



Croatian physicians' and nurses' experience with ethical issues in clinical practice

I Sorta-Bilajac, K Bazdaric, B Brozovic and G J Agich

J. Med. Ethics 2008;34:450-455
doi:10.1136/jme.2007.021402

Updated information and services can be found at:
<http://jme.bmj.com/cgi/content/full/34/6/450>

These include:

References

This article cites 30 articles, 15 of which can be accessed free at:
<http://jme.bmj.com/cgi/content/full/34/6/450#BIBL>

Rapid responses

You can respond to this article at:
<http://jme.bmj.com/cgi/eletter-submit/34/6/450>

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:
<http://journals.bmj.com/cgi/reprintform>

To subscribe to *Journal of Medical Ethics* go to:
<http://journals.bmj.com/subscriptions/>

Croatian physicians' and nurses' experience with ethical issues in clinical practice

I Sorta-Bilajac,¹ K Baždarić,² B Brozović,³ G J Agich⁴

¹ Department of Social Sciences, Medical Faculty, University of Rijeka, Rijeka, Croatia;

² Department of Medical Informatics, Medical Faculty, University of Rijeka, Rijeka, Croatia; ³ Student, Medical Faculty, University of Rijeka, Rijeka, Croatia; ⁴ BGeXperience Program, Bowling Green State University, Bowling Green, Ohio, USA

Correspondence to:
Iva Sorta-Bilajac, Department of Social Sciences, Medical Faculty, University of Rijeka, B Branchetta 22, 51 000 Rijeka, Croatia; iva.sorta@medri.hr

Received 27 April 2007
Revised 11 July 2007
Accepted 20 July 2007

ABSTRACT

Aim: To assess ethical issues in everyday clinical practice among physicians and nurses of the University Hospital Rijeka, Rijeka, Croatia.

Subjects and methods: We surveyed the entire population of internal medicine, oncology and intensive care specialists and associated nurses employed at the University Hospital Rijeka, Rijeka, Croatia (n = 532). An anonymous questionnaire was used to explore the type and frequency of ethical dilemmas, rank of their difficulty, access to and use of ethics support services, training in ethics and confidence about knowledge in ethics.

Physicians (n = 113, 55% of them female) ranged in age from 27 to 61 years, and nurses (n = 251, 95% female), from 20 to 52.

Results: The most frequent ethical dilemmas concerned uncertain or impaired decision-making capacity (66% of physicians, 47% of nurses, p = 0.008), limitation of treatment at the end of life (60% of physicians, 31% of nurses, p < 0.001) and disagreements among family members (47% of physicians, 31% of nurses, p = 0.025). The most difficult dilemmas concerned euthanasia and physician-assisted suicide (49% of physicians, 52% of nurses) and limitation of treatment at the end of life (14% of physicians, 18% of nurses). Only a minority reported ever using any kind of ethics support services (12% of physicians, 3% of nurses, p = 0.001) or being very confident about knowledge in ethics (5% of physicians, 6% of nurses).

Conclusions: Similar ethical difficulties are present in the clinical practice of both physicians and nurses, with important differences in access and use of ethics support services. A need for systematic ethics educational activities was identified. Inclusion of individual ethics consultants in Croatian healthcare ethics support services is strongly advised.

Morally challenging situations routinely arise in clinical settings.¹ Ethics support services have become an integral part of US health institutions services² and are currently developing in various European countries.³⁻⁶ Development of these services is highly encouraged,⁷ since there is growing evidence of their usefulness.⁸⁻⁹ Most research regarding outcomes of ethical issues in clinical settings focuses mainly on characteristics and experiences of institutional ethics committees and ethics consultation services.¹⁰⁻¹² There have been few systematic studies of the moral values and strategies used by physicians and other healthcare professionals in dealing with morally challenging situations, whether with or without the help of a hospital ethics committee or a consultant.^{2 7 13-17}

The paper by Hurst and colleagues represents the first European attempt to identify the clinical

situations that healthcare professionals consider the most ethically difficult to resolve, attitudes towards the decisions made in such situations, and the type of ethical support service that might be useful.¹⁸ This paper suggests further research in different cultural environments and in different healthcare systems, and especially emphasises the need for comparative data from countries of central and eastern Europe.

Croatia is a transitional country culturally, geographically, economically and politically; hence, it provides an important site for empirical research on clinical ethics. A literature review showed that currently all clinical ethics work in Croatia is done by ethics committees.¹⁹⁻²⁴ Thus, the Croatian experience of clinical ethics is shaped only by ethics committees, one of the three types of ethics consultations used effectively elsewhere. Consultations by smaller consultation groups (team consultations) or individual consultations are not reported.²⁵ An important obstacle in obtaining clinical ethical support from hospital ethics committees is that the main function of these committees in Croatia is the review of clinical research protocols. These committees are thus not constituted to address the other important functions such as education, case analysis and development of guidelines.¹⁹⁻²⁴ For these reasons, we studied the actual clinical ethics needs of health practitioners of the University Hospital Rijeka (UH-Rijeka), the second largest clinical hospital centre in Croatia.

PARTICIPANTS AND METHODS

Participants

The study included 140 (26%) physicians and 392 (74%) nurses (532 total), the entire population of internal medicine, oncology and intensive care specialists and associated nurses employed at the Clinic for Internal Medicine, the Clinic for Anaesthesiology and Intensive Care and the Institute for Radiotherapy and Oncology of the UH-Rijeka, Croatia.

The population was selected to capture physicians and nurses who serve patients with life-threatening illnesses and patients whose care is generally provided in the outpatient setting and requires more routine decisions.^{7 13} To capture both inpatient and outpatient care physicians, general physicians were excluded from our survey, because in Croatia they work exclusively in outpatient care in the primary care setting.²⁶ In this research, both physicians and nurses of the related clinics or institute were included, to take into account the situational features, such as time constraints or interprofessional relations, that can influence the

way in which ethical decision-making actually occurs.² Nurses were included on the assumption that healthcare professionals other than physicians may perceive and solve ethical problems in clinical practice differently.^{16 17 27} The study was conducted from January to April 2007.

Questionnaire

We used items from the original questionnaire developed by Hurst and colleagues to assess ethical issues among European physicians,¹⁸ with the permission of the authors. The questionnaire was translated into Croatian and back translated; we compared the meanings of items and found them equivalent in meaning. The questionnaire was distributed and collected by the authors in the UH-Rijeka, and respondents administered it to themselves.

The introductory part of the questionnaire contains a statement on respect for privacy and data confidentiality. The second part is composed of questions on ethical dilemmas occurring in everyday clinical practice. We used the Ethics experience scale,¹⁸ together with items identifying the type of

ethical dilemma considered to be the most difficult. We also gathered information on access to and use of ethics support services. The third part of the questionnaire contains questions on sociodemographic data, prior training in ethics and confidence about knowledge in ethics.

Protection of human subjects

Participation was voluntary and anonymous. Procedures to ensure confidentiality of data were included. The Ethics Committee of the Medical Faculty, University of Rijeka, and the Ethics Committee of the UH-Rijeka authorised the use of the questionnaire for the purpose of this research.

Statistical analysis

Characteristics of respondents are presented as frequencies. In the Ethics experience scale, the categories “never”, “rarely”, “sometimes”, and “often” were combined into two categories: “never and rarely” and “sometimes and often,” because of the low frequencies in some categories and the consequent inappropriateness of carrying out a χ^2 test.

Mean and standard deviation (SD) were used as values of central tendency and variability of work experience. Median and centiles were used to express mean and spread age of respondents. A χ^2 test was used to assess differences between physicians and nurses in experience with ethical difficulties and ethics support services. The level of significance for which conclusions were considered statistically significant was $p < 0.05$. Data were analysed using Statistica 7.1. (StatSoft, Tulsa, Oklahoma, USA).

RESULTS

Respondents

Respondents' characteristics are shown in table 1. The total number of survey respondents was 364, or 68% of the eligible sample. Physicians ($n = 113$, response rate 81%, female 55%), mean age 42 years (range 27–61), with 18.37 (SD 10.61) years in practice. Nurses ($n = 251$, response rate 64%), were predominantly female (95%), mean age 35 years (range 20–52) with 14.98 (SD 8.89) years in practice.

The primary practice site is the UH-Rijeka for all respondents, a public not-for-profit hospital with each clinic/institute being affiliated as a teaching centre with the Medical Faculty, University of Rijeka. The city of Rijeka has a population of 144 000, but UH-Rijeka serves as a referral centre for an area with a population greater than 500 000.

About half of both populations of respondents (45% of physicians, 52% of nurses) reported having had ethics courses in medical school. Only a minority of both populations reported attending other ethics training, such as six or more medical ethics case presentations (8% of physicians, 3% of nurses), a medical ethics conference (17% of physicians, 10% of nurses) or an intensive course in medical ethics (4% of physicians, 8% of nurses). Only a minority reported being very confident about knowledge in ethics (5% of physicians, 6% of nurses). Respondents' characteristics are shown in table 1.

Experience with ethical difficulties

Respondents most often reported the following ethical dilemmas, but with statistically significant difference between the two professions: uncertain or impaired decision-making capacity (66% of physicians, 47% of nurses, $p = 0.008$), limitation of treatment at the end of life (60% of physicians, 31% of nurses,

Table 1 Respondents' characteristics

Characteristics	Physicians	Nurses
	No (%)	No (%)
Gender	113	234
Male	51 (45)	10 (4)
Female	62 (55)	224 (89)
Years in practice	110	227
1–5	17 (15)	41 (16)
6–15	34 (30)	91 (36)
16 and more	59 (52)	95 (38)
Specialty	113	235
Internal medicine	66 (58)	166 (66)
Oncology	10 (9)	26 (10)
Intensive care	37 (33)	59 (24)
Medical training outside Croatia	113	233
All of it	4 (4)	2 (1)
Part of it	68 (60)	13 (5)
None of it	41 (36)	218 (87)
Training in ethics		
Attendance at medical ethics case presentations	98	186
None	72 (64)	160 (64)
1–5	17 (15)	19 (8)
6 and more	9 (8)	7 (3)
Ethics course in medical school	110	208
Yes	51 (45)	130 (52)
No	59 (51)	78 (31)
Attendance at medical ethics conference	106	199
Yes	19 (17)	25 (10)
No	87 (77)	174 (69)
Attendance at intensive medical ethics course	103	195
Yes	5 (4)	19 (8)
No	98 (87)	174 (69)
Confidence about knowledge in ethics	110	216
Very confident	6 (5)	14 (6)
Somewhat confident	41 (36)	74 (29)
Not very confident	50 (44)	108 (43)
Not at all confident	13 (12)	20 (8)
Former/current clinical ethics committee member	113	228
Yes	6 (5)	1 (0)
No	107 (95)	227 (90)

Table 2 Experience with ethical difficulties

Difficult medical decision-making (dilemma)	Never or rarely, No (%)		Sometimes or often, No (%)		Statistics	
	Physicians	Nurses	Physicians	Nurses	χ^2	p Value
1) You cared for a terminally ill patient and the question of limiting life-sustaining treatment or writing a Do Not Resuscitate order came up.	45 (40)	153 (61)	68 (60)	79 (31)	21.21	<0.001
2) You cared for adult patients whose capacity for decision-making with respect to their own health was uncertain or impaired.	38 (34)	114 (45)	75 (66)	118 (47)	7.42	0.008
3) You were uncertain whether to maintain confidentiality of medical information.	86 (76)	202 (80)	23 (20)	30 (12)	3.77	0.056
4) There was significant disagreement among family members or care givers on the proper course of treatment for the patient.	60 (53)	152 (61)	53 (47)	79 (31)	5.18	0.025
5) Your preferred course of treatment conflicted with institutional policies, professional codes of ethics or laws.	92 (81)	185 (74)	18 (16)	41 (16)	0.16	0.761
6) The preferred course of treatment was not pursued because of a patient's insurance status.	101 (89)	203 (81)	12 (11)	27 (11)	0.09	0.857
7) Rules for payment of services prevented you from using your preferred course of treatment.	95 (84)	209 (83)	17 (15)	17 (7)	4.85	0.034
8) Scarcity of resources required you to make a difficult choice.	83 (73)	202 (80)	30 (27)	26 (10)	12.63	0.001
9) A patient's cultural or religious views conflicted with your proposed course of treatment.	94 (83)	205 (82)	17 (15)	22 (9)	2.31	0.148
10) The patient disagreed with your preferred course of treatment for other reasons.	73 (65)	156 (62)	38 (34)	74 (29)	0.14	0.713
11) You were uncertain if a diagnosis should be disclosed to the patient.	76 (67)	158 (63)	33 (29)	69 (27)	0.11	0.803
12) You were asked for assisted suicide or euthanasia.	111 (98)	230 (92)	2 (2)	3 (1)	0.12	0.663

$p < 0.001$), and disagreement among family members (47% of physicians, 31% of nurses, $p = 0.025$) (table 2).

Most difficult ethical issues

Both physicians and nurses reported that euthanasia or physician-assisted suicide (PAS) (49% of physicians, 52% of nurses) and limitation of treatment at the end of life (14% of physicians, 18% of nurses) were the most difficult ethical dilemmas they faced. The frequency of other items varied between the two populations (table 3).

Ethics support services

Results are shown in table 4. A minority of both populations reported ever using any kind of ethics support services (12% of physicians, 3% of nurses, $p = 0.001$). There was a statistically significant difference in access to different types of ethics support services between physicians and nurses: 44% of physicians reported having access to a clinical ethics committee, versus only 7% of nurses ($p < 0.001$). Access to an individual ethicist was very low in both populations (16% of physicians, 6% of nurses, $p = 0.011$). Access to ethics consultation in individual cases was reported by 31% of physicians, versus 11% of nurses ($p < 0.001$).

DISCUSSION

This is the first survey in Croatia assessing the nature of ethical dilemmas physicians and nurses face in their everyday clinical practice, and their access to and use of ethics support services. Almost half of the physicians (45%) and more than half of the nurses (52%) reported having taken an ethics course in medical or nursing school. The high percentage is explainable because ethics became a required subject in the Croatian medical and nursing curricula in the period 1991–95.²⁸ The percentages correlate with both physicians (45%) and nurses (52%) who had been in practice for up to 15 years. Participation in other types of training in ethics, however, is disappointing. Only a minority reported attending a medical ethics case presentation (23% of physicians, 11% of nurses), and a smaller percentage attended six or more (8% of physicians, 3% of nurses) presentations. Participation in more focused types of training such as medical ethics conferences (17% of physicians, 10% of nurses) or

intensive medical ethics courses (4% of physicians, 8% of nurses) are also discouraging. These findings highlight the need for systematic ethics education during residency and for continuing education programs, and are comparable to the findings of DuVal and colleagues on US internists' experiences with ethical dilemmas,⁷ especially the need for and usefulness of ethics continuing education while in practice.^{29–31} In addition, lack of time or low motivation may contribute to the low participation in non-obligatory types of ethics education, for both physicians and nurses. Collectively, these findings could explain why only a minority of physicians (5%) and nurses (6%) feel very confident about their knowledge in ethics.

Ethical dilemmas are present in clinical practice of physicians and nurses. Both populations reported a high frequency of problems dealing with uncertain or impaired decision-making capacity (66% of physicians, 47% of nurses, $p = 0.008$), limitation of treatment at the end of life (60% of physicians, 31% of nurses, $p < 0.001$), and disagreement among family members (47% of physicians, 31% of nurses, $p = 0.025$). The results obtained regarding physicians in our study accord with those obtained by Hurst and colleagues regarding European physicians' experiences,¹⁸ and with those of DuVal and colleagues from two surveys on experiences with ethical dilemmas and ethics consultation of US physicians.^{7, 13} These findings are especially relevant, since in both surveys US physicians reported the same types of difficulty as being the most difficult and the ones most frequently leading to ethics consultations. Because Croatian physicians also reported these dilemmas as most difficult, one might expect that the difficulties would trigger requests for consultations. Croatian ethics committees, however, provide little case analysis, guidance or reassurance to physicians facing difficult ethical issues,^{19–24} which may point to a need for developing other types of ethics support services, such as those of individual ethics consultants.

Statistically significant differences between physicians and nurses in those three dilemmas (table 2), as well as in dilemmas regarding rules for payment of services or scarcity of resources (although the last two were rarely reported), could be explained by differences in the form and content of moral reasoning of these two professional groups. These situations are clearly

Table 3 Issues most frequently described as the most difficult

Rank	Dilemma	Physicians	Dilemma	Nurses	Dilemma	Total
1	Euthanasia/PAS	49%	Euthanasia/PAS	52%	Euthanasia/PAS	52%
2	Limiting life-sustaining treatment	14%	Limiting life-sustaining treatment	18%	Limiting life-sustaining treatment	18%
3	Scarcity of resources	8%	Uncertainty whether to disclose diagnosis	4%	Uncertainty whether to disclose diagnosis	5%
4	Conflict with cultural or religious views	5%	Patient's insurance status	4%	Patient's insurance status	4%
5	Uncertainty whether to disclose diagnosis	5%	Conflict with cultural or religious views	2%	Conflict with cultural or religious views	3%
6	Disagreement among care givers	4%	Rules for payment	2%	Scarcity of resources	3%
7	Patient's insurance status	4%	Patient's disagreement for reasons other than religious	2%	Rules for payment	2%
8	Impaired decision-making capacity	4%	Scarcity of resources	1%	Conflict with institutional policies, codes, laws	2%
9	Conflict with institutional policies, codes, laws	3%	Conflict with institutional policies, codes, laws	1%	Impaired decision-making capacity	2%
10	Rules for payment	3%	Impaired decision-making capacity	1%	Disagreement among care givers	2%
11	Confidentiality of medical information	0%	Confidentiality of medical information	1%	Patient's disagreement for reasons other than religious	1%
12	Patient's disagreement for reasons other than religious	0%	Disagreement among care givers	0%	Confidentiality of medical information	0%

PAS, physician-assisted suicide.

emotionally challenging, frequently involving conflicts.¹³ It has been claimed that curing is the primary concern of physicians and caring is the concern of nurses.³² It could be argued that the differences are related to the fact that the nurses were oriented towards care, while the physicians were oriented towards both care and justice (deontology). Our findings suggest that nurses have greater emotional involvement in their patients' care, in contrast with physicians and registered nurses, who function more as staff leaders.¹⁷ Croatian nurses are subordinate to physicians, in the sense that they function under protocols and physician orders, rarely having the opportunity for leadership or involvement in the decision-making processes.

The most difficult ethical dilemmas that respondents identified concerned euthanasia/PAS (49% of physicians, 52% of nurses, total 52%) and limiting life-sustaining treatment (14% of physicians, 18% of nurses; total 18%). These findings accord with those reported by Hurst and colleagues, with euthanasia and assisted suicide in particular being ranked high by respondents from all countries.¹⁸ Our findings are not surprising, since euthanasia is illegal in Croatia and is forbidden by the code of medical ethics and deontology of the Croatian Medical Association.³³ Also, Croatia is a predominantly (88%) Catholic country.³⁴ In a survey by Rietjens and colleagues on attitudes towards end-of-life decisions, the non-religious showed more support for active ending of life.³⁵ Similarly, DeCesare reported that public attitudes towards euthanasia and suicide for terminally ill persons show a greater proportion of non-Catholic than Catholic respondents expressed approval of both euthanasia and suicide.³⁶ Thus, legal and professional standards as well as religious commitments seem to explain our findings.

A minority of both groups reported using any kind of ethics support services, but with a statistically significant difference ($p = 0.001$) between physicians (12%) and nurses (3%). The Ethics committee of the UH-Rijeka focuses primarily on research protocol review.²⁴ This focus discourages physicians

from turning to the committee for help with ethical issues relating to patient care. The previously mentioned subordination of nurses to physicians, under the so-called military model of nursing still predominant in the Croatian healthcare system,³⁷ implies no perception of need for ethics support services in nurses. Our findings suggest, however, that both physicians and nurses face ethical difficulties and agree regarding which types occur most often and are most difficult. In order to enhance the perception of ethics support services as something useful in nurses' everyday clinical practice, the Croatian healthcare system should, through redefinition of its regulations, allow them to shift from the military model to the advocacy model of nursing, which recognises the nurse as an active member of the staff, capable of autonomous decision-making and taking a proactive approach in meeting patients' need as a patients' advocate.³⁷ This change would facilitate a more mature sense of responsibility among nurses, which, in turn, would be likely to increase their use of ethics support services.

There is a significant difference between physicians and nurses in access to different types of ethics support services: 44% of physicians reported having access to a clinical ethics committee, versus only 7% of nurses ($p < 0.001$). Access to an individual ethicist is very restricted in both populations (16% of physicians, 6% of nurses, $p = 0.011$). This result is expected, since individual clinical ethicists do not exist in Croatian healthcare institutions. In the UH-Rijeka, however, "off-the-record" consultations in the form of informal advice are sometimes sought from the staff of the Department of Social Sciences of the medical faculty in Rijeka. This practice might explain why a minority of respondents recognised the existence of individual consultants, even though an individual-focused ethics consultation service does not officially exist. We interpret the report of access to ethics consultation in individual cases by 31% of physicians and 11% of nurses ($p < 0.001$) as most likely being a reference to discussions with colleagues on practical matters regarding ethically challenging decisions and situations.

Table 4 Access to and use of ethics support services

Variable	Physicians, No (%)	Nurses, No (%)	Statistics	
			χ^2	p
Access to clinical ethics committee	107	216		
Yes	50 (44)	18 (7)	63.48	<0.001
No	29 (26)	99 (49)		
Don't know	28 (25)	99 (39)		
Access to individual ethicist	106	212		
Yes	18 (16)	14 (6)	9.07	0.011
No	42 (37)	105 (42)		
Don't know	46 (40)	93 (37)		
Access to other help with ethical difficulties	95	219		
Yes	9 (8)	14 (6)	0.69	0.709
No	38 (34)	77 (31)		
Don't know	48 (42)	108 (43)		
Access to ethics consultation for individual cases	110	225		
Yes	35 (31)	28 (11)	19.45	<0.001
No	32 (28)	100 (40)		
Don't know	43 (38)	97 (39)		
Ever used ethics support service	110	223		
Yes	14 (12)	7 (3)	11.46	0.001
No	96 (85)	216 (86)		

Limitations of the study

There are several limitations of our study. Although the results can be taken as representative of the entire Croatian population of the three specialties we studied, we have no evidence that they are applicable to other specialties, and certainly no basis for drawing conclusions about the whole region of central and eastern Europe. An additional limitation is that the questionnaire was originally targeted to physicians, and was therefore designed as such. The lower rate of participation of nurses may be attributable to less comfort with this research method. Further study of nurses' attitudes might benefit from the use of a different study design.

CONCLUSIONS

Both Croatian physicians and nurses perceive that ethical dilemmas are present in everyday clinical practice. Although the two groups reported the same type of difficulties, there are significant differences between them.

Our findings on prior training in ethics lead us to conclude that a systematic approach to ethics education programs through residency or continuous, life-long education is needed. Such an approach might improve confidence about knowledge in ethics for both groups.

There are significant differences between physicians and nurses in their access to and use of ethics support services. A shift from the military model for Croatian nurses might promote a more engaged stance for nurses and enhance their orientation towards the ethics of patient care. Taking into account the agreement of our findings with previous studies of common clinical ethical difficulties leading to requests for consultations,^{7 13 18} a redefinition of functions and goals of Croatian clinical ethics committees is needed. Inclusion of individual ethics consultants in Croatian ethics support services should also be explored and the capacity to offer such services should be developed.

Further comparative exploration of physicians' and nurses' experiences facing ethical difficulties in clinical practice at the other three university hospitals in Croatia as well as in other countries of central and eastern Europe would be especially interesting.

Acknowledgements: The authors wish to thank Marion Danis and Samia A Hurst for allowing us to use their Values at the Bedside questionnaire. We especially thank Samia A Hurst for her help in framing the questionnaire for Croatian language speakers, and invaluable criticism of the research design. We also wish to thank all the physicians and nurses of the University Hospital Rijeka who took the time to complete the questionnaire.

Competing interests: None declared.

REFERENCES

- Lo B, Schroeder SA. Frequency of ethical dilemmas in a medical inpatient service. *Arch Intern Med* 1981;**141**:1062–4.
- Hurst SA, Hull SC, DuVal G, et al. How physicians face ethical difficulties: a qualitative analysis. *J Med Ethics* 2005;**31**:7–14.
- Reiter-Theil S. Ethics consultation in Germany: the present situation. *HEC Forum* 2001;**13**:265–80.
- Salathé M, Leuthold M, Amstad M, et al. [Clinical ethics committees in Switzerland: the current situation.] (In German.) *Bulletin of Swiss Physicians* 2003;**84**:2264–7.
- Slowther A, Johnston C, Goodall J, et al. Development of clinical ethics committees. *BMJ* 2004;**328**:950–2.
- Meulenbergs T, Vermeylen J, Schotsmans PT. The current state of clinical ethics and healthcare ethics committees in Belgium. *J Med Ethics* 2005;**31**:318–21.
- DuVal G, Clarridge B, Gensler G, et al. A national survey of U.S. Internists' experiences with ethical dilemmas and ethics consultation. *J Gen Intern Med* 2004;**19**:251–8.
- Heilicser BJ, Meltzer D, Siegler M. The effect of clinical medical ethics consultation on healthcare costs. *J Clin Ethics* 2000;**11**:31–8.
- Schneiderman LJ, Gilmer T, Teetzel HD, et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. *JAMA* 2003;**290**:1166–72.
- Reiter-Theil S. Ethics consultation on demand: concepts, practical experiences and a case study. *J Med Ethics* 2000;**26**:198–203.
- Simon A. Support for ethical dilemmas in individual cases: experiences from the Neu-Mariahilf Hospital in Göttingen. *J Med Ethics* 2001;**27**(Suppl 1):18–20.
- The Royal College of Physicians. Ethics in practice: Background and recommendations for enhanced support. *Bull Med Ethics* 2006;**Apr-May**(214):9–13.
- DuVal G, Sartorius L, Clarridge B, et al. What triggers requests for ethics consultations? *J Med Ethics* 2001;**27**(Suppl 1):24–9.
- Frederick WC, Wasieleski D, Weber J. Values, ethics and moral reasoning among healthcare professionals: a survey. *HEC Forum* 2000;**12**:124–40.
- Kuhse H, Singer P, Rickard M, et al. Partial and impartial ethical reasoning in health care professionals. *J Med Ethics* 1997;**23**:226–32.
- Holm S, Gjersoe P, Grade G, et al. Ethical reasoning in mixed nurse-physician groups. *J Med Ethics* 1996;**22**:168–73.
- Norberg A, Udén G. Gender differences in moral reasoning among physicians, registered nurses and enrolled nurses engaged in geriatric and surgical care. *Nurs Ethics* 1995;**2**:233–42.
- Hurst SA, Perrier A, Pegoraro R, et al. Ethical difficulties in clinical practice: experiences of European doctors. *J Med Ethics* 2007;**33**:51–7.
- Borovecki A, ten Have H, Oreskovic S. Developments regarding ethical issues in medicine in the Republic of Croatia. *Camb Q Healthc Ethics* 2004;**13**:263–6.

20. **Borovecki A**, Oreskovic S, ten Have H. Ethics and the structures of health care in the European countries in transition: hospital ethics committees in Croatia. *BMJ* 2005;**331**:227–9.
21. **Borovecki A**, ten Have H, Oreskovic S. Ethics committees in Croatia in the healthcare institutions: the first study about their structure and functions, and some reflections on the major issues and problems. *HEC Forum* 2006;**18**:49–60.
22. **Borovecki A**, ten Have H, Oreskovic S. Education of ethics committee members: experiences from Croatia. *J Med Ethics* 2006;**32**:138–42.
23. **Frkovic A**, Gotic N. Practical experiences in the work of institutional ethics committees in Croatia on the example of the Ethics Committee at Clinical Hospital Center Rijeka (Croatia). *HEC Forum* 2006;**18**:37–48.
24. **Borovecki A**, ten Have H, Oreskovic S. [A critical analysis of Croatian hospital ethics committees: opportunity or bureaucratic cul-de-sac?] (In Croatian.) *Druš Istraž* 2006;**6**:1221–38.
25. **Frkovic A**. [Bioethics in clinical practice.] (In Croatian.) Zagreb: Pergamena, 2006:42–7.
26. **Croatian Parliament**. [Healthcare Protection Act. NN121/2003.] (In Croatian.) <http://www.nn.hr/sluzbeni-list/sluzbeni/index.asp> and navigate to the act (accessed 17 April 2008).
27. **Reiter-Theil S**. Balancing the perspectives. The patient's role in clinical ethics consultation. *Med Health Care Philos* 2003;**6**:247–54.
28. **Gotic N**. [Bioethics education.] (In Croatian.) Zagreb: Pergamena, 2005:163–97.
29. **Arnold R**. Teaching clinical medical ethics: a model programme for primary care residency. *J Med Ethics* 1988;**14**:91–6.
30. **Perkins H**. Teaching medical ethics during residency. *Acad Med* 1989;**64**:262–6.
31. **Jennett P**, Crellinsten G, Kinsella T. Advanced training in biomedical ethics: a curriculum in clinical specialty programmes. *Med Educ* 1993;**27**:484–8.
32. **Jecker NS**, Self DJ. Separating care and cure: an analysis of historical and contemporary images of nursing and medicine. *J Med Philos* 1991;**16**:285–306.
33. **Croatian Medical Association**. [Code of medical ethics and deontology.] (In Croatian.) <http://www.hlk.hr/Download/2008/02/21/kodeks.pdf> (accessed 17 April 2008).
34. WWW.HR - Croatian Homepage. Religions. <http://www.hr/croatia/people/religion> (accessed 22 Apr 2008).
35. **Rietjens JAC**, van der Heide A, Onwuteaka-Philipsen BD, et al. A comparison of attitudes towards end-of-life decisions: survey among the Dutch general public and physicians. *Soc Sci Med* 2005;**61**:1723–32.
36. **DeCesare MA**. Public attitudes toward euthanasia and suicide for terminally ill persons: 1977 and 1996. *Soc Biol* 2000;**47**:264–76.
37. **Segota I**. [Nursing ethics]. (Original in Croatian.) Zagreb: Pergamena, 1997:47–53.

Call for contributions

Medical Humanities, a twice-yearly supplement of the *Journal of Medical Ethics*, aims to be a leading international journal that reflects the whole field of medical humanities, with high-quality articles relevant to all those interested in medical humanities, particularly to healthcare professionals, humanities and arts scholars, social scientists and policy makers, medical educators and patients.

Medical Humanities aims to encourage a high academic standard for this evolving and developing subject and the enhancement of professional and public discussion. It features original articles relevant to the delivery of healthcare, the formulation of public-health policy, the experience of being ill and of caring for those who are ill, as well as case conferences, educational case studies, book, film and art reviews, editorials, correspondence and news and notes. To ensure international relevance *Medical Humanities* has Editorial Board members from around the world.

We welcome original papers from any part of the world, from all relevant approaches, as well as interesting empirical studies. We also welcome educational case studies, book, film and art reviews, letters, personal viewpoints and poetry and prose relevant to the experience of illness.

Papers should be written in a non-specialist language and should ideally be readable by any well-informed individual, in particular by both healthcare professionals without specific expertise in the humanities, arts or social sciences and by scholars in the humanities, arts or social sciences with no practical healthcare experience.

For our part, the Editors will:

- ▶ ensure that all important issues in medical humanities are welcome in the journal.
- ▶ ensure that a fair, independent peer review system is in place.
- ▶ adhere to the highest ethical standards concerning editorial and research conduct.

To submit your paper please go to <http://submit-mh.bmj.com/>. If you have any queries or require assistance, please contact the Editorial Office (email: mh@bmjgroup.com; tel: +44 (0)207 383 6139).