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Ethics Knowledge, Attitude and Behaviors of University Hospital Residents in Korea

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Purpose : To identify residents' personal perception of their work environment regarding medical ethics in Korea.

Method : We administered a questionnaire to the 2,000 residents who work in the university hospitals.

Results : Nine hundreds forty residents responded. Most of residents had experienced a serious ethical dilemma or intimidation from patients or their families during their practices. Only 4.3% of the responding residents were familiar with the medical laws. 20.1% of respondents had the experience of trying to get a signed consent without a detailed explanation. In addition, most of the residents felt uncomfortable disclosing bad information directly to patients.

The patient's family or the attending staff mainly influenced the decision of do-not-resuscitate orders. Faced with the family's insistence on withdrawing life-sustaining therapy, a majority of respondents accepted the request. Most of the residents expressed their opinions personally to colleagues concerned, which had unethical practices. They usually solved their ethical dilemmas by discussion with the senior residents or colleagues. Most of the respondents desired ethics training during residency.

Conclusion : It is urgent that educational program directors for residency should

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provide a regular educational program for medical ethics and law to address the complex ethical obligations.

Introduction

Paternalistic attitudes and behaviors among physicians have dominated professional demeanor in Korea until recently. As medicine provides more advanced and complicated therapies to patients without accompanying and appropriate communications between the patient and professional, the patient-physician relationship has deteriorated. The decrease in public trust of physicians leads to increasing medical disputes in our society. The reasons may, in part, rest on increasingly complicated ethical issues and perhaps by increased patient's expectations of modern medicine. However, a very important source of difficulty may be the inappropriate management of ethical conflicts in patient care as addressed by physicians. Although medical ethics education in medical schools has grown rapidly since 1990, like the American medical schools in the 1970s,[1] the education in undergraduate medical school and during residency training is currently inadequate in Korea. The major goals for resident education are primarily directed toward the development of clinical knowledge and skills in patient care. Most residency training programs in university hospitals in Korea are just beginning to try to meet the requirements for ethics education in patient care. There are no clinical ethicists or active hospital ethics committees to help residents resolve ethical dilemmas encountered daily by physicians in university hospitals. Therefore, residents are expected to encounter frequent ethical problems during routine patient management with insufficient knowledge and immature attitudes toward resolving ethical conflicts. However, the ethical environment perceived by the trainees, as well as resident knowledge, attitudes, and behaviors of ethical conflicts during training remain hardly addressed in Korea.

The aims of the study were; first, to assess resident perceptions of the ethical environment across four years of education; second, to describe the knowledge,

1) Veatch RM, Sollitto S. Medical ethics teaching. Report of a National Medical School Survey. *JAMA* 1976;235(10):1030-3.

attitude, and behaviors regarding commonly encountered ethical conflicts during residency training. The results of this study are directly applicable to residency education programs in university hospitals. We assert that professional and personal ethical problem solving abilities importantly influence ethical patient care and the integrity of the patient-physician relationship, as well as fostering public trust for physicians, which requires professional self-regulation.

Methods

In the summer of 1998, the authors distributed a confidential questionnaire to randomly selected 2, 000 residents in four years of medical residency at the 14 major university hospitals in Korea.

The 29 topics of the questionnaire included demographic information, their experience of medical disputes, 15 topics commonly encountered as an ethical dilemmas during patients' care such as discontinuation of therapy, and residents' desire for medical ethics education. To analyze their attitude and behavior, we asked questions about methods of resolving the ethical dilemmas encountered and their personal observations of unethical and unprofessional conduct in medicine. We arbitrarily grouped residents from Internal Medicine, Neurology, Pediatrics, Psychiatry, Dermatology, Emergency Medicine, and Family Medicine as Medical residents. Residents in the department of General Surgery, Orthopedics, Thoracic Surgery, Neurosurgery, Plastic Surgery, Obstetrics and Gynecology, Urology, Opthalmology, and Ear, Nose, and Throat were grouped as Surgical residents. The residents in Rehabilitation, Diagnostic Radiology, Pathology, Clinical Pathology, Anesthesiology, Therapeutic Radiology, and Nuclear Medicine were grouped as Support residents.

Results are expressed as percent of respondents or odd ratio (OR) with 95% of confidence interval (CI). Data were analyzed with SAS statistical program (SAS Institute Inc., version 6.12, Cary, NC, U.S.A). Two-tailed Student' s t-tests, analyses of variance, the Chi-square test, Mantel-Haenszel Chi-square test, and logistic regression analysis were used to test the significance of differences in responses where appropriate. Differences were considered to be statistically significant if p-value is lower than 0.05. This study was approved by the Institutional Review Board

at Asan Medical Center.

Results

Demographic characteristics of the respondents

Nine hundreds forty residents returned the survey, for a response rate of 47%. Male residents comprised 80.7% (n=759), while 19.3% (n=181) were female residents. Among the respondents, 37.2% of residents had completed 3 year military service, that is a national obligation for the healthy Korean man. The number classified as Medical residents were 539 (57.4%), Surgical residents 353 (37.6%), and residents in Supportive medicine 48 (5.0%). The number of residents in the first year was 245 (26.1%), second year 251 (26.7%), third year 252 (26.8%), and fourth year 192 (20.4%). More than half of residents (510, 54.3%) reported no religion, while 13.6% were Catholics, 27.1% Christian, and 5.0% Buddhist.

Situations in which ethical dilemmas were encountered

A significant 77.2% of residents encountered a serious ethical dilemma during medical practice at least once per year (Figure 1). Among them, 44.5% of residents experienced serious ethical dilemmas more than 2 times per year (Figure 2). Only 12.2% of respondents did not experience any ethical dilemmas. There was no difference in the frequency of experienced ethical dilemmas according to the year of

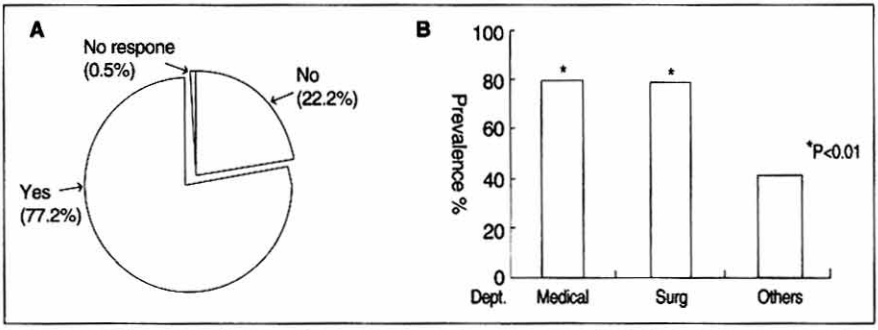

Figure 1. The prevalence of experience of encountered ethical dilemmas during clinical practice (A), and the differences in the prevalence according to their specialty (B). The medical (79.7%) or surgical (79.1%) residents experienced ethical conflicts more frequently than the support residents (42.6%) did (p=0.001).

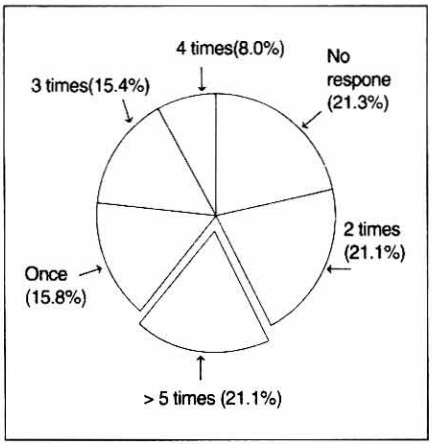

Figure 2. The annual frequencies of encountered ethical dilemmas during patient management among the 77.2% of 940 responding residents.

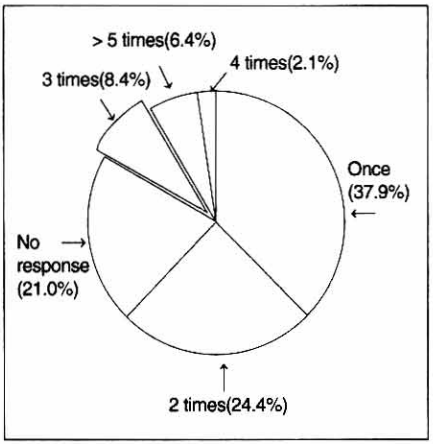

Figure 3. The annual frequencies of encountered medical disputes during patient management among 62.2% of 940 responding residents

residency (p=0.211) or gender of resident (p=0.058). The Medical (79.7%) or Surgical (79.1%) residents experienced the ethical conflicts more frequently than the Support residents (42.6%) (p=0.001) (Figure 1). Residents working in the national university hospitals (68.9%) and in hospitals (69.7%) located other than Seoul (the capital city of Korea) experienced the dilemmas more frequently compared with the residents working in the private university hospitals (59.9%) or at the hospitals located in Seoul (60.1%) (p<0.01 in each). Of the 62.2% of respondents who experienced an instance of intimidation from patients or their families by abusive language or physical threat, 16.9% of them suffered the threats more than 2 times per year (Figure 3). Surprisingly, 6.4% of residents experienced these threats more than 5 times per year. Medical (63.8%) and Surgical (64.7%) residents experienced the threats more frequently than the Support residents (31.3%) (p=0.001). Women reported fewer threats (53.0%) compared with men (64.7%) (p=0.004). Third year (OR=1.8, 95% CI; 1.1-3.1) and fourth year (OR=2.5. 95% CI; 1.4-4.3) residents were significantly less likely to experience a threat compared with first year residents.

Attitudes and knowledge of medical ethics and law

Only 4.3% of the responding residents reported that they possessed detailed

knowledge of the law as it relates to professional responsibility for patient care. One third (35.6 %) of residents did have any knowledge of the law relevant to medicine. One fifth (20.1%) of respondents had experienced obtaining informed consent for a medical procedure without providing a detailed explanation of the procedure to the patient. This experience was significantly less frequent for fourth year residents compared with first year of residents (OR=0.6, 95% CI; 0.3-0.9). Even in those cases where residents attempted to meet the requirements for obtaining consent, 43.9% of respondents thought that patients or their family did not fully understand their explanations.

Regarding truth telling, most residents were uncomfortable disclosing 'bad news' directly to a patient. Only 4.8% of the residents routinely disclosed truthful information directly to patients. Disclosure of information by residents to patients was guided by attending physicians for 33.7% of residents, and determined by the suggestion of the patient' s surrogate in the 49.9% of residents. In addition, 10.0% of the responding residents believed that 'bad news' , which would adversely affect the patient' s emotions, should not be disclosed to the patient. The respondents regarded patient' s spouse (66.1%) as the appropriate surrogate, followed in frequency by the patient' s parents (20.9%), a child older than 18 years (8.2%), a legally-appointed agent (3.0%), brothers and sisters (1.3%), and a guardian who supports the patient' s medical cost (0.5%).

The decision to enter a do-not-resuscitate (DNR) order for a terminally ill patient was mainly influenced by the family' s opinion (46.3%) or by the attending physician (39.1%). For 9.7% of responding residents determined the DNR orders without consultation. In addition, 2.8% of the respondents thought that DNR orders should not be performed in incapacitated patients such as comatose patients. When there is a disagreement over decisions of DNR orders between doctors and the patient or family, residents followed the opinion of the family (46.3%) or of the attending physician (12.3%). One third (35.3%) of the respondents persuaded the patients or their family to accept the DNR decision. Third (42.9%) and fourth year (46.1%) residents attempted more to persuade patients or their family to follow the physician' s decision compared with first (30.6%) and second (34.0%) year residents (p=0.013). Only 17.7% of respondents routinely considered the medical expense to patients as a factor in decision making. However, as residents become more experienced, there is

an increasing tendency to give patient's medical expense greater weight in decision making (p=0.01 by Mantel-Haenszel Chi-square test). Almost all (96.3%) respondents had the experience of discontinuing life-sustaining therapy for a patient due to financial difficulty in meeting medical expense. The decision to discontinue life-sustaining therapy was determined by the attending physician (34.7%) or by the patient's family (23.2%).

Only 2 of 905 respondents had consulted the hospital ethics committee in making such a decision. Faced with a family's insistence on the withdrawal of life-sustaining therapy in a critically ill patient, the majority of respondents (71.2%) accepted the family's request. They expressed the belief that the decision about continuation of therapy rests with patients or their family in case of an incompetent patient. However, 14.1% of residents did not agree with the request for discontinuation of therapy for patients, who seem to have a little chance to recover, even though the decision reflected the patient's request. Moreover, in the case of incompetent patient who can not decide the withdrawal of life-sustaining therapy alone, 9.5% of residents reported to deny such a request from the patient's family. The reasons given for opposing the requested discontinuation of therapy were the sanctity of life (76.2%), residents' personal values (8.8%), advise from the attending physicians or senior residents (6.2%), or a determination by the hospital ethics committee (1.4%). Conflicts which created the greatest difficulty in continuing life-sustaining treatment against a family's wishes included: the expectation of blame from the family (36.7%); the family's concern about the medical expense (32.2%); violent language or physical insult from the family (15.9%); or, the stress from the unwillingness to countermand an attending physician's order to discontinue therapies (7.7%). Religious values affected their ethical decisions related clinical practice for 37.3% of respondents. With respect to resident experience in clinical research, 43.0% of residents experienced ethical dilemmas.

Ways of addressing unethical conduct of colleagues

Regarding resolution of unethical and unprofessional conduct by colleagues, most of the residents (n=781, 83.1%) expressed their opinions personally to the colleague concerned (Figure 4). Only 3.4% of respondents reported the problem to attending faculty (n=27, 2.9%) or hospital ethical committee (n=5, 0.5%). Furthermore, 11.4%

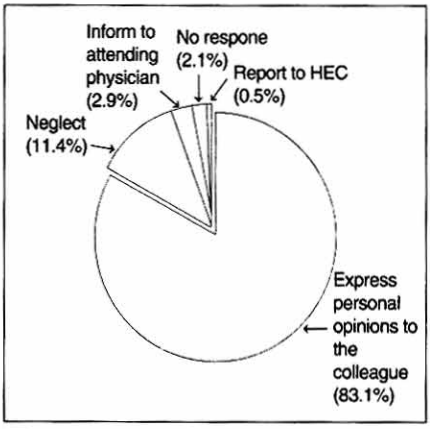

Figure 4. Ways of addressing unethical conduct of colleagues.
HEC; hospital ethics committee

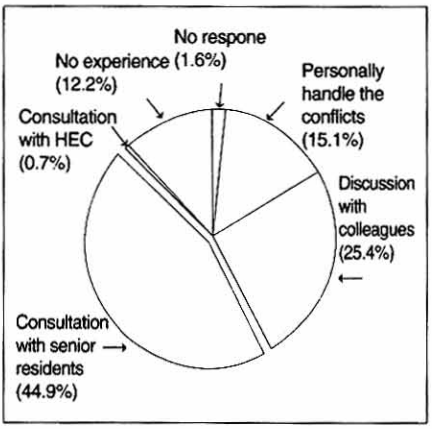

Figure 5. Ways to address encountered ethical conflicts.
HEC; hospital ethics committee

of respondents (n=107) left the matter unresolved. When they faced with ethical dilemmas, respondents resolved conflicts alone (15.1%), by discussion with the colleagues (25.4%), or by consultation with senior residents (44.9%), or consultation with the hospital ethics committee (0.7%) (Figure 5).

Experiences of education in medical ethics

A majority (71.1%) of respondents reported having had a medical school ethics course. However, only 16.6% of residents had been educated in an ethics program provided by the hospital during their residency. A requirement for education about medical ethics and law was reported by 57.0% of the respondents and 38.4% of residents reported an intention to attend education programs if provided by the hospital. Only 2.3% of the residents reported no necessity to be educated about medical laws. Compared with first year residents, third year residents were inferior in knowledge of medical law (OR=0.7, 95% CI; 0.5-0.9). The third year residents had a stronger desire for the education in medical law compared with first year residents (OR=1.5, 95% CI; 1.0-2.1).

Discussion

The medical ethics education is not well developed in most university hospitals of

Korea where ethical decision makings have been largely dependent on physician's personal values, attitudes, and behaviors. Although medical ethics education has rapidly grown in undergraduate medical schools since 1990, the goals for resident education in university hospitals of Korea are still mainly focused on the development of clinical knowledge and skills in patient care. Residency educational program providers have not given great attention to the vital contribution of ethics and humanities to patient care together with clinical knowledge and skills. This study revealed that residents' perception of their work environment is seriously lacking in the ethics dimension of patient care and professional responsibility. In addition, this investigation also showed that residents faced perceived ethical dilemmas or interpersonal disputes beginning as early as the first year of residency. However, inferring from the answers to the questions how to resolve ethical conflicts, residents did not seem to be supported by a systematic education for their ethical dilemmas or medical disputes in the hospitals. While there were no differences in the experiencing frequency of ethical dilemmas according to gender or seniority, residents who work in private university hospitals or in hospitals located in Seoul had experienced the problems less frequently. Women and third and fourth year residents experienced a lower frequency of exposure to abusive language or physical threats compared with men or first year residents. The reasons for these differences are not evident from this study. However, it may be simply explained by the facts that senior residents meet patients or their family less frequently than first or second year residents.

Respect for patient autonomy, which balances the principle of beneficence, has been the central principle underpinning the changes in recent medical practice in Korea. To promote respect for patient's autonomy, the first step would be to engage the patient in a process of respectful and compassionate listening together with full disclosure by the physician and telling the truth to patients. However, residents in this study were uncomfortable with disclosure of 'bad news' directly to a patient. Only 4.8% of the residents routinely and truthfully revealed clinical information directly to patients. In addition, 20.1% of respondents had reported an experience of obtaining consent without offering a detailed explanation related to the medical procedure. Even in cases of successfully obtaining informed consent, 43.9% of responding residents thought that the patients or their family did not fully understand their explanations. Although other studies show that physicians are reluctant to initiate

discussions about end-of-life issues with patients or their family,[2][3] it was a disappointing result for us that the decision of DNR orders for critically ill patients was made by the residents alone in 9.7% of the time. Moreover, 1.7% of responding residents decided alone to discontinue therapy according to the patients or their family's request, a decision based on difficulty meeting medical expenses. Resident physician's misunderstanding of the law with respect to patient care obligations may be a partial explanation for these decision.

In fact, only 4.3% of the responding residents reported that they knew the medical laws in any detail. It is certainly a physician's obligation to understand a patient's personal values to appropriately manage decisions about truth telling, informed consent, discontinuation of life-sustaining measures, or the other myriad issues common to daily practice. However, the heavy load of resident's clinical responsibilities at university hospitals in Korea significantly compromises the quality of time available to the resident for evaluation of patient's value in the detail necessary for optimum patient care. To overcome these problems, institutional leaders should reduce residents' clinical burden, in addition to providing appropriate training in communication including how to listen to, and deliver information to, patients appropriately.

Cost awareness regarding patient care is a perspective that balances the physician's ethical obligations toward individual patients with their duties toward society whose pooled resources pay for medical services.[4] Although there was an increasing tendency to give patient's medical expense more weight in decision making as residents become more experienced, only 17.7% of respondents routinely considered the medical expenses of patients. The physician's unawareness to the medical cost may, in part, contribute to the frequent requests to discontinue a life-sustaining therapy of the patients from patient's family based on difficulty to meet the medical expenses.

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2) Emanuel LL, Barry MJ, Stoeckle JD, Ettelson LM, Emanuel EJ. Advance directives for medical care—a case for greater use [see comments]. *New England Journal of Medicine* 1991;324(13):889-95.

3) Brunetti LL, Carperos SD, Westlund RE. Physicians' attitudes towards living wills and cardiopulmonary resuscitation. *Journal of General Internal Medicine* 1991;6(4):323-9.

4) Garland MJ. Integrating cost awareness with ethics in the undergraduate medical curriculum. *Journal of Medical Education* 1985;60(1):44-52.

Unethical conduct in medicine is not rare during resident's training.[5] According to this study, only 3.4% of residents consulted attending physicians or hospital ethical committee for ethically inappropriate behaviors of colleagues. The residents did not discuss their colleagues' ethical conflicts with attending physicians, although most of them (83.1%) expressed their opinions personally to the person concerned. The 3.4% consultation rate was far below compared with that of Shreves' report.[6] Therefore, most of attending physicians may not have been aware of the ethical conflicts. Residents usually resolved ethical dilemmas through discussion with their colleagues (25.4%) or senior residents (44.9%). These attempts at resolving conflicts are not ideal, do not necessarily serve patient interest or resident's well-being, and may reflect a lack of knowledge among residents about conflict resolution strategies and ethical decision making.

However, respondent's desire for the education of medical ethics and law was high. Over one-half (57.0%) of the respondents in this study, in addition to the 38.4% of residents who had an intention to attend the education if provided, believed the ethical training should be mandatory during their residency. These results are very similar to Sulmasy's report, in which 65% of house officers wanted ethics training.[7] In fact, residency is a critical time to foster ethical reasoning.[8]

Therefore, educational program directors for residency should encourage attending physicians to deliver education for medical ethics and law during regular attending rounds.[9][10] The faculty member's resistance to, and limited knowledge of medical ethics, is considered to interfere with their abilities to teach ethics to house officers. Regular education programs for faculty and resident physicians should also be

5) Baldwin DC, Jr., Daugherty SR, Rowley BD. Unethical and unprofessional conduct observed by residents during their first year of training. *Academic Medicine* 1998:73(11):1195-200.

6) Shreves JG, Moss AH. Residents' ethical disagreements with attending physicians: an unrecognized problem. *Academic Medicine* 1996:71(10):1103-5.

7) Sulmasy DP, Dwyer M, Marx E. Knowledge, confidence, and attitudes regarding medical ethics: how do faculty and housestaff compare? *Academic Medicine* 1995:70(11):1038-40.

8) Barnard D, Clouser KD. Teaching medical ethics in its contexts: Penn State College of Medicine. *Academic Medicine* 1989:64(12):744-6.

9) Jacobson JA, Tolle SW, Stocking C, Siegler M. Internal medicine residents' preferences regarding medical ethics education. *Academic Medicine* 1989:64(12):760-4.

10) Carson RA, Curry RW, Jr. Ethics teaching on ward rounds. *Journal of Family Practice* 1980:11(1):59-63.

provided by hospitals. Moreover, other barriers including time constraints of residents and faculty,[11] should be also addressed for the successful implementation of the programs for residents. In addition, easy access to consultants should be available for resolution of ethical uncertainties and conflict in hospitals. The long-term solution to improve residents' confidence in dealing with ethical issues may be well-programmed continuing ethics education from undergraduate medical education through residents training programs.[12][13] We hope that these suggestions will lead to improvement in working conditions of residents and ethics education, which may lead to improved patient care at reduced cost.[14]

This study is limited in its scope by the fact that residents who participated were all in training at university hospitals. The ethical difficulties of the residents working in general hospitals should also be investigated in the near future.

In conclusion, university residents are commonly exposed to medical disputes, and ethical dilemmas in Korea. Thus, residency program directors have an urgent obligation to provide ethics educational curricula in medical ethics and law for resident physicians. Additionally, residency program directors should encourage residents to discuss their ethical conflicts with attending physicians or hospital ethics committees to help residents fulfill their complex ethical obligations to patients and families in daily medical practice. Finally, the faculties must model appropriate professional attitudes and behaviors at the patient's bedside for resident education in ethical patient care.

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11) Strong C, Connelly JE, Forrow L. Teachers' perceptions of difficulties in teaching ethics in residencies [see comments]. *Academic Medicine* 1992:67(6):398-402.

12) Sulmasy DP, Geller G, Levine DM, Faden R. Medical house officers' knowledge, attitudes, and confidence regarding medical ethics [see comments]. *Archives of Internal Medicine* 1990:150(12):2509-13.

13) Pellegrino ED, Hart RJ, Jr., Henderson SR, Loeb SE, Edwards G. Relevance and utility of courses in medical ethics. A survey of physicians' perceptions. *JAMA* 1985:253(1):49-53.

14) Holloran SD, Starkey GW, Burke PA, Steele G, Jr., Forse RA. An educational intervention in the surgical intensive care unit to improve ethical decisions. *Surgery* 1995:118(2):294-8: discussion 298-9.

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Key Words : Medical Ethics, Residents, Knowledge, Attitude, Behavior

= 한글 초록=

대학병원 전공의들의 의료윤리 문제에 관한 지식, 태도 및 실천에 대한 조사연구

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

연구 배경 : 전공의들은 환자나 그 보호자들과의 관계에서뿐만 아니라 치료자 상호간에 환자 진료와 연관된 의료윤리 문제들과 마주치게 된다. 지금까지 우리나라 대부분 의과대학들의 정규 교육과정에 의료윤리 교육이 부족하며 또한 전공의 수련 중에 이에 대한 교육을 받는 경우도 매우 드물다. 이로 인해 전공의들은 흔히 겪는 크고 작은 의료윤리 문제들의 해결에 어려움을 겪을 것으로 예상되나 이에 대해 잘 알려져 있지 않다. 본 조사는 전공의들이 경험하는 의료윤리 문제들의 현황을 파악하여 전공의 대상 의료윤리 교육의 기초 자료로 활용하고자 시행하였다.

대상 및 방법 : 전국 14개 의과대학 병원에 근무하는 전공의들을 대상으로 무작위로 설문조사를 시행하였다. 설문 내용은 의료 현실(19개), 문제 해결 방식(2개), 의료윤리 교육(2개) 및 병원윤리위원회(4개) 등에 관한 것으로 총 27개 문항들로 구성되었다.

결 과 :

1. 회신률 : 설문지는 총 2,000부 배포되었으며 그 중 11개 의과대학 병원 940명이 회신하여 회신률은 47%이었다. 회신 지역별로는 서울 75.5%(709명), 경기, 강원, 충남북 10.7%(101명), 경남북 8.8%(83명) 및 전남북 5.0%(47명)이었다.
2. 회신자 구성 : 전공과목별로는 내과계 전공의 57.4%, 외과계 전공의 37.6% 및 기타(마취과, 방사선과, 임상 및 해부 병리과, 산업의학과) 5.0%이었고 1년차에서 4년차까지 고루 분포하였다. 남자가 80.7%였으며 그 중 군복무를 마친 전공의는 37.2%이었다. 전체 응답자의 54.3%가 종교가 없었으며 기독교 27.1%, 가톨릭교 13.6% 및 불교 5.0%이었다.
3. 의료 현실에 관한 사항 : 진료 중 의료윤리 문제로 갈등을 경험한 경우가 77.2%이었고 이들 중 1년에 3번 이상 경험한 경우도 41.8%였으며 내과계 79.7%, 외과계 79.1%로서 기타 42.6%보다 높았다(p=0.001). 전체 응답자 중 환자나 보호자들로부터 심한 욕설이나 신체적 위협을 당한 경우가 62.2%였고 내 · 외과계 전공의들이(63.8% 및 64.7%) 기타 과들(31.3%)에 비하여, 남자 전공의들이(64.7%) 여자

전공의들에(53.0%) 비하여, 국립대학병원 전공의들이(68.9%) 사립대학병원에 근무하는 전공의들에(59.8%) 비하여, 서울에 위치한 병원에 근무하는 전공의들보다(60.1%) 서울 외 지역 전공의들이(69.7%) 더 많이 경험하는 것으로 나타났다(각 $p<0.01$). 환자 대상 임상 연구 중 의료윤리 문제로 43.0%가 갈등을 경험하였다.

전체 응답자의 78.8%는 의료행위에 관련된 동의서를 받을 경우 설명을 하였으나, 환자나 보호자의 43.9%가 그 내용을 잘 이해하지 못한 채 동의하고 있다고 전공의들은 생각하고 있었다. 의료행위 동의서를 받을 때 설명을 하지 않은 경험은 사립대학병원 근무 전공의가(22.7%) 국립대학병원 전공의에(14.6%) 비하여, 남자 전공의가(22.5%)가 여자 전공의에(11.24%) 비하여 높게 나타났다(각 $p<0.01$). 환자의 상태에 대해 사실을 말하기 어려운 경우에 응답자의 49.9%는 보호자가 원하는 방향대로 얘기하며 4.8%만이 환자에게 모든 것을 말해야 한다고 응답하였다. 진료관련 결정시 가장 중요한 참고인은 66.1%가 배우자라고 응답하였다. 동료 전공의가 윤리적으로 부적절한 행위를 할 때 83.1%는 해당 동료의사에게 사적으로 자신의 의견을 말하며 11.4%는 자신과 상관이 없으므로 방치한다고 응답하였다.

진료비에 대해서는 환자가 어려움을 호소할 때만 고려하는 경우가 46.5%이었으며 소생 가능성이 있으나 진료비 부담의 어려움 때문에 진료를 중단한 경우를 응답자의 96.3%가 경험하였다. 소생 가능성이 희박한 경우 환자나 그 가족이 퇴원을 강력히 요구할 때 그 의사를 받아 들이는 경우가 응답자의 71.2%였으며 소생가능성이 조금이라도 있다면 14.1%는 퇴원 요구를 받아 들이지 않는다고 하였다. 이와 같이 환자나 그 가족과 치료 지속 여부에 대한 이견이 있을 때 전공의들의 판단 기준은 생명의 존엄성이 76.2%, 종교적 신념이나 자신의 가치관이 8.8%로서 선배 의사들의 충고(6.2%)나 병원윤리위원회의 결정(1.4%)보다 우선하였다. 이러한 경우 진료 지속의 어려움은 환자 상태가 악화되었을 때 보호자들의 비난(36.7%)과 진료비 부담(32.2%)에 대한 염려가 보호자들의 폭언(15.9%)보다 높게 나타났다.

4. 환자나 그 보호자들과의 갈등 해결 방식 : 60.8%가 응답하지 않았으며 31.5%의 전공의들은 관계를 호전시키기 위하여 노력하며 관계 형성을 포기하거나 환자와의 관계가 소원해지는 경우는 3.9%이었다. 해결 방법은 선배의사나(44.9%) 동료들과(25.4%) 상의하여 결정하며 종교적인 신념이 진료관련 의사 결정에 영향을 미치는 경우는 응답자의 37.3%가 있다고 대답하였다.
5. 의료법에 관한 지식 및 의료윤리 교육 사항 : 전체 응답자의 4.3%만이 의료법을 자세히 알고 있었으며 대강 알고 있는 경우가 59.2%, 잘 모르는 경우가 35.6%이었다. 연차별(1년차 31.3%, 2년차 35.3%, 3년차 41.2%, 4년차 36.0%; $p=0.044$), 성

별(남 33.1%, 여 48.0%; p=0.001)에 따라 의료법 지식의 차이가 있었으며 응답자의 95.4%는 의료법 교육을 받을 의사가 있다고 하였다. 의과대학 재학 시 71.1%가 의료윤리 교육을 받았다고 하였으며 연차가 낮을수록(1년차 80.6%, 2년차 72.0%, 3년차 68.2%, 4년차 69.7%) 교육을 많이 받았다(p<0.05). 병원 근무 중 의료윤리 교육을 받은 응답자는 16.6%이었으며 서울지역(15.8%)보다 서울외 지역 병원에 근무하는 전공의(20.9%)들이 교육을 받은 경우가 많았다(p<0.01).

6. 병원윤리위원회에 관한 사항 : 근무하는 병원에 윤리위원회의 존재 여부를 모르는 전공의가 66.6%였으며, 51.9%가 윤리위원회의 도움이 필요하다고 느끼며 특히 서울 외 지역 전공의가(60.3%) 서울지역 전공의에(52.6%) 비하여 필요성을 더 느끼고 있었다(p<0.05).

   또한 의료윤리문제로 환자나 그 보호자와 갈등을 경험한 전공의들이(59.4%) 경험하지 않은 전공의들에(37.0%) 비하여, 환자나 가족들로부터 욕설 등을 경험한 전공의들이(60.4%) 경험하지 않은 전공의들에(45%) 비하여 그 필요성을 더 많이 느꼈다(각 p=0.001). 필요한 이유로는 발생 가능한 법적 부담을 줄이기 위하여(27.3%), 갈등의 원만한 해결을 위하여(13.5%) 등의 순이었다. 윤리위원회의 운영은 타과진료방식과 같은 형태(38.4%)나 전화상담(12.1%), 개인상담(10.9%) 방식을 원하였다. 병원윤리위원회의 성공적인 운영을 위해서는 윤리위원회 위원들의 적극적인 문제 해결 의지(32.6%)가 이용의 편이성(13.1%)이나 위원들의 전문성(6.7%)보다 중요하다고 응답하였다. 윤리위원회가 다루어야 할 사항으로는 진료비 관련 진료 지속여부(59.5%), 심폐소생술 자문(53.1%), 안락사문제(51.2%), 환자 권리(50.6%), 의료인의 비윤리적 행위(46.4%), 환자대상 연구(45.3%) 등의 순서로 중요하다고 하였다.

결 론 : 응답자의 대부분이 의료윤리에 관련된 갈등을 경험하고 있으며 전공의 과정 중 의료윤리에 관련된 교육이 시행되기를 원하고 있어 체계적인 의료윤리 교육을 전공의에게 제공해야 할 것으로 생각한다.

색인어 : 의료윤리 · 전공의 · 지식 · 태도 · 실천

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