

empowerment component to the existing country profiles that are being published by different organisations (such as “health in transition”).

The recent votes in France and the Netherlands against the European Constitution showed that the “democratic deficit” is not just the concern of the new member states. A democratic revolution should become an integral part of the ongoing healthcare reforms. WHO supports this process, since “participation” is one of the guiding values of the new “health for all” policy framework.

The Solidarity movement, glasnost, and perestroika contributed to the European political transition of the 1990s. We now again need social solidarity—“health glasnost,” with informed patients in the lead role, and

“health perestroika,” which will allow the current binding instruments to grow (including patients’ rights and citizens’ empowerment).⁴ In the emerging European healthcare systems patients and citizens refuse to play Cinderella; they demand a new play in which they can participate as co-creators. Lessons from the “East side story” could help create the “empowered europatient story.”

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Ethics and the structures of health care in the European countries in transition: hospital ethics committees in Croatia

Ana Borovečki, Henk ten Have, Stjepan Orešković

Hospital ethics committees are a recent phenomenon in countries in transition. Croatia’s example shows they are staffed mainly by older doctors with no specialist knowledge of ethical issues. The importance of professional relationships and the educational function of ethics committees have been ignored

Healthcare structures, organisations, and institutions have ethical characteristics that are about relationships. These groups are composed of individuals and groups of people with moral obligations. Healthcare structures embody particular organisational cultures that, good or bad, affect people and reflect values. Also, healthcare structures have certain purposes, and they can be evaluated and held accountable whether or not they fulfill their purposes, particularly those affecting and effecting health care. For these reasons, healthcare structures have ethical attributes, and ethical analysis of the healthcare system could be performed.¹

We use hospitals ethics committees in Croatia to explore the issues connected with structural ethics in healthcare institutions in the countries in transition, and we present it as an example that applies also to other countries in transition. We chose hospital ethics committees because we believe that such an analysis can explain structural ethics issues in a healthcare system.

Hospitals and structural ethics

Hospitals are healthcare structures made of intricate webs of relationships between people. They have attributes relevant to ethics: they promote values embodied in medical ethics, reinforcing certain kinds of behavior and discouraging transgressions. Hospitals create and promote ethical cultures within their walls. Hospitals have purposes: they protect the wellbeing of patients, foster their healing process, and help patients and their families to cope with disease. On the basis of these purposes, hospitals have responsibilities towards patients and their families. Observing how hospital ethics committees function makes it possible to “read” a hospital. Hospitals and hospital ethics committees

are part of the patchwork of a healthcare system, as are the other institutions and organisations. Thus by observing the work of hospital ethics committees one can tell a lot about the ethical climate of the healthcare system itself.

European countries in transition, ethics, and healthcare structures

Countries in transition in central, eastern, and southeastern Europe have a similar path of development and historical background.² The healthcare structures in countries in transition were regarded as health factories. The number of beds, the number of patients processed, the level of technical sophistication in these healthcare factories were most important in evaluations of their work. Little if any attention was paid to the age, personal characteristics, religious beliefs, and gender differences of patients or to ethical problems that arose in the process of providing health

Andrija Štampar
School of Public Health, Medical School, University of Zagreb, 10 000 Zagreb, Croatia
Ana Borovečki
research assistant
Stjepan Orešković
professor of medical sociology

University Medical Centre, Radboud University Nijmegen, the Netherlands, Postbus 9101, 6500 HB Nijmegen, Netherlands

Henk ten Have
professor of medical ethics

Correspondence to: A Borovečki
abor@mef.hr

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Ethics comes to Croatia’s former healthcare factories

History of ethics committees in Croatia

1970s: First steps towards bioethics institutionalisation (hospital drug commission, institutional review boards) for international multicentre trials

1990s: Ethics committees formed in medical schools, medical associations

First legal requirements for ethics committees in healthcare institution (Law on Health Protection): committees must combine the functions of institutional review boards and hospital ethics committees; they are to have five members, of whom two are not from the medical field

2001: Formation of the National Bioethics Committee for the Medicine of the Government of the Republic of Croatia (20 members; issues recommendations, guidelines, and reports on various ethical issues)

Committees are found in scientific institutes and the schools of dentistry, veterinary medicine, and pharmacy, along with National Bioethics Committee and committees in healthcare institutions, medical schools, and professional regulatory bodies

care. The bureaucratic approach in health care was omnipresent. Unfortunately, the legacy of such an approach can still be seen in healthcare structures in the countries in transition. Thus the process of institutionalisation of bioethics is regarded by some authors as especially important to European societies in transition. The development of hospital ethics committees, especially, could encourage the development of ethical professional behaviour and the creation of important networks within a specific country.³ However, if institutionalisation is carefully implemented, it can produce scepticism and bureaucratic behaviour.⁴

Croatian ethics committees and healthcare structures

Ethics committees in Croatia are a relatively new phenomenon (box).

In 2002 and 2003, the National Bioethics Committee for Medicine conducted a study of ethics committees in Croatia, asking about the number of members, structure of membership, issues discussed during meetings, number of meetings so far, standing orders, working guidelines, and documents related to their work. The survey had a response rate of 82% and showed a highly formal and legalistic approach to the formation of ethics committee.⁵ Those findings prompted us to further analyse the situation, especially regarding ethics committees in hospitals in Croatia, because we felt that analysing the work of hospital ethics committees would provide information about structural ethics issues within a healthcare system.

Survey and results

We sent a questionnaire to 241 members of hospital ethics committees. Their names were obtained from the 2002-3 survey of the National Bioethics Committee. The questionnaire had four parts: data on age, sex and occupation, number of members in the committee, educational practices, frequency of meetings, issues dealt with in everyday practice; a 42 question self-evaluation questionnaire (assessed on a Likert scale); 23 questions testing knowledge of ethical issues; and 19 "bioethics consensus statements" (agreement measured on a Likert scale).

The survey had a response rate of 61% (74 men, 73 women); mean age of the respondents was 51; 73% of respondents were doctors. The survey showed that the

structure and the composition of hospital ethics committees followed the legal requirements. Most committees were formed after 1997, when the legal provisions for ethics committees in Croatia were introduced. The number of members and their occupation was an exact replica of the structure of the committees required by the law: three doctors and two members from other professions, of whom lawyers and theologians were the most likely candidates.

The main task of ethics committees in hospitals was an analysis of research protocols, thus neglecting the other functions important for a hospital ethics committee: education, case analysis, and development of guidelines. The level of knowledge of the members was average, but not sufficient for the complicated tasks that they were supposed to perform in their everyday work. Their views on the doctor-patient relationship and bioethical dilemmas showed a high level of paternalism and overprotectiveness of their patients. These results may be due to the fact that most of those who participated in our survey were 50 years and older and had no formal education in the field of bioethics.

A bureaucratic approach

The legalistic approach to the formation of ethics committees, as in the Croatian case, is not uncommon, and transforms ethics committees into bureaucratic bodies.⁴ Hospital ethics committees exist only to fulfill the legal requirement. This is a drawback in developing a healthcare institution or a healthcare system with ethical standards.

This top down approach is common in countries in transition,⁶ where the development of civil society has been constrained by a former totalitarian government. Those societies feel more at ease when the regulatory frameworks in all areas as well as in health care are implemented by the state. This is to be expected in healthcare systems which were monitored and regulated by the government in a highly bureaucratic manner with no sensitivity to the reality of the everyday work of healthcare professionals. In such a climate, healthcare professionals were usually required to conform to bureaucratic requirements, thus putting their judgment in conflict with the requirements of the system.⁷

The top down approach and highly legalistic framework has created confusion about the tasks of ethics committees in hospitals. Although the committees combine the functions of institutional review boards and hospital ethics committees, they have made the analysis of research protocols their main function. This is also not uncommon, since in other countries in transition institutional review boards have been present for many years in one form or another because of multicentre trials.⁸ Thus members of ethics committees have considerable knowledge from this field. However, this jeopardises the other, more important, functions of an ethics committee in hospital: education about ethical issues, development of guidelines, and analysis of cases that raise ethical questions.^{9 10}

This lack of recognition of the broad range of functions of a hospital ethics committee, especially the educational function, can be seen in the insufficient level of knowledge of the committees' members. This

draws attention to the need for developing bioethics education on all levels in the countries in transition; efforts to improve the level of knowledge have been made in Lithuania, Estonia, Latvia, Poland, Slovenia, Czech Republic, Slovak Republic, Hungary, Romania, Bulgaria, and Croatia.^{3 6}

Another trait is a strong paternalistic tendency, especially among older healthcare staff who have a more traditional view on the doctor-patient relationship and medical ethics.⁶ This is reflected in the work of ethics committees, which are often made up of older doctors, as in the Croatian case—probably because the experience of older doctors is equated with their competence in medical ethics. Here we find a traditional approach to medical ethics: older, more experienced doctors are thought to be competent enough to converse about ethical issues just because they have considerable experience to draw their knowledge from.

Conclusions

The work of ethics committees in Croatia can be viewed as one of satisfying norms and requirements within a healthcare system. However, healthcare systems are also about people and relationships, and when that is ignored it can create a lot of strain on both providers and users, creating unresolved issues and tensions as well as ethical problems. Healthcare organisations should be based on webs of relationships and interactions between people, promoting ethical values, trying to foster patients' best interests, and having responsibilities.

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Commentary: Ethics committees and countries in transition: a figleaf for structural violence?

Richard E Ashcroft

Borovečki and colleagues argue that hospitals are ethical institutions, and that the norms they embody are subject to pressure and change as the institutions and their contexts change.¹ They discuss how bioethics as an explicit way of discussing ethical norms and moral dilemmas has increasingly been institutionalised within Croatian hospitals, and analyse some of the defects of this process to date. In particular they identify three main features of hospital ethics committees which undermine their effectiveness: a continuing tradition of paternalism within medical practice; the bureaucratic, top-down implementation of ethics committees within the Croatian healthcare system; and the confusion of roles between hospital ethics committees and research ethics committees.

Some of their findings bear further analysis: for instance, it is not clear what is "average" in terms of the ethical knowledge of ethics committee members, either in absolute terms (what is the ideal for what they ought

Summary points

In European countries in transition, like Croatia, the healthcare system has a bureaucratic climate and approach

Ethics committees in such a climate are bureaucratically constituted entities whose functions consist mainly of analysing research protocols

Members of hospital ethics committees have insufficient knowledge of ethical issues and a paternalistic approach

Ignoring people and relationships can strain both providers and users, creating unresolved issues and tensions and ethical problems.

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to know?) or in relative terms (average compared with whom?). These issues remain open questions in most of the countries in which ethics committees and ethics consultation have been implemented for much longer.^{2 3} Yet the issues presented in this article resonate across European health systems, despite considerable variation in the implementation of and rationale for ethical decisions in clinical practice.

Given the nature of health systems reform and socioeconomic transition in eastern Europe, what problems is clinical ethics supposed to address, and why should it be a solution to them? Many health systems in Europe are under considerable strain: problems of inadequate resources, high direct costs for patients, inequalities in access, corruption, and formal or informal rationing are as real as the "traditional" clinical ethics issues concerning decision making at the end of life or resolution of conflicts between family members and staff. In addition, as clinical research

Imperial College
London, London
W6 8RP
Richard E Ashcroft
reader
r.ashcroft@
imperial.ac.uk