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FEATURES AND FUNCTIONS OF HEALTHCARE ETHICS
IN THE CROATIAN TRADITION

1. *The Beginnings*

In order to understand the story of the development of Croatian healthcare ethics one should start from the beginnings. Discussion on medical ethics has been ever-present within Croatian medical circles. In the last century, columns were written on the topic in *Liječnički Vjesnik*, the oldest Croatian medical journal, which is still published today by the Croatian Medical Association. At medical schools a number of hours were devoted to the subject. The main conception of medical ethics was related to the idea of good and virtuous physicians from whom a young apprentice aspiring to be a medical doctor should learn, and whom s/he should imitate. This notion of apprenticeship was inherent in medical practice in Croatia in the eighteenth and nineteenth centuries, when the first trained medical professionals became prominent public, historic and literary figures.¹ However, medical ethics and the idea of human rights were later more ornaments in a society that, although open to foreign influences, was deeply rooted in the socialist paradigm. If one is to describe the importance of ethics in everyday clinical practice in Croatia at that time, one may state that it was important, but the solving of possible issues was left to the physicians and nurses to deal with. It was assumed that, because they were engaged in the practice of medicine, they knew from their experience what was in the patient's best interest. Everything seemed to be perfect, the standards had been set, and possible transgressions were never mentioned. Everyone was living in this

¹ A. Borovecki, H. ten Have, S. Oreskovic, *Developments Regarding Ethical Issues in Medicine in the Republic of Croatia*, «Cambridge Quarterly of Healthcare Ethics», 3 (2004), vol. 13, pp. 263-266.

utopia. However, it was the advent of the 1990s that saw the further development of ethical issues.²

It was during the 1990s that the development of medical ethics really took off in Croatia. The impetus for the development was imparted by changes in the political system. Croatia had previously been part of the former Socialist Federative Republic of Yugoslavia. In the 1990s, the socialist political system collapsed, and the democratic changes began. Croatia's transition from a socialist to a democratic society was further complicated by the Serbian aggression and the war of the 1990s.³ The subject of medical ethics was introduced in Croatian medical schools in the 1990s, first at the University of Rijeka and then at the University of Zagreb. Previously, the subject of medical ethics had been taught in a brief cycle of lectures and seminars at the Zagreb School of Medicine. Moreover, the Hastings Centre, through an exchange program, invited several teachers of the Zagreb and Rijeka medical schools to visit, and provided them with additional materials for the development of future courses in medical ethics and bioethics. The Croatian scholars invited to the Hastings Centre worked in a variety of disciplines. Some of them decided to take this opportunity to reinvent themselves as teachers of a new discipline and leave behind their past teaching experience in subjects like Marxism.⁴

Nevertheless, the ethical issues of everyday clinical practice were present in discussions in Croatia even before the 1990s. It was after the implementation of clinical trials – which began in the 1970s with the creation of the so-called 'commissions for drugs' – that the debate on ethical issues in clinical settings began. The 'commissions for drugs' were the first institutional review boards. They were established for the purpose of joint Croatian-international clinical research projects by the main clinical and teaching hospitals in Croatia. Just before their foundation, in order

² A. Borovecki, S. Oreskovic, H. ten Have, *Ethics and the Structures of Health Care in the European Countries in Transition: Hospital Ethics Committees in Croatia*, «British Medical Journal», 23 (2005), vol. 331, pp. 227-229.

³ Borovecki, ten Have, Oreskovic, *Developments Regarding Ethical Issues*.

⁴ Borovecki, ten Have, Oreskovic, *Developments Regarding Ethical Issues...*; N. Zurak, D. Derezic, G. Pavlekovic, *Students' Opinions on the Medical Ethics Course in the Medical School Curriculum*, «Journal of Medical Ethics», 1 (1999), vol. 25, pp. 61-62; R. Nicholson, *Editor's response (to letter)*, «Bulletin of Medical Ethics», 2 (2004), vol. 196, p. 2.

to obtain well-trained members of such committees, a new postgraduate and specialty training program was introduced – clinical pharmacology – which included courses on Good Clinical Practice and research ethics.⁵ Moreover, founded at the *Vrapče Psychiatric Clinic* was one of the first ethics committees dealing with real clinical ethics dilemmas pertaining to the field of psychiatry.⁶

2. *The Main Issues for Healthcare Ethics in Croatia during the Past Years. Patients' Rights - Case*

Recently, in 2011 a survey concerning informed consent and patients' rights was conducted on a representative sample of citizens of the Republic of Croatia (1032 respondents). More than one quarter (30%) of all the subjects stated that they did not know their rights as patients, and one in ten of them stated that they knew their rights completely. In one third (34%) of cases, the decision about the patient's treatment was made by the doctor alone. The most subjects unacquainted with informed consent were found amongst those with lower education levels, those who had attended only elementary school, and the older subjects. Younger and better-educated subjects were more informed, and women and respondents aged 46 to 65 mostly made decisions on treatment together with their doctor.

From 1990 onwards, the issues of patients' rights became increasingly important for Croatian society and the Croatian healthcare system. After the Republic of Croatia became independent from the Socialist Federative Republic of Yugoslavia in 1990, work began on aligning the health care system and health insurance with the new political and economic system. However, although these were changes primarily aimed at the organizational and financial aspects of the system, with the purpose of rationalizing and limiting health care expenditure, the Health Care Act of 1993 (*Zakon o zdravstvenoj zaštiti*, Narodne Novine 75/1993) already granted citizens as patients a set of rights: to

⁵ A. Borovecki, I. Francetic, A. Mujkic, *Ethics and Biomedical Research in Croatia*, «Bioethica Forum», 1 (2010), pp. 26-29.

⁶ <http://www.bolnicavrapce.hr/site2/Aktualnosti/Za%C5%A1tojePredsjednikRepublikeodlikovao.aspx> accessed 20.1.2012.

receive accurate information and answers to all questions related to their health: to choose between several possible forms of medical procedure; to refuse examinations and treatment, including the right to change primary health care doctors in the course of treatment; to refuse observation, examinations and treatment by students; to refuse to take part in scientific research; to refuse surgery and other medical procedures insofar as they are conscious and able to decide; to be assured of the confidentiality of all data relating to their health; to receive food in line with their world view; and to perform religious rites during their stay in a health institution.

Furthermore, this Act entitled patients who considered their rights to have been violated to seek redress, either directly or in writing, from the head of the health institution or the private health worker. These officials were obliged to act without delay on a complaint and to inform the patient in writing on the measures taken – within no more than three days. Patients, who were not satisfied with the measures taken to protect their rights could seek redress from the relevant professional chamber, the Minister of Health, or the competent court. In 2003 a new Health Care Act (*Zakon o zdravstvenoj zaštiti*, Narodne novine 121/2003) was adopted, but its provisions relative to the rights of citizens as patients were almost identical to those of the above-mentioned Act of 1993.

The trend of legalizing patients' rights in Croatia continued in 1997 with adoption of the Act on the Protection of Persons with Mental Disorders (*Zakon o zaštiti osoba s duševnim smetnjama*, Narodne Novine 111/1997) which came into force on January 1998. In November 2004 the Act on the Protection of Patients' Rights was adopted (*Zakon o zaštiti prava pacijenata*, Narodne Novine 169/2004). The main reasons for its adoption were alignment of domestic health legislation with the Council of Europe's *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine* of 1997, which Croatia ratified in 2003, but also the more detailed application of the provisions of the World Health Organization's *Declaration on the Promotion of Patients' Rights in Europe* of 1994 (known as the *Amsterdam Declaration*). Pressure from NGOs, especially those directly concerned with health issues, accompanied by media emphasis on the frequent violations of patients' rights in the Croatian health care system and

society, was also one of the reasons for adoption of the Act. However, the NGOs were not satisfied with the law on the protection of patients' rights, and especially with the extremely complicated procedure for patients' complaints. In order to realize, protect and promote patients' rights, Article 30 of the Act prescribed the creation of a commission to protect patients' rights in each unit of regional self-government (County Commissions), whilst at a state level, Article 38, section 1 obliged the Ministry responsible for health care to create a national commission to protect and promote patients' rights (the Commission of the Ministry of Health and Social Welfare of the Republic of Croatia). Today, the county commissions, which have five members representing patients, NGOs, and experts in the protection of patients' rights (Article 32), perform the following tasks. They monitor violations of individual patients' rights and propose measures to protect and promote patients' rights in their area, that is, their county; report without delay to the Commission of the Ministry of Health and Social Welfare on serious violations of patients' rights; report to the public on violations of patients' rights; and submit an annual report on their work to the county assembly (Article 33). The procedure for the protection of patients' rights before a county commission begins with a complaint lodged by a patient who believes that one of his/her rights – as established by the Act – has been violated. This commission is obliged to inform the patient within no more than fifteen days of all the measures taken following his/her complaint. The County Commission also has right of access to premises where health care is provided and the right to inspect how patients' rights are being respected in individual health institutions. The commission must write reports on the inspections that it undertakes and send them within no more than eight days to the competent inspection service (health or sanitary), or the bodies supervising health workers. These bodies are the various vocational chambers in the health service (the Croatian Medical Chamber, the Croatian Dental Chamber, the Croatian Chamber of Nurses, the Croatian Chamber of Pharmacists and the Croatian Chamber of Medical Biochemists). These bodies are obliged to report to the Commission on the action taken within thirty days of receiving the report – and in urgent cases without delay. If, on the basis of the procedure undertaken, the competent body (inspection service or chamber) has reasonable grounds to believe that a misdemeanour

or criminal offence has been committed by the violation of the patient's rights, it is obliged to file a misdemeanour or criminal report, without delay and within no more thirty days, and then report to the Commission on the outcome of the procedure. The commission informs the patient about the outcome within eight days. This procedure is extremely complicated, and many complaints are not properly addressed. According to some NGOs and legal experts that have conducted studies on implementation of the Law, changes that could improve the Croatian situation would be, for example, creation of an ombudsman system. Moreover, a study on the work of County Commissions found that their members were often confused about the tasks of the Commission. The Commissions themselves were unsure of their role, so that they frequently dealt with complaints relative to health insurance rights rather than patients' rights. Even more confusing is the issue of patient decision-making. Article 16 of the 2004 *Law on the Protection of Patients' Rights* states that the patient can refuse medical treatment except when such refusal may jeopardize either the patient's health and life or those of other people. However, article 22 of the 2008 *Law on Health Protection* states that one can refuse medical treatment and medical examinations except when such refusal may jeopardize the life and health of other people. Therefore even if the refusal may jeopardize one's own life or health, one can refuse medical treatment. Here we have two different approaches to the same issue by two different laws. These discrepancies should be corrected.⁷

The protection of persons with mental disorders is regulated by the *Law on the Protection of Persons with Mental Disorders*. Involuntary hospitalisation is permitted, but without a court order, patients cannot be held in a hospital for more than seventy-two hours. After the Court's decision on involuntarily commitment, the case of the patient must be re-evaluated within thirty days. After that period the commitment can be extended for up to six months and then re-evaluated. Much has been done to de-stigmatise persons with mental disorders. However, there still occur high-profile cases in which psychiatric patients have been either

⁷ A. Borovecki, S. Babic-Bosanac, H. ten Have, *Stadiul implementrii legi privind drepturile pacientilor din Croatia-studiu pilot*, «Revista Romana de Bioetica», 3 (2010), vol. 8, pp. 36-48; S. Babic-Bosanac, A. Borovecki, K. Fister, *Patients' Rights in the Republic of Croatia – between the Law and Reality*, «Medicinski glasnik Ljekarske komore Zenicko-dobojskog kantona», 1 (2008), vol. 5, pp. 33-36.

released and then committed crimes or held in psychiatric hospitals without clear diagnostic evidence debated in public.⁸

3. End-of-Life Decision Making and DNR. Case

At a local hospital in a small town in Croatia, a 23-year-old young woman died as a consequence of an overdose of tablets given to her by her father, who at the same time also slashed her veins. He also decided to take tablets and slash his own veins. His son found them and took them to the hospital. The father survived. The young woman had been bedridden for four years as a result of a neurosurgical operation which she had undergone in order to relieve severe headaches. Her mother quit her job to take care of her because she needed 24-hour assistance. Before the operation the young woman had been a university student, very beautiful and with a modelling career. Her father decided to end her suffering, which he could no longer bear to watch. After his recovery, father expressed contrition for his acts. The public prosecutor decided to bring the case to court.⁹

End-of-life decision making is an important issue for Croatia, a country with a rapidly aging population. Palliative care and palliative care institutions are part of legal healthcare provisions, but they have not yet been implemented in the Croatian healthcare system. Although palliative care institutions are to be introduced at primary healthcare level, to date only one has been established, in Zagreb. There is discussion on the need to extend and improve palliative care services. A current initiative by the Ministry of Health is to convert a number of hospitals whose capacities are deemed superfluous to the system's needs into hospices throughout Croatia. Notwithstanding a constant lack of financial resources in the healthcare system, the advocates of improved palliative care are endeavouring to bring about changes within the existing healthcare structures. There is also the initiative of the Catholic Church, which is now becoming involved in the building of

⁸ V. Jukic, M. Goreta, O. Kozumplik, M. Herceg, Z. Majdancic, L. Muzinic, *Implementation of First Croatian Law on Protection of Persons with Mental Disorders*, «Collegium Antropologicum» 2 (2005), vol. 29, pp. 543-549.

⁹ <http://www.jutarnji.hr/ubojstvo-iz-samilosti-tesko-bolesnu-kcer--23--predozirao-tabletama--a-onda-pokusao-presuditi-i-sebi/1058680/> accessed 20.1.2012.

hospices. Croatian law does not allow any type of euthanasia (active or passive) (The Criminal Law, *Kazneni zakon*, Narodne Novine, 125/2011).

There are still no clear guidelines in Croatia on the implementation of DNR-orders.¹⁰ Since the do-not-resuscitate decision is taken by the individual physician, families are seldom involved. The Croatian Society of Intensive Care Medicine has discussed the issue of introducing DNR orders and has sought to find appropriate ways to do so.¹¹

4. *Beginning-of-Life Issues*

Case 1

A public television channel recently broadcast a report on a woman struggling financially to take care of her prematurely born twins, who as a consequence of their prematurity suffered from severe neurological deficits. The pregnancy was a result of an IVF procedure.

Case 2

According to the official statistics published by the Croatian National Institute of Public Health, there were 41,321 births in the year 2011. There were 4,347 legally induced abortions (64.1% of them were performed on women aged between 30 and 39 who already had children). 4,553 were reported as not specified abortions. It is not clear what lies behind this figure. The rate of induced abortions is declining, but some experts in the field claim that the statistics are not correct since a number of abortions are performed in private clinics not legally allowed to perform such operations.¹²

¹⁰ 'DNR-orders' means Do-Not-Resuscitate orders: they are instructions not to treat, and more specifically not to resuscitate, patients already in a very serious condition (e.g. in an Intensive Care Unit) and for whom the intervention would be futile in the opinion of the physicians and with the agreement of the patient/the family [Editor's note].

¹¹ A. Borovecki, K. Makar-Ausperger, I. Francetic, S. Babic-Bosnac, B. Gordijn, N. Steinkamp, S. Oreskovic, *Developing a Model of Healthcare Ethics Support in Croatia*, «Cambridge Quarterly of Healthcare Ethics», 3 (2010), vol. 19, pp. 395-401.

¹² http://www.hzjz.hr/publikacije/hzs_ljetopis/index.htm accessed 20.1.2012.

The main controversies in Croatia have arisen in debates on beginning-of-life issues. In Croatia, the *Law on Health Measures for the Promotion of the Right on Freedom and Decision-making about Birth (Zakon o zdravstvenim mjerama za ostvarivanje prava na slobodu i odlučivanje o rađanju djece, 1978)* regulates contraception measures and abortion in Croatia. Although there have been several attempts to change the law, the law stands today as it was. In 2009, after several attempts had failed, Croatia implemented the *Law on Medical Fertilization (Zakon o medicinskoj oplodnji, 2009)*. The law was one of the most restrictive in Europe. It allowed the freezing of female egg cells but not the freezing of embryos. This meant that in vitro fertilization was performed with defrosted female egg cells and then only three embryos were implanted and created. Some medical practitioners were not happy with this solution, arguing that such a procedure has no proven efficacy and that the implantation of defrosted embryos is a better procedure. This was supported by a number of NGOs. However, other medical professionals who were performing the procedures in accordance with law claimed that the success rate of such procedures was rather good. The Law did not allow surrogate motherhood, heterologous donation of gametes by both parents, or embryo donation. It allowed in vitro fertilisation for heterosexual common-law couples and legally married couples. It did not allow the creation of embryos for research purposes. A child conceived by medical procreation had a right to know the donor of eggs or sperm if the latter had consented to disclosure of their identity. The new government elected in 2011 decided in 2012 to create the new law regulating the field of artificial procreation entitled the *Law on Medically Assisted Fertilization (Zakon o medicinski pomognutoj oplodnji, 2012)*. The new law now allows freezing of the embryos instead of freezing of the eggs, and medical procreation is also allowed for single women and not only for couples. All the religious communities and a number of NGOs opposed implementation of this law. There were calls for a referendum, but the government did not want to organize a referendum on the issue. Before these laws Croatia had no legislation on medical procreation. Hence a huge number of surplus embryos had been

created for artificial procreation purposes and been frozen. It is not clear what will become of these embryos.¹³

5. Transplantation

Before the 1990s, Croatia was actively involved in organ transplantation. The first legal provisions envisaged an opt-in system. After the 1990s and after the war, Croatia rejuvenated its transplantation programs. However, these programs were not initially very successful. But this changed, and Croatia is now extremely successful in organ donation and transplantation. Croatia has changed its legal framework with the *Law on Procurement and Transplantation of Human Body Parts for the Purpose of Therapeutic Procedures (Zakon o uzimanju i presađivanju dijelova ljudskog tijela u svrhu liječenja, 2004)* and now has an opt-out system of organ donation and is a member of Eurotransplant. Croatia is the third country in the world for the number of organ donors. However, even today after the introduction of the opt-out system, when it comes to organ procurement the members of the transplantation team still feel obliged to ask the family of the deceased person if they are willing to donate his/her organs, and to not proceed with the organ procurement if the family refuses.¹⁴

6. Ethics Committees and Clinical Ethics Services

In the 1990s, ethics committees became required by law, with articles 51 and 52 of the 1997 *Law on Health Protection* establishing the framework for their duties. According to this law, each healthcare institution in Croatia must have an ethics committee consisting of five members, two of them from outside the medical field. Committee functions include:

- monitoring implementation of the medical profession's ethical principles,
- approving research activities (protocols) within the health institution,
- overseeing drug and medical device trials,

¹³ H. ten Have, B. Gordin (eds), *Compendium and Atlas of Global Bioethics*, Springer, Dordrecht 2013.

¹⁴ R.M. Langer, B. Cohen, A. Rahmel, *History of Eurotransplant*, «Transplantation Proceedings», 7 (2012), vol. 44, pp. 2130-2131.

- overseeing organ procurement, and
- resolving other ethical issues in the health institution.

It is clear from this description that at that time Croatia had a mix of ethics committees in healthcare institutions which performed functions of both the institutional review boards.

Research on the functions of ethics committees showed that, at that time, this mixed type of ethics committee only performed reviews of research protocols, while they seldom discussed clinical ethical issues.

In 2003 a new version of the *Law on Drugs* was implemented. This entailed significant changes in the work of ethics committees. According to this law, the review of research protocols for clinical trials was now transferred to the independent central research ethics committee at the Croatian Agency for Drugs and Medical Devices. However, the new version of the 2008 *Law on Health Protection* did not significantly change the work of ethics committees in healthcare institutions. They still had the following functions:

- monitoring implementation of the ethical and deontological principles of the healthcare profession in the everyday work of healthcare institutions,
- approving research activities (protocols) within the health institution,
- overseeing organ procurement of parts of the human body after dissection for medical, research and teaching purposes,
- resolving other ethical issues in the health institution.

It seems that the work of ethics committees in Croatian hospitals has not significantly changed. They still tend not to discuss clinical ethical cases and review research protocols. However, research undertaken on the possible need to implement clinical ethics services has shown that physicians would like to have such services. There is a need finally to establish the difference between ethics committees reviewing research protocols (i.e. IRBs)¹⁵ and ethics committees reviewing individual cases in patient healthcare treatment (i.e. HECs).¹⁶ Thus, while HECs are allowed to focus exclusively on conflict resolution in individual patient-oriented clinical cases, other ethics committees will be responsible for the

¹⁵ IRBs are the Institutional Review Boards, the committees responsible for the evaluation and approval of research protocols and clinical trials [Editor's note].

¹⁶ HECs are the Hospital Ethics Committees dealing with clinical ethics questions within hospitals [Editor's note].

review of clinical research. By excluding hospital ethics committees from the practice of research protocol review of any type, the current confusing situation will be avoided, and it will be possible to establish legal requirements for the transformation of hospital ethics committees into real healthcare ethics committees.

Nevertheless, improving legal provisions is not the only guarantee of the successful establishment of healthcare ethics committees in Croatia. The bioethical knowledge of the members of hospital ethics committees in Croatia is in need of enhancement. It is therefore necessary to establish extensive educational practices. Educational workshops are important for improving the level of knowledge of ethics committee members.

With the necessary changes to the Croatian healthcare system, hospital ethics committees will become the means to improve quality standards in healthcare delivery, and HECs can indirectly improve the quality of care by providing support to clinicians, nurses, and managers as they face difficult clinical decisions. They will help to create the kind of reflective and critical culture within the healthcare institutions which is essential for clinical governance to be a genuine rather than cosmetic change. From the standpoint of quality control, ethics committees can also be good catalysts for the improvement of physician-patient communication. Hospital ethics committees could be transformed into forums for debate on this issue. By educating both hospital staff and patients with the help of patients' rights NGOs, they could be responsible for changing physician-patient encounters in healthcare institutions. This would require transformation of the membership structure of committees, allowing representatives of patients' rights NGOs and representatives of the local community to be members, which is not the case in Croatia at present. Improvements in this direction could also be made in regard to the age of committee members. Recruiting younger physicians – who have approaches and experiences when encountering their patients different from those of their older colleagues and who, according to our research, tend to be more paternalistic – could transform hospital ethics committees into more patient-oriented structures.

Not only could hospital ethics committees be instrumental in improving the quality of care in healthcare institutions, but they themselves should adhere to quality standards. This approach would also include selection criteria for their members, with emphasis on knowledge and expertise rather than on the social

perception of the status of members in their professions or preferences of the hospital administration which at present, in the majority of cases, are decisive for the election of members of hospital ethics committees in Croatia.

Adequate legal provisions, educational efforts, and the introduction of mechanisms of quality control and orientation to patient rights will transform Croatian hospital ethics committees into bodies able to address policy formation and case consultation – functions that are now almost non-existent in the everyday work of Croatian ethics committees. The case-consultation practice of Croatian ethics committees can be further improved by the creation of databases of cases that have been subjected to ethical analysis and consultation in various hospitals. These databases could be created locally at the hospital level, where an ethics committee could register the case deliberation process and its outcomes in specific cases without identifying the committee members or patients involved. Such databases could provide a corpus of committee case-consultation work. These local databases could be interconnected nationwide so that every hospital ethics committee member, when working on a specific case, could consult the database and see what other committees have recommended in similar cases. This could serve as a practical educational tool for committee members in the case-deliberation process. It should be emphasised that the purpose of these databases would not be to interfere with the decision-making process of other committees, but rather to provide educational guidance.¹⁷

¹⁷ A. Borovecki, H. ten Have, S. Oreskovic, *A Critical Analysis of Hospital Ethics Committees: Opportunity or Bureaucratic Cul-de-Cac*, «Društvena istraživanja», 6 (2006), vol. 15, pp. 1221-1238; A. Borovecki, *Clinical Ethics Consultation in Croatia*, in J. Schildman, J.S. Gordon, J. Vollmann, eds., *Clinical Ethics Consultation: Theories and Methods, Implementation, Evaluation*, Ashgate Publishing Limited, Farnham 2010, pp. 139-147; A. Borovečki, H.M. Sass, *Use of Checklists in Clinical Ethics*, Škola narodnog zdravlja «Andrija štampar», Medicinski fakultet u Zagrebu, Zagreb - Institut für Ethik in der Praxis, Recklinghausen 2008.

