

## Hospital Ethics Committees in Korea<sup>†</sup>

KOH Younsuck\*, MENG Kwang-ho\*\*, KOO Young-Mo\*\*\*,  
SOHN Myong-sei\*\*\*\*, HWANG Sang-Ik\*\*\*, HONG Changgi D\*\*\*\*\*

**Objectives :** To identify the present status of the Hospital Ethics Committees (HECs) activities in Korea.

**Design, setting, participants :** A postal survey was sent to 76 major residents training hospitals. Additionally, we included the data related to HEC obtained from our another survey to identify residents' personal perception of medical ethics.

**Main measurements and results :** HECs were present at 48 of the 58 responding hospitals. Theologians, social workers, and lawyers are rarely involved with HECs. Only five HECs have held a meeting more than once per month. The main barriers to having an active, consistent HEC were time shortages of the members, and inadequate knowledge of medical laws or medical ethics. The thirteen respondents believed their HEC's recommendations had a major influence on clinical practices. Two-third (66.6%) of responding residents did not know the existence of HEC in their hospitals. The most common reasons to develop a new HEC was to lighten a physician's burden in terms of ethics and law.

**Conclusion :** The HECs activities were poor. To address the growing number of ethical dilemmas or medical disputes at the hospitals, systematic assistance to promote the activity of HECs seems to be urgently required in our society.

---

<sup>†</sup> This study was supported by Asan Research Institute for Society and Medicine.

\* Department of Internal Medicine, Asan Medical Center, College of Medicine, University of Ulsan:  
Corresponding Author (email : yskoh@www.amc.seoul.kr)

\*\* Department of Preventive Medicine, College of Medicine, Catholic University of Korea

\*\*\* Department of the History of Medicine and Medical Humanities, Seoul National University  
College of Medicine

\*\*\*\* Department of Preventive Medicine and Public Health, College of Medicine, Yonsei University

\*\*\*\*\* Department of Internal Medicine, Asan Medical Center, College of Medicine, University of Ulsan

## Introduction

The recent and enormous advancements in modern medicine demand a collaborative and multidisciplinary approach, requiring combined efforts from medicine, philosophy, law, theology, and social and behavioral sciences. Ethical decision-making in complicated clinical cases naturally needs a professional approach. However, a physician's knowledge regarding ethics is usually obtained from his/her undergraduate education, which tends to focus on the teaching of ethical theories or concepts around prominent ethical issues such as euthanasia. This type of training has been difficult to apply to clinical practice. Therefore, it is not strange that physicians experience considerable difficulty in making competent ethical decisions in their day-to-day clinical practices. Paternalistic attitudes and behaviors among physicians have dominated professional demeanor in Korea until now. However, the changes in patient-physician relationship and the decrease in public trust of physicians, lead to increasing medical disputes in our society.

Hospital Ethics Committees (HECs) can help to identify ethical issues, as well as provide professional advice to address ethical conflicts. In contrast to the important roles of HECs in clinical practice in North America,<sup>1,2)</sup> the role of ethics committees relative to clinical matters has been very limited in Korea. Moreover, it can be expected that the role of the HEC in clinical practices would be very different depending on hospitals in Korea, because there is no universally mandated role of a Hospital Ethics Committee.

The aims of the study were to assess the current status of HEC in resident training hospitals and to describe the opinions of respondents regarding the improvement of HEC activity in Korea.

By addressing the detected problems in HEC management, we would like to improve the activities of the committees, which would lead to the improvement of the physicians' work environment and to foster the public trust in physicians.

---

1) Perkins HS, Saathoff BS. Impact of medical ethics consultations on physicians: an exploratory study. *American Journal of Medicine* 1988;85(6):761-5.

2) Rosner F. Hospital medical ethics committees: a review of their development. *JAMA* 1985;253(18):2693-7.

## Methods

In the summer of 1998, the authors distributed a confidential questionnaire to 76 major residents training hospitals in Korea, which includes 34 university hospitals and 42 general hospitals. The 26 topics of the questionnaire include organization, support from the hospital, activities related to the meeting, treated areas, influence of the committee's decision on the physician's practice, and barriers for effective HEC activities. The questionnaire was sent to the chairperson of each hospital under the auspices of the Korean Hospital Association. To analyze residents' personal perception of their HEC, we included the data obtained from another survey, which was done to identify residents' perceptions regarding medical ethics, at the same time as this survey. The survey for the residents' medical ethics was done at all four grades of medical residency, randomly at the 14 major university hospitals in Korea. We randomly administered the questionnaire to the 2,000 house officers. Nine hundred forty medical residents responded to the survey for a 47% response rate.

Results are expressed as a number or percentage of respondents. Data were analyzed with SAS statistical program (SAS Institute Inc., version 6.12, Cary, NC, USA). The Chi-square test and Mantel-Haenszel Chi-square test were used to test the significance of differences in responses. Differences were considered to be statistically significant if  $p < 0.05$ . This study was approved by the Institutional Review Board at Asan Medical Center.

## Results

### Characteristics of the responding hospitals

Fifty-nine hospitals (77.6%) responded; 31 university hospitals (91.2%) and 28 general hospitals (66.7%). The hospital beds numbered more than 1,000 in eight hospitals, more than 500 and less than 1,000 in 24 hospitals, and more than 100 and less than 500 in 27 hospitals (Table 1).

The residents in first year comprised 26.1% of respondents ( $n=245$ ), second year 26.7% ( $n=251$ ), third year 26.8% ( $n=252$ ), and fourth year 20.4% ( $n=192$ ).

### Organization of HEC

HECs were present at 48 hospitals (81.4% of respondents). Among the eight hospitals, which had more than 1,000 beds, two hospitals did not have HEC. There was no difference in the organization of the HEC according to hospital size divided by patient beds as in three groups in this study (81.5%, 83.3%, and 75.0% according to increase in beds) ( $p > 0.05$ ) or between university hospitals (90.3%) and general hospitals (71.4%) ( $p = 0.063$ ) (Table 1). They were mostly organized on or after 1990 (38, 79.2%). Only one university hospital had HEC previous to 1980. The most common name of HEC was ethics committee (26, 54.2%) followed by HEC (7, 14.6%). HECs mainly consisted of doctors (43, 83.3%) and nurses or office workers (41, 83.3%) from the same institution. Theologians, social workers, and lawyers involved were 11 (23.0%), 7 (14.6%), and 4 (8.3%) HECs in each of the levels examined (Figure 1). The operation was managed by documented regulation in 79.2% of HECs. The supports from the hospitals included manpower and financial help (8 HECs, 16.7%), clerks (13, 25%), or strong interest from the leaders of the hospital (16, 33.3%). However, only 12 HECs (25%) had a full-time clerk to conduct desk works for the committee. Twenty-five per cent of respondents had not received any support from the hospitals. Fourteen hospitals (29.2%) opened the HEC to the patients.

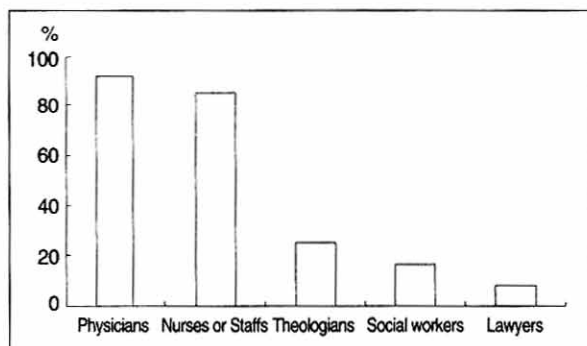
### Operation of HEC

They held the committee meetings as needed (32, 66.7%) or regularly (15, 31.3%)

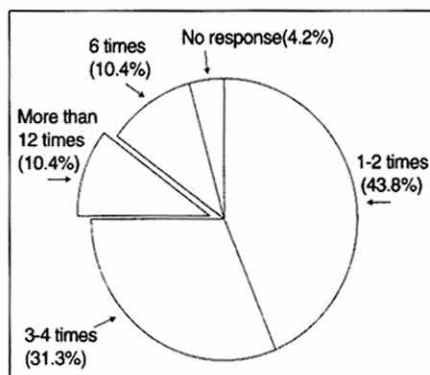
**Table 1.** Presence of Hospital Ethics Committee Depending on Status or Size of Hospitals

	With HEC	Without HEC
<b>University Hospitals</b>		
≥ 1,000*	6	1
999 - 500	18	2
< 500	4	0
<b>General Hospitals</b>		
≥ 1,000	0	1
999 - 500	2	2
< 500	18	5
<b>Total</b>	<b>48</b>	<b>11</b>

The rate of organization was 90.3% in university hospitals and 71.4% in general hospitals ( $p = 0.063$ ). The rate was not different depending on hospital size. HEC: hospital ethics committee \*: Number of beds

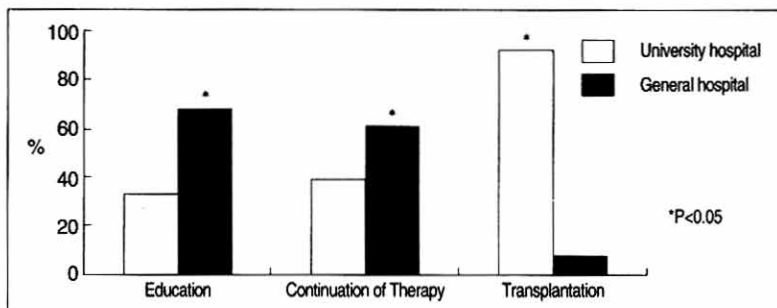


**Figure 1.** The proportion of members of 48 hospital ethics committees. Theologians, social workers, and lawyers involved were 11 (23.0%), 7 (14.6%), and 4 (8.3%) respectively in each of the levels examined.



**Figure 2.** The meeting frequencies of 48 hospital ethics committees per year.

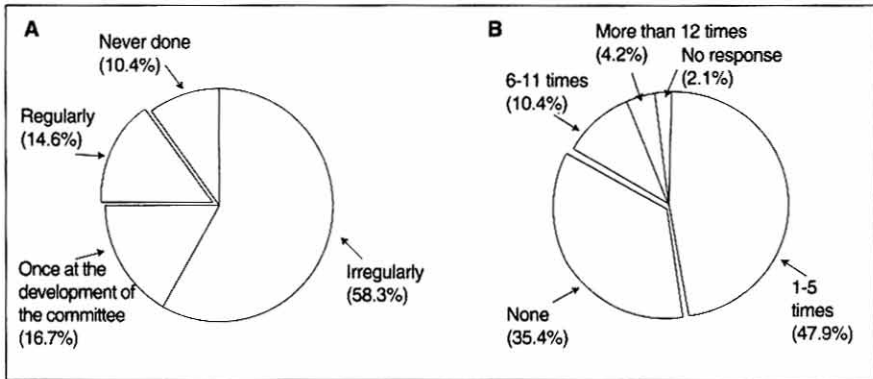
(Figure 2). The average interval of the meeting was one month (5, 10.4%), 2 months (5, 10.4%), 3 or 4 months (15, 31.3%), or more than 6 months (20, 41.7%). There was no difference in the frequency of meetings between the university hospitals and the general hospitals, nor was it dependent on the presence of a full-time clerk, or on the frequency of information regarding the committee to the staff ( $p > 0.1$  in each). Only seven hospitals (14.6%) regularly publicized their HEC activities to the physicians and hospital staff (Figure 3). Others did public relations irregularly (28, 58.3%) or only once when the HEC was developed. Five hospitals did not announce the presence of HEC to their staff. The annual frequency of consultation from caregivers to HEC was more than 12 times (2, 4.2%), 6 to 11 times (5, 10.4%), 1 to 5 times (23, 47.9%), or none (16, 33.3%) (Figure 3). There was also no difference in the frequency of consultation between the university hospitals and the general hospitals



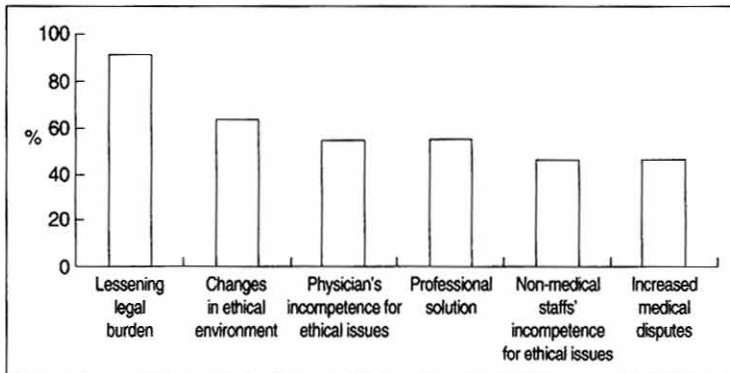
**Figure 3.** The different areas managed by the committees between university hospitals and general hospitals. The preparation of regulation associated with medical ethics, and the issues related to the continuation of therapy due to medical cost were more frequently handled subjects in general hospitals (68.0%, 60.9% in each) compared with those in university hospitals (32.0%, 39.1% in each) ( $P < 0.01$ ). In contrast, ethics related to transplantation was undoubtedly more frequently managed in the university hospitals (92.3%) compared with that in general hospitals (7.7%) ( $p = 0.04$ ).

or in the frequency of information regarding the committee to the staff ( $p > 0.1$  in each). They managed physician's unethical conduct (39, 81.3%), issues associated with patients' rights (33, 68.8%), preparation of regulations regarding medical ethics (32, 66.7%), medical ethics education for the hospital staff (25, 52.1%), issues related to the continuation of therapy and associated medical costs (23, 47.9%), consultation regarding specific therapy (21, 43.8%), issues related to clinical research (18, 37.5%), do-not-resuscitate (DNR) orders (12, 25%), transplantation (12, 25%), and euthanasia (8, 16.7%).

Depending on the status of hospitals, treated areas were different. Medical ethics education, preparation of regulation associated with medical ethics, and issues related to the continuation of therapy and associated medical costs were more frequently handled subjects at the general hospitals (68.0%, 90.0%, 60.9% in each) compared with those at the university hospitals (32.0%, 53.6%, 39.1% in each) ( $P < 0.01$ ). In contrast, ethics related to transplantation was undoubtedly more frequently managed at university hospital (92.3%) compared with that at general hospitals (7.7%) ( $p = 0.04$ ) (Figure 4). There was a system to provide hospice to the patients in 17 hospitals (35.4%). In case, 2 of 17 hospitals held a joint meeting with HEC. The system for hospice was more prevalent at university hospitals (53.6%) than at general hospitals (16.7%) ( $p = 0.012$ ). Twenty-three hospitals had a person responsible for a program



**Figure 4.** Activity of 48 hospital ethics committees in public relations (A) and number of times physicians consulted HEC (B).



**Figure 5.** The reasons to newly develop a hospital ethical committee in 11 hospitals; to alleviate the physicians' burden from ethics and law (9, 81.8%), to cope with recent changes in work environment in medical ethics (7, 63.6%), due to deficient perception to medical ethics among the medical staff (5, 45.5%) or non-medical staff (5, 45.5%) of hospital, for professional solutions to ethically inappropriate conducts (5, 45.5%), and increased incidence of medical disputes (4, 36.4%).

for medical ethics education for the hospital staff.

Regarding documented hospital regulations for medical records, confidentiality, DNR, or clinical research, the numbers were 42 (87.5%), 38 (79.2%), 4 (8.3%), or 23 (47.9%) of 48 hospitals in each. Among the 28 hospitals to perform organ transplants, 16 hospitals (57.1%) reported having documented regulations associated with transplantation ethics. Only 10 of 48 (35.7%) hospitals reported a system to support medical expense for poor patients. When they were consulted, the members were

given a written summary of the case considered by the referring physician and were allowed extra days to investigate the case, then met for discussion, and followed up the problem until the completion in 18 HECs (37.5%). Sixteen HECs (33.4%) had held committee meetings and reported to the referring clinician without a close follow-up of the recommendations of the committee. In 11 HECs (22.9%), members of the committee just received a written summary of the case, which was provided by the chairperson of the committee according to the summary by the referring clinician, and were asked to consider their response.

The execution of a decision made by the committee was confirmed by close investigation with documentation (26, 54.2%) or by a report from the related staff (19, 39.6%). Two HECs (4.2%) reported that they had not confirmed the final results. The barriers for the effective activity of HEC were described as time shortage of the members (35, 72.9%), inadequate knowledge of medical laws (21, 43.8%) or medical ethics (14, 29.2%), or financial difficulty (6, 12.5%). The respondents believed that participation of a medical ethics specialist (29, 60.4%), public relations to hospital staff and patients or their families for HEC (25, 52.1%), expert knowledge of the members (25, 52.1%), systemic support and guaranteed authorization for the committee's decision (24, 50.0%), legal connection with local law court (23, 47.9%), full time clerk (22, 45.8%), and financial support for the activity (18, 37.5%) were required for the efficient management of HEC.

#### The effect of HEC's decision on the resolution to the issued problem

The thirteen respondents (27.1%) believed their HEC's recommendations had major influences on physicians' clinical practices. Others believed that the decision had seemed to be considered just as advice to the associated physicians (25, 52.1%) or did not seem to have any effect on the physician's practice at all (5, 10.4%).

#### Residents' personal perception to the HEC

Two-thirds (66.6%) of residents did not know that HEC was available for consultation in their hospital. However, 51.9% of residents experienced the need for the opinion of such a committee.

Respondents reported that HEC participation was necessary in resolving medical disputes (40.8%); to teach residents how to resolve ethical dilemmas (10.4%) or to



resolve ethical dilemmas (7.1%). They liked easy access to the HEC by brief written consultation (38.4%), by telephone (12.1%), or by direct consultation (10.9%) in stead of detailed written report (2.4%).

The requisites for successful ethics committee participation included; the commitment of the members to resolve requested conflicts (32.6%), convenience of consultation (13.1%), guaranteed authorization for the committee's decision (8.0%), the expert knowledge of the members (6.7%), connections with local court of law (4.8%), and publicity for their role in the hospital (2.6%).

### The reasons to set up newly HEC

All of the 11 hospitals at which HEC was not available had a plan to set up HEC. The reasons to create HEC were to alleviate physicians' burden regarding the ethics and law (9, 81.8%), to cope with recent changes in work environment in the aspect of medical ethics (7, 63.6%), due to deficient perception to medical ethics among the medical staff (5, 45.5%) or non-medical staff (5, 45.5%) of the hospital, for professional solutions to ethically inappropriate conduct (5, 45.5%), and increased incidence of medical disputes (4, 36.4%) (Figure 5).

## Discussion

The usual methods to resolve an ethical issue in Korea have depended on personal discussions with patients or their families or clinical colleagues, because there are no available professional ethical consultants at most hospitals. That is, ethical decision making processes used to be largely dependent on a physician's personal values, attitudes, and behaviors. According to our other survey intended for the residents, which was done at the same time as this investigation, residents' perception of their work environment in terms of medical ethics was poor. More than two-third (77.2%) of 940 residents encountered serious ethical dilemmas during medical practice at least once per year in that survey. However, they did not seem to be supported by systematic assistance for their ethical dilemmas or medical disputes from the hospitals. In reality, despite of rapid growth in the quality and quantity of clinical practice, our medical care system seems merely concerned with caring for diseases, injury, and infirmity. In fact, there has been no system that focuses its efforts on the

total care of patients including medical ethics in most hospitals. A well-managed HEC could be one of the solutions to meet these requirements in spite of some pitfalls.<sup>3)</sup>

Although most HECs in Korea were developed on or after 1990 (38, 79.2%), it was a positive finding that all of the responding hospitals realized the necessity of HEC. HEC may be helpful at least in three situations;<sup>4)</sup> firstly, when clinicians need guidance for medical ethics involved in patients' care, secondly, when it may be desirable to test public opinion before acting on a decision that might provoke damaging opposition, thirdly, when clinicians' working team is unable to reach a consensus for an ethical decision associated with medicine. In fact, HEC may help to facilitate communication with patient surrogates and among the patient's caregivers, and help to inform the surrogates about the availability of resources to provide their patient with the best possible future.<sup>5,6)</sup> Majority of the committee members consisted of physicians, nurses, and hospital staff in Korea. Theologians, social workers, and lawyers were involved in only 11 (23.0%), 7 (14.6%), and 4 (8.3%) HECs in each.

Each hospital is recommended to demonstrate a respect for the patient by developing policies to recognize the rights of, and respect for personal dignity.<sup>7)</sup> According to this study, regulations regarding medical records and confidentiality were equipped at most of the responding hospitals. However, many of them were not equipped with regulations regarding DNR order (8.3%), clinical research (47.9%), and transplantation (57.1% of among the 28 hospitals to perform organ transplantation). Only 10 of 48 (20.8%) hospitals reported having system to support medical expense for poor patients.

Mostly, the HEC has been held by the clinicians' referral. Therefore, regular communications to the hospital staff and patients for the committee's activity is very important for the active HEC. However, only 7 hospitals (14.6%) regularly

---

3) Lo B. Behind closed doors. Promises and pitfalls of ethics committees. *New England Journal of Medicine* 1987;317(1):46-50.

4) Thornton JG, Lilford RJ. Clinical ethics committee. *BMJ* 1995;311(7006):667-9.

5) La Puma J, Toulmin SE. Ethics consultants and ethics committees. *Archives of Internal Medicine* 1989;149(5):1109-12.

6) Simpson KH. The development of a clinical ethics consultation service in a community hospital. *Journal of Clinical Ethics* 1992;3(2):124-30; discussion 131-7.

7) Sexson WR, Thigpen J. Organization and function of a hospital ethics committee. *Clinics in Perinatology* 1996;23(3):429-36.

announced their HEC activity to the physicians and hospital staff. Not surprisingly, 66.6% of responding residents did not know that HEC was available for consultation in their hospitals. Only 10 HECs (20.8%) reported the average meeting interval as less than 2 months. One of the interesting findings in this study was that the frequency of meetings or physicians' consultation rates were not associated with the frequency of public relations regarding the committee to staff or with the status of hospitals. These results may partly relate to insufficient public relations about the committee to the staff. However, the attitude of physicians to the consultation would be also causally related to the results. In fact, the residents working in university hospitals in Korea addressed their ethical dilemmas alone (15.1%) or by discussion with colleagues (25.4%), or by consultation with senior residents (44.9%). Only 0.7% of responding residents brought the problems to HEC. In addition, the committee activity, which would be lower than the expectation of physicians, could be another important reasons. Actually, only 18 HECs (37.5%) did follow up the consulted issues until completion. In 11 HECs (22.9%), the members of the committee just received a written summary of the case without meeting for discussion. In such cases, it is hard to say that the committee's recommendations give serious consideration. With these findings, we can say that the HECs are inactive at present in Korea. Therefore, systematic assistance to promote the activity of HEC seemed to be urgent to address growing ethical dilemmas or medical disputes in our society. In fact, only 12 HECs (25%) had a full-time clerk. Moreover, to get the credit from the referring physicians the committee should give a reasonable and practical advice for consulted problems by including suitable experts for professional ethical or legal opinion. More than 50% of respondents believed that participation of medical ethics specialists (29, 60.4%), publicizing activities of HEC to staff and patients or surrogates (25, 52.1%), expert knowledge of the members (25, 52.1%), and systemic support and guaranteed authorization for the committee's decision (24, 50.0%) are prerequisites for the efficient running of HEC. The residents described that the commitment of the members to resolve requested conflicts, convenience, or guaranteed authority for the committee's decision would be the requisites for successful management of HEC. In addition, adoption of professional consultants for medical ethics who can handle a case more urgently than the committee, can be another way to resolve ethical dilemmas in the teaching hospitals.<sup>8)</sup> However, the shortage of professional medical

ethicists is another problem in our situation.

Regarding the authority of the committee, the HECs have been purely consultative rather than prescriptive in Korea as recommended by the American Medical Association.<sup>9)</sup> The reason that guaranteed authorization for a committee's decision by the agency responsible for the hospitals was considered an important factor might be, in part, associated with the finding that 10.4% of responding HECs believed their advise no affect to the physician's practice at all. However, it is not ideal that the committee would absolutely stand by the decision that it offered. Fourteen hospitals (29.2%) opened the HEC to the patients. It is desirable for HEC to be accessible to all interested persons, including patients, too. For that, HECs should try to fairly address ethical dilemmas that affect the patient's care and to directly promote the interests of patients instead of serving the interests of the hospital. In addition, the committee should be cautious not to reach a decision just to minimize their exposure to criticism. Moreover, HEC may offer an attractive alternative to the court, and may reduce the risk of litigation and/or prosecution.<sup>10)</sup> In fact, the most common cause to develop HEC in the hospitals, in which the committee was not organized, was revealed to lessen physicians' burden from the ethics and law in this study.

This study is limited in its scope by the fact that investigated hospitals were all resident training hospitals. The current status of the HEC in other general hospitals should also be investigated in the near future.

In conclusion, although the number of hospitals with HEC has increased rapidly since 1990, the activities were still poor. To address the growing ethical dilemmas or medical disputes at the hospitals, systematic assistance to promote the activity of HEC seemed to be urgent in our society. In addition, the committee can cope with problems by including suitable experts for professional ethical or legal opinion. Finally, the committee needs to encourage the hospital staff and patients to discuss their ethical conflicts with HEC.

**Key Words :** Hospital Ethics Committee, Korea, Medical Ethics

- 
- 8) Swenson MD, Miller RB. Ethics case review in health care institutions. Committees, consultants, or teams? *Archives of Internal Medicine* 1992;152(4):694-7.
- 9) Anonymous. Guidelines for ethics committees in health care institutions. Judicial Council. *JAMA* 1985;253(18):2698-9.
- 10) Fost N, Cranford RE. Hospital ethics committees. Administrative aspects. *JAMA* 1985;253(18):2687-92.

## **Acknowledgements**

The authors thank Dr. Yong Moon Park for his valuable contribution in the statistical analysis and the Korean Hospital Association for their assistance to this survey. We thank the Asan Research Institute for Society and Medicine for their support to this investigation.

= 한글 초록 =

## 우리나라의 병원의료윤리위원회

고윤석\* · 맹광호\*\* · 구영모\*\*\* · 손명세\*\*\*\* · 황상익\*\*\* · 홍창기\*\*\*\*\*

**연구 배경 :** 최근 사회적으로는 진료 중 발생하는 다양한 의료윤리 문제들에 대해 전문적이고도 체계적인 접근을 의료계에 요구하고 있다. 또한, 의료윤리에 연관되어 환자를 진료한 의사에게 법적인 제재를 가하려는 범조계의 움직임도 있어 의료윤리에 관련된 문제들을 더 이상 의사 개인의 가치관과 판단에 맡길 수 없게 되었다. 본 연구는 대학병원과 대학협력병원들을 대상으로 의료윤리 문제를 나름대로 해결해 나가는 방식에 대하여 설문 조사를 통하여 그 현황을 파악함으로써 한국적 의료 상황에 있어 실질적이고도 효율적인 병원의료윤리위원회의 모델을 갖추기 위한 기초자료로 활용하고자 시행하였다.

**대상 및 방법 :** 전국 76개 전공의 수련병원(대학병원 34개, 종합병원 42개)을 대상으로 설문조사를 시행하였다. 설문 내용은 병원의료윤리위원회가 구성되어 있는 병원에 대해서는 윤리위원회의 구성 및 운영(8개), 활동 상황 및 현황(15개), 윤리위원회의 영향력(2개) 및 윤리위원회의 운영상 개선점(1개) 등에 관한 것이었다. 구성되어 있지 않은 경우는 구성 계획에 대한 의견과 구성할 경우 구성 이유, 구성 시 예상되는 어려움 점 및 윤리위원회가 다루어야 할 영역에 관해 질의하였다. 구성할 계획이 없는 병원에 대해서는 그 이유에 대해 질의하였다.

### 결 과 :

1. 회신 : 설문지는 총 76부가 배포되었으며 그 중 대학병원 31개(91.2%)와 종합병원 28개(69.1%)에서 회신하여 총 회신률은 73.7%이었다. 회신한 병원들의 지역 분포는 서울 30.5%(18개), 경기, 강원, 대전, 충남 25.4%(15개), 부산, 대구, 경남 북 30.5%(18개) 및 전남북 13.6%(8개)이었다.
2. 병원의료윤리위원회의 구성 유무 : 응답한 대학병원 31개 중 28개(90.3%), 종합병원 28개 중 20개(71.4%)에서 윤리위원회가 구성되어 있었다. 대부분 90년 이후에 구성되었으며(38개/48개; 79.2%) 가장 많이 사용되는 공식 명칭은 윤리위원회(54.2%)였다. 윤리위원회의 구성원으로 11개 병원(23.0%)에서 종교인이, 4개 병

원(8.3%)에서 법조인이, 그리고 7개 병원에서 사회사업가(14.6%)가 참여하였다. 13개 병원(27.1%)에서 윤리위원회의 전담 사무요원이 있었다.

3. 의료윤리위원회의 운영 : 정기적으로 회의를 소집하는 경우보다(31.3%) 필요 시 소집하는 경우가(66.7%) 많았으며 한 달에 1회 이상 회의를 소집하는 경우는 10.4%, 1년에 1-2회만 소집하는 경우는 41.7%였다. 회의 빈도는 대학병원과 종합병원 사이에 차이가 없었다.

79.2%가 윤리위원회 운영지침서가 준비되어 있었고 병원지휘부로부터 적극적인 지원을 받는 경우는 16개 병원(33.3%)이었으며 25%는 전혀 지원이 없었다.

4. 활동 상황 및 현황 : 의료인의 비윤리적 행위(81.3%), 환자의 권리에 관한 사항(68.8%), 의료윤리에 연관된 병원 규정 작성 및 검토(66.7%), 직원대상 의료윤리 교육(52.1%), 진료비와 관련된 진료 지속 문제(47.9%), 특정 치료 여부에 대한 자문(43.8%), 환자 대상 임상연구의 윤리적 타당성(37.5%), 심폐소생술 수행여부에 대한 결정(25.0%) 등의 순이었다. 윤리위원회의 활동을 환자나 그 가족들에게 홍보하는 경우는 29.2%였고 의사들에게 정기적으로 윤리위원회에 관하여 홍보하는 경우는 14.6%였다. 의사들이 윤리위원회에 자문을 구하는 빈도는 1년에 12회 이상이 4.2%, 6-11회가 10.4%, 1-5회가 47.9%이었으며 33.3%의 병원은 전혀 받지 못했다고 응답하였다. 자문을 받았을 경우 37.5%의 위원회는 회의 소집 후 문제가 해결될 때까지 적극적으로 관여하며, 33.4%의 위원회는 회의 소집과 상황에 대한 보고나 조사만을 하며, 22.9%의 위원회는 회의 소집 없이 보고서만 제출받는다고 하였다. 윤리위원회의 결정 사항 이행 여부에 대한 추적은 93.8%의 위원회에서 시행하고 있었다.

5. 윤리위원회의 영향력 : 전체 응답의 27.1%가 윤리위원회의 결정이 절대적인 영향력을 미친다고 하였으며 52.1%는 참고 정도의 영향력이 있다고 판단하였으며, 10.4%는 전혀 영향력이 없다고 하였다.

6. 윤리위원회의 활동에 어려운 점과 개선해야 할 사항 : 위원들의 위원회 활동에 할애하는 시간의 부족(72.9%), 관련의료법의 지식 부족(43.8%), 위원들의 의료윤리 관련 전문지식 부족(29.2%) 및 재정적 어려움(12.5%) 등이 윤리위원회 활동에 제약을 초래하였다. 운영을 개선하기 위한 사항으로 의료윤리 전문가의 참여(60.4%), 위원회 활동에 대한 병원 내 홍보(52.1%), 위원 대상 전문 교육의 필요(52.1%), 위원회 활동에 대한 제도적 지원(50.0%), 법적 자문이 가능하도록 위원회와 지역 법원과의 연계(47.9%), 전담 사무요원의 확보(45.8%) 및 병원의 재정적 지원(37.5%) 등이 지적되었다.

7. 윤리위원회가 없는 병원들 : 윤리위원회가 없다고 응답한 11개 병원 모두가 향후

윤리위원회를 구성할 계획을 갖고 있으며 필요한 이유는 의료인들을 윤리적 및 법적 부담으로부터 보호(81.8%), 진료 행위에 대한 법적 규제와 같은 최근의 의료환경(63.6%), 의료직 및 비의료직 직원들의 의료윤리에 대한 인식부족(각 45.5%), 보호자와 의료진의 잦은 마찰(36.4%) 등의 빈도로 나타났다.

**결론** : 본 설문 조사를 통하여 최신 병원 모두에서 병원의료윤리위원회의 필요성을 느끼고 있었으나 구성된 병원들도 대부분 윤리위원회의 활동이 미미한 것으로 나타났다. 윤리위원회의 활동을 활성화시키기 위하여 환자와 그 가족 및 병원 직원들을 대상으로 보다 적극적인 홍보와 제도적인 지원을 통한 전문위원의 영입 및 위원들의 전문성 확보 등이 필요한 것으로 생각된다.

색인어 : 병원의료윤리위원회 · 한국 · 의료윤리

---

\* 울산대학교 의과대학 내과학교실, 책임저자 (email : yskoh@www.amc.seoul.kr)

\*\* 가톨릭대학교 의과대학 예방의학교실

\*\*\* 서울대학교 의과대학 의사학교실

\*\*\*\* 연세대학교 의과대학 예방의학교실

\*\*\*\* 울산대학교 의과대학 내과학교실