned to work at the hospital, but her salary was still not reinstated. The hospital constantly neglected her claim, and she decided to consult with an appropriate public agency on the issue. Although she had no previous experience working in a hospital, she had worked in a company and thus, had a sense of employee rights. She was convinced that the hospital was in the wrong concerning the wage and business expenses.

In either case, deciding to blow the whistle was ultimately motivated by a strong *conviction* and not by the seriousness of the situation. On the back side of conviction, there were feelings of *anger* and *fear of complicity*. One subject felt extremely angry against the intentional misdiagnosis of patients, and said, "I couldn't accept the reason. It could not be permitted." "Patients were not treated as human." When a subject found nursing staff appropriating medical supplies to themselves, she thought "they are rotten!"

The more wrongdoings subjects witnessed, the more they felt fear of complicity. A subject said, "I was very scared, as I happened to hear of many wrongdoings. I might get into trouble unless I leave here soon." And she collected evidence which could protect

her. Whistleblowing requires courage, but subjects were propelled to the act by their own convictions.

After Whistleblowing

Immediately following whistleblowing the subjects experienced *wavering emotions* which were mixed with a *guilty conscience*, *fear of retribution*, and *pride*. These were followed by *stable emotions* which contained a *sense of relief* and *regret*.

Wavering emotions

Subjects inevitably pondered whether they should have disclosed the information after blowing the whistle. A sense of betraying colleagues led to a *guilty conscience*. They stated, "I wondered whether I should have told about affairs in the hospital," and "I was sorry to tell about such things."

Both subjects faced no fear of dismissal because of their prior resignation. But they felt another fear. Their *fear of retribution* was expressed in the statements, "I have heard that the director was related to gangsters. When I walked or got on a train, I always looked over my shoulder. I had a cellular phone with me to call my husband or son at any time," and "When you spoke to outside contacts, you could be easily identified. I contacted the hospital only with a lawyer's supervision."

Despite these negative feelings, they also felt *pride*. They believed that

"whistleblowing should not be thought of as wrong," and they "would like to express every detail of the hospital's wrongdoings in public."

Stable emotions

Years after whistleblowing, the wavering emotions were transformed to *stable emotions*, which consisted of a *sense of relief* and *regret*. *Relief* arises from feeling fortunate to have resigned their positions, expressed in "I was lucky to have been able to quit the job." And "I can go out on my own now."

Regret is targeted at both having assisted in wrongdoings as well as not publicly disclosing the wrongs earlier. They said, "I assisted in the wrongdoing. I should not have done such things," "I should have noticed earlier," and "I should have blown the whistle earlier."

Discussion

For a nurse, or any individual, whistlebowing poses a major ethical dilemma.[7, 19] Rhodes and Strain state, "by living in a society and absorbing its culture, we develop an aversion to exposing the misconducts of others."[20] The social significance of belonging to a group, psychological pain of disloyalty, obedience to the chain of command, fear of being exposed as the whistleblower, and fear of accusation and retribution all hinder whistleblowing.[20] This is especially true in Japan for the following reasons. First,

harmony is the most fundamental value,[21] even though western ethics are now accepted. Harmony is derived from Confucian ethics. Considering some practical moral precepts of courtesy of the young for the old, or distinction between the roles of husband and wife in Confucian ethics,[22] it is true that the Japanese, especially younger ones, have less respect for Confucian values than before. This is different from other East Asian countries like Korea, but Confucian ethics still heavily influence social behavior. Additionally, the Japanese do not believe in God. Moral duties (obligations, responsibilities) in Western society are required by God, but those in Japan are based on relationships among people.[23] Thus people intend to keep harmony in their groups. Whistleblowing counteracts these virtues, and may present a bigger challenge for the Japanese than for western cultures.[22]

Second, the Japanese law, Act of Public Health Nurses, Midwives, and Nurses, positions one of the roles of the nurses as assisting medical doctors. Autonomy of nursing is now penetrating, but recognition of nurses as subservient to doctors still remains. This discourages nurses from judging ethically.

Third, confidentiality has been interpreted beyond the realms of its original scope in Japan. For example, 20-30% of patients were informed of their prognosis, while patients were informed of their diagnosis just over half the time in 2001-2002.[24] Daily routines and standard operating procedures are kept confidential from patients, not to mention outsiders, as standard practice. In this study, the nurse's aid was explicitly told that under

no circumstances was she to violate hospital confidentiality. This must also be an obstacle to whistleblowing.

Finally, whistleblowers are insufficiently protected. In Japan, the Safeguards Act was enacted in 2004 to protect whistleblowers after a series of disclosures of major companies endangered the health and security of customers.[25-26] This act aims to safeguard those who disclose information in the public interest from unjustified treatments such as dismissal. However, its effectiveness is debatable because external whistleblowing is stipulated to have occurred only when the wrong is not set right by internal whistleblowing. Whistleblowers may also be charged with the wrongdoing committed by their organization while organizations that retaliate against whistleblowers face no penalty.[12, 27]

It is said that the process of whistleblowing consists of two decisions by the whistleblower: First, Is the observed activity illegal, immoral or illegitimate? And second, Should the activity be reported?[2] It is also said that even when these two questions are answered affirmatively, "many observers do not blow the whistle."[2] The subjects in this study overcame the dilemma, because they had firm convictions. This indicates that we the nurses should have accurate knowledge, with which we can affirm what is right *is* right, and what is wrong *is* wrong.

In this study, shortly after the whistleblowing events, the nursing staff who blew the whistle felt fear of retribution and a guilty conscience. In contrast, they were also proud,

and confident that they were right. A few years later, they were relieved. Regret was expressed for delaying their actions, and not for the fact that the whistle had been blown. Unless they publicly disclosed the wrongdoings, malpractices would continue, more patients would be endangered, and they would have to live with a disturbed peace of mind. Whistleblowing may be a psychologically painful experience, but it ultimately results in peace and satisfaction.

How to act becomes an ethical conflict for a professional who finds patients in danger. To diminish the conflict nurses should reaffirm their primary responsibility to patients, not to organizations. This is also a challenge in nursing education. Nurses should develop professional judgment for appropriate allegiance and actions. However, if whistleblowers suffer from retribution and negative publicity, it is natural for people to have reluctance against public disclosure of wrongdoing. Thus, legal protection should be enacted to safeguard the brave individuals who blow the whistle for the protection of others.

This study has several limitations. First, only two subjects were interviewed. While more whistleblowers should be examined, they are usually anonymous, making it very difficult to find whistleblowers to interview. In the future, if the guilt of whistleblowers lessens, more may be examined. Second, the subjects were interviewed a few years after the incident. While this allows the full evolution of their psychological process, the subjects' memories may also have changed. In spite of these limitations, this study is

significant for revealing the process of whistleblowing for the first time.

Final Word

The event in question was revealed approximately a decade ago. Social attitudes towards whistleblowing are now changing in Japan, due to widespread whistleblowing in the Japanese food industry in 2007. Under certain circumstances whistleblowing is slowly becoming regarded as one's duty. Transparency and accountability are now required not only in food industry but also in medical field. These changes in social attitudes will begin to influence psychiatric care even through the firmly closed doors of hospitals.

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Table 1: Categories and subcategories derived from data

categories	subcategories
suspicion of wrongdoing	surprise
	indignation
	dubiousness
	sympathy for patients
awareness of wrongdoing	awareness of wrongdoing
firm conviction	conviction of wrongdoing
	anger
	fear of complicity
driving force to continue to work	appreciation
	affection
	sense of duty
wavering emotions	guilty conscience
	fear of retribution
	pride
stable emotions	sense of relief
	regret

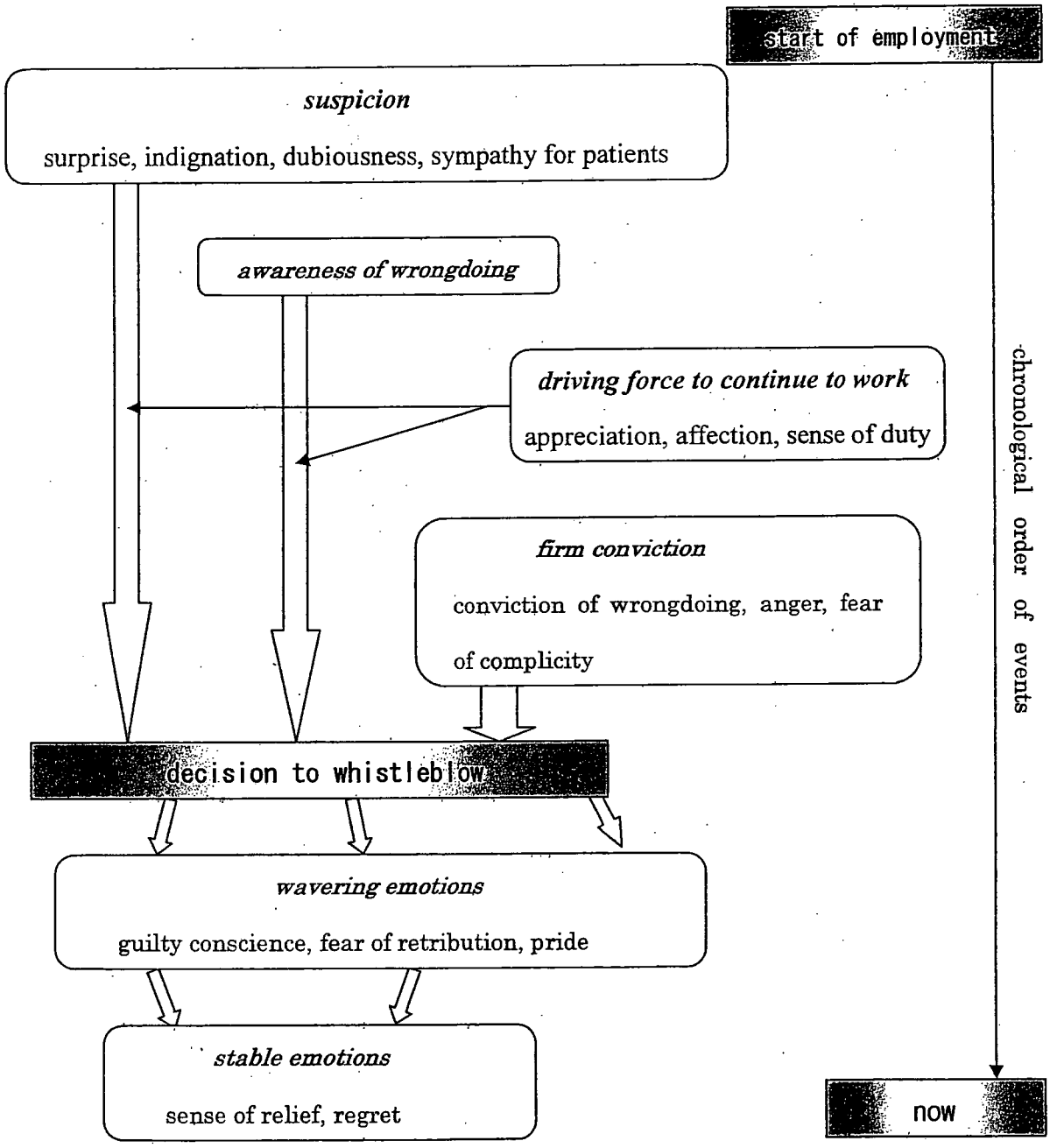

Figure 1: The process of whistleblowing

Clinical Ethics Consultation: Examining how American and Japanese experts analyze an Alzheimer's case

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Abstract

Background: Few comparative studies of clinical ethics consultation practices have been reported. The objective of this study was to explore how American and Japanese experts analyze an Alzheimer's case regarding ethics consultation.

Methods: We presented the case to physicians and ethicists from the US and Japan (one expert from each field from both countries; total = 4) and obtained their responses through a questionnaire and in-depth interviews.

Results: Establishing a consensus was a common goal among American and Japanese participants. In attempting to achieve consensus, the most significant similarity between Japanese and American ethics consultants was that they both appeared to adopt an "ethics facilitation" approach. Differences were found in recommendation and assessment between the American and Japanese participants. In selecting a surrogate, the American participants chose to contact the grandson before designating the daughter-in-law as the surrogate decision-maker. Conversely the Japanese experts assumed that the daughter-in-law was the surrogate.

Conclusions: Our findings suggest that consensus building through an "ethics facilitation" approach may be a commonality to the practice of ethics consultation in the US and Japan, while differences emerged in terms of recommendations, surrogate assessment, and assessing

treatments. Further research is needed to appreciate differences not only among different nations including, but not limited to, countries in Europe, Asia and the Americas, but also within each country.

Background

Ethics consultation 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]. In the United States (US), ethics consultation services have rapidly expanded since the 1980s; currently, this service is provided at all hospitals with 400 or more beds. Thirty-six thousand cases are requested yearly, involving roughly 29,000 consultants [2]. Several studies on ethics consultation have been published in the US, including discussions based on case studies [3,4], evaluations of ethics consultation [5,6], and analyses of consultation recommendations and their relevant factors [7,8]. Recently reports on ethics consultation have also been published in countries such as Australia, Canada, Italy, Japan, Germany, Norway, Switzerland and the UK [9-15]. These reports highlight a diversity in modality of clinical ethics consultation among and even within different nations. However, there is very little international comparative research that identifies similarities and differences in ethics consultation.

The practice of ethics consultation has often depended on clinical ethical judgments and practical knowledge. Even in the US, 95% of the individuals performing ethics consultation have not completed any formal graduate level training [2]. Comparisons based on case

studies are therefore an appropriate means of beginning to assess the similarities and differences in practical knowledge that guide ethics consultation in diverse international contexts.

The objective of this study was to explore how American and Japanese experts analyze an Alzheimer's case regarding ethics consultation. This case focused on the nutritional management of an elderly Alzheimer's patient. We used this case because a review of the literature showed that it has certain key elements that are likely to provoke dilemma or controversy among healthcare practitioners: the patient is incompetent, there are questions about whether or not to opt for terminal care, and disagreements easily arise among the interested parties [16,17]. In this paper, we analyze the recommendations and approaches of ethics consultants from the US and Japan concerning this case and also discuss the legal and institutional aspects of terminal care issues that are presented. Because it is necessary to identify practical knowledge in ethics consultation, this study may assist in educating ethics consultants.

Methods

Study Design

We chose experts from both the US and Japan and conducted our research from July to August 2006 using a questionnaire survey, followed by expert interviews. We divided the participants into American and Japanese teams, had them examine the case of an Alzheimer's patient, and conducted follow-up interviews. Participants were told to approach the case as if it occurred in their respective countries. We conducted a content analysis of the teams' approaches and conclusions. All the interviews were performed by three authors of this paper (NN, YN, MF). The study was approved by the Ethics Committee of the Graduate School of Medicine, University of Tokyo.

Participants

Participants were recruited from among researchers who have published several reports on ethics consultation, medical ethics, and bioethics in academic journals. Many of the individuals practicing ethics consultation in the US are healthcare workers, chaplains, or ethicists [2], while ethics consultation in Japan is often performed by physicians and ethicists. We therefore selected four experts from the fields of medicine and ethics from the US and Japan as participants (Table 1). All participants were male. We explained to all participants their role in this study and received their consent in writing.

The Japanese participants tended to have fewer years of ethics consultation experience and

have handled a smaller number of cases. This was because ethics consultation in Japan has only been initiated in recent years. The Japanese participants selected for this study, however, had been active in research and clinical ethics consultation. Physician C, for example, had undertaken research on topics such as advance directives; and ethicist D had undertaken research on medical ethics education. It was therefore appropriate to regard physician C and ethicist D as experts in ethics consultation for the purposes of this explorative study.

Data Collection

1. Questionnaire: The questionnaire asked participants about their affiliations and ethics consultation experiences, to describe some of the typical cases they have handled, and included questions related to Alzheimer's patients (patient competency, surrogates, and selection of treatment methods). We created an interview guide based on the responses received in the questionnaire.
2. Expert interview: We conducted a semi-structured expert interview with each participant based on the results of the questionnaire. The expert interview was designed to increase our understanding of the technical and practical knowledge of professionals from that specialty. Accordingly, the interviewee is not merely treated as a case, but as an expert within that particular field [18]. During this interview, we asked the participants how

they receive requests for ethics consultation and how they assist and advise their clients. We also asked the participants about the Alzheimer's case, including their recommendation, surrogate evaluation, and treatment assessment.

3. Team case study: We had the four experts divide into two respective teams – one from the US and one from Japan. The two teams individually discussed the case before submitting their recommendation in writing. The teams first exchanged their written recommendation for this case and then met to comment on and discuss each other's recommendation. The Japanese and American team members neither knew each other nor had conversations regarding bioethical issues prior to this study.
4. Follow-up interview: We conducted a semi-structured follow-up interview based on the recommendations of the two teams. We interviewed each participant concerning how they developed their recommendation for the Alzheimer's case as a member of a two-party team.

The questionnaire and case were first developed in Japanese and then translated into English. We confirmed the accuracy of translation by performing a native check and back-translation. The interview was done in the participant's native language and was recorded with their informed consent. We interviewed each participant for three to four hours in total.

Data Analysis: