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ETHICS IN COMMUNICATION IN ORGANIZATIONAL CULTURE IN HEALTHCARE FACILITIES

Abstract. The presented study on ethics in communication in organizational culture in healthcare facilities deals generally with ethics in health care. It touches the Hippocratic oath and ethical codes. Describes the patient's relationship as a client of a healthcare facility and a physician in terms of the specificity of their situation. Indicates the difference between the standard market client and the clients of the healthcare market. In view of these differences, the communication process and possibilities are characterized.

Keywords: ethics, medical ethics, communication, relationship patient – physician

ETYKA W KOMUNIKACJI W KULTURZE ORGANIZACYJNEJ W PLACÓWKACH SŁUŻBY ZDROWIA

Streszczenie. Prezentowany artykuł porusza etyczne aspekty komunikacji w kulturze organizacyjnej w ogólnej etyce opieki zdrowotnej. Przedstawia on przysięgę Hipokratesa i kodeksy etyczne. Opisuje relację pacjenta jako klienta placówki opieki zdrowotnej i lekarza ze względu na specyfikę ich sytuacji. Wskazuje różnicę między standardem klienta a rynkiem opieki zdrowotnej. Z uwagi te na różnice scharakteryzowano proces komunikacji i możliwości.

Słowa kluczowe: etyka, etyka lekarska, komunikacja, relacja między lekarzem a pacjentem

We are currently in the beginning of the third millennium, full of state-of-the-art technologies. These technologies bring a wide array of new possibilities. They provide patients with greater security and improve the efficiency of individual medical services. This is however happening at the expense of communication and mutual dialogue between the doctor, the nurse and the patient. The classic form of communication is nevertheless

indispensable at all levels of hospital departments. If this communication does not work properly, it leads to many problems, because the overall satisfaction of the patient with the provided health services depends also on the communication. Work in healthcare thus puts high demands on healthcare professional both on a professional and moral level. Every healthcare professional can contribute to improving the quality of health care and increasing patient satisfaction through his/her responsiveness and action. This requires appropriate expertise and ethical knowledge.

As Haškovcová (2002) states: “*ethics is a science of morality.*” Time ago ethics was called “*mrvoveda*” (science of manners) or “*dobroveda*” (science of good), practical philosophy and so on. “*The subject of ethics includes the examination the regularity of moral behaviour of individuals and societies,*” says the author (Haškovcová, 2002). Regularity of moral behaviour is represented by the morality, which consists of a set of rules that are binding for individuals in specific situations.

The concept of medical ethics collectively describes all ethical issues related to medicine (Bužgová, 2013). However, this concept is not yet settled as it is largely in competition with concepts such as medicinal ethics and health ethics. Medicinal ethics is basically the same concept, health ethics represents an area of ethics in health, and the notion of healthcare ethics refers to issues related to health care and, in particular, to healthcare systems.

Its historical basis is considered to be the deontological code. Medical deontology is a teaching about the duties of a doctor and is part of medical ethics. It concerns all legal and moral obligations and rules of behaviour of healthcare professionals. For several years the Hippocratic Oath has been considered the only deontological code. Some parts of it have already been overcome, but as far as the professional morals of those involved in the disease treatment, they are still valid.

There is a number of other documents that focus on medical ethics, but they were overshadowed by the Hippocrates oath. Haškovcová (2002) point to Oath of Asaph and Prayer of Maimonides. In the past century, documents relating to medical ethics were also adopted: the Geneva Declaration (1948), also called the Physician's Oath; International Code of Medical Ethics (1949); Declaration of Lisbon on the Rights of the Patient (1981) and others.

In Slovakia several laws relating to ethics in healthcare were also adopted, e.g. Code of Ethics of the Slovak Medical Chamber (October 20, 1996); Code of Ethics for Healthcare Workers (as Annex to Act No. 578/2004 Coll. On Healthcare Providers); Code of Ethics for the Nursing and Occupation of a Midwife (part of Act No. 311/2002 Coll. on Nursing, on the Occupation of Midwives, on the Slovak chamber of nurses and midwives and on Amendments and Supplements to the Act No. 14/1992 Coll. on Slovak chamber of Secondary health workers and the Slovak dental technicians, with effect from August 1, 2002) and the Deontological Code of the Slovak Medical Chamber (September 19, 2014). From the point of

view of the patient, the function of the Code is provided by the Charter of Patient Rights adopted by the Government of the Slovak Republic on April 11, 2001.

The subject of medical ethics is defined by the challenges that science, research, practice and medicine itself bring. The most serious problems include the ethical criteria of the experiment, the issues of ideal and accessible medicine, the rights of the fetus, children's rights, patients' rights, the rights of mentally ill, the rights of the disabled, the rights of mentally dying, thanatology, euthanasia, the sense of human life with the disease, right for healthy life and duty to health, truth on the hospital bed and life in old age.

The subject of medical ethics is the patient and the relationship of the doctor/healthcare staff to the patient. The relationship between the doctor and the patient is a constantly debated issue that develops to a certain extent. This relationship is given by the degree of mutual expectation and it is also the source of many communication and attitude misunderstandings. With a previous idea that the patient is just a sum of the organs to be corrected, none of the doctors would have been successful today. In the early days, only the doctor decided whether or not to treat the patient and in what way. Compared to the current state, the patient had no decision-making powers. Nowadays, the patient has the right to choose a doctor, has the right to look into his or her documentation and may decide to discontinue the treatment.

An ill person is in a certain crisis situation. *“Such person suffers insecurity, anxiety about the sense of danger of his or her physical and social existence and seeks help”* (Kapř, 1998). When the patient visits the doctor, there are certain expectations, for example, he or she automatically expects an increased interest in himself or herself. The visit happens with the conviction that the doctor is a specialist who recognizes the symptoms and eases the pain as quickly as possible and then removes it completely.

The patient also relies on medical secrecy and for this reason reports to the doctor all the information he/she thinks might be related to his/her illness. This creates a certain personal relationship between the doctor and the patient. In addition, the patient expects support from the doctor who will inform him/her about anything important and that the patient can truly rely on the doctor. In a situation where a person feels really ill, he/she is willing to comply with full medical advice and ordinance. The patient respects the doctor, but also fears the doctor in a certain sense. These fears are caused by the fear of the severity of the disease. Last but not least, the patient is expecting an unworldly and sacrificial help from the doctor.

If the diagnosis is very bad, many patients expect from a “merciful lie” from the doctor. Some doctors really take this approach. However, the patients then have to go through a greater shock when they realize the truth. The doctor can calm down the patient for a while, but in the longer term it may cause the patient to lose confidence in the doctor. I think that the patient should always be aware of the severity of the illness and of the true state of health; even though I agree that it is necessary to take into account the mental state of the patient.

There are however still some expectation from the doctor. When treating the patient, for example, the doctor expects the patient to follow his or her instructions and that the health

condition will improve as soon as possible and the patient is healed. This also creates one of the greatest mistakes of a doctor. The patient only works with the doctor if he or she feels like a patient. The patient must always be motivated by the doctor, who persuades him/her to respect his exact instructions. Although, observing the treatment instructions should be the main concern of the patient himself. In case of sick children, there is a lesser nonfulfillment of instructions given by the doctor. This is because they are supervised by caring parents. The adult patient is more likely to fail to comply with the given instructions. It is very common for a patient to stop taking the medication once he or she feels better. Professional publications report that 30-50% of patients treated in their homes do not observe the correct use of medications. Among other things, there is also proven better cooperation in the treatment of women and children compared to men and adolescents (Vymětal, 2010).

Contact of the patient and the doctor is also specific according to the age group of patients (children, adolescents, adults and elderly), the department and the type of disease. Nevertheless, we agree with Vymětal (2010): *“The relationship between the doctor and the patient is not something given, but develops over time. Very much depends on mutual communication between the two sides.”*

Professional literature tends to claim that good communication accounts for up to a third of the doctors's own work. The patient's influence lies predominantly in verbal contact where the patient needs to be interested in his/her current situation, expressing patience and feeling in, with maximum permissivity, without condemnation. The doctor should be calm with the patient, should be sure about himself and know that he can help the patient. The doctor should try to relax the patient's emotions, which will make the reasoning of the patient more mature. When communicating, it is advisable to choose an optimistic approach, but it does not mean that the doctor should make health condition and the necessary efforts easier for the assure the ill patient about something that is not real.

The basic situation of communication between the doctor and the patient is called a diagnostic interview. In this interview, the doctor and the patient *“have to agree on a common language, on the definition of difficulties, on the priorities of therapy, on acceptable compromise”* (Kapr, 1998). The doctor should provide information based on: *“the type of personality of the patient, his/her education, intelligence, characteristics and depth of interest in the given medical problem, not least the severity of the patient's disease and the degree of risk in the treatments”* (Lindhart , 2006). It is very important to consider:

- what the doctor wants to report to the patient and prepare sufficiently;
- when the patient is to be informed;
- the right place where communication takes place;
- the most appropriate way of communication, especially not to forget to speak clearly and comprehensibly and to choose the corresponding speech tempo.

The doctor must never manifest feelings from which the ill person would feel his/her presence harasses the doctor in any way and requires a lot of unnecessary information that others ill like him or her do not require. *“The body language, along with the tone and the colouring of the voice, gives words meaning by clarifying them and also shows the relationship between the talking people”* (Vymětal, 2010). During the discussion, both the doctor and the patient should observe each other. Both can tell what they see, the style of sitting or standing, how the expression in the face changes, what gestures are used, how hands are kept and moved around. Doctors are advised to maintain reasonable eye contact with the patient and check their non-verbal expression.

From the non-verbal communication of the doctor the patient can see whether the doctor is patient, trustworthy person who is genuinely interested and willing to take care of him. In the opposite, negative case; the doctor can act as a superficial, nervous and agitated person who wants to get rid of the patient as soon as possible.

However, medical ethics does not only affect the relationship between the doctor and the patient. Considering that currently the healthcare providers are essentially part of the business sector, we can say that the healthcare organization should approach the patient as a client to whom it offers particular services with the patient having the right to choose. In order to have this in place, it is necessary not only to have some form of competition but also to monitor the quality and customer satisfaction (Bruthans, 1999). We can thus talk about a healthcare market that has its own specifics:

- the nature of the demand,
- expected behaviour of medical personnel,
- uncertainty of the resulting product,
- supply conditions.

Here is where the medical ethics also comes into play. The main difference in the nature of the demand when comparing the standard and healthcare markets is the asymmetric buyer awareness. The patient always enters the healthcare market with less knowledge. In majority of cases the patient is left with nothing but trusting the doctor. The patient buys something for which he does not know the real price and only thinks it will improve his health. The demand on the healthcare market is very irregular and cannot be predicted. Price elasticity of demand in this market cannot be determined.

Competitive struggle in the healthcare market is mostly not pursued through pricing and advertising, among doctors from different departments. Services typically require higher quality control, credibility of their provider and some form of adaptability. *“Differentiation of services provided by healthcare facilities can therefore be based on short waiting times for examinations, pleasant approach of the doctor, thorough information for the patient and advice to patients, etc.”* (Morvay, 2013).

In this market, it is possible to see different recommendations for further specialist examinations. These recommendations are considered wholly justified and are independent of

the doctor's own benefit. The doctor prescribes a treatment method tailored to the needs of the individual. The doctor is still considered to be a person who understands the issue. Treatment is not preferentially limited in financial terms.

Another difference in the healthcare market is the method of payment. Currently, the services provided to the patient are mostly paid through a third party, which is a health insurance company. The patient may, in some cases, be able to pay for the extra-standard services. The patient is therefore in the position of a client of the respective health facility, but also of a client of his health insurance company. It has the duty to provide its clients with solid physicians who will provide adequate care to patients. If patients are dissatisfied with the services provided, they have the right to report it to their health insurer and the procedures of the doctor will be investigated.

If the patient does not like his health insurance company, he may change it once a year. In addition, the patient has the right to defend himself from the behaviour of the doctor at the medical chamber, which has a duty to deal with any complaints and verify the validity of such complaints.

Approximation of the healthcare market to the standard market breaches with number of ethical objections. For instance, the ability to assess health, with the use of economic criteria. Whether it is moral to have the whole system distributed according to the price where the poor do not receive the necessary care. Moreover, it is also impossible to find out who is most needed. Technical challenge also includes the difficulty to define the resulting product in the sector and the limitation of resources.

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