

MENAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	SOCIO-MEDICAL ASPECTS AND ETHICAL DIMENSIONS OF THE HEALTH PRACTICE
Module: 1.4	ECTS (suggested): 0,25
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Keywords	Health policy, health priorities, doctor-patient relationship
Learning objectives	After completing this module students and public health professionals should be able to: <ul style="list-style-type: none"> • Understand the spectrum of socio-medical problems in health practice; • Define and describe difference between doctor-patient and institution-patient relationship; • Explain the main root causes of socio-medical problems; • Understand the instruments, mechanisms and responsibility flow for solving socio-medical problems in health practice; • Use a problem-solving technique to a given scenario/case.
Abstract	The dramatic social and economic changes that have taken place in the past two decades in SEE, have caused the existing inequalities in health to grow even bigger, not only between but also within the countries in the region. Backed up with the national health statistics, which gives a stark illustration of the effect of economic crisis and reveals a growing health divide, the issue is recognized to deserve greater attention; the once strong and sole focus of the health services to offer better care, newer treatments and more effective drugs, in the contemporary society requires to be accompanied with the much wider scope of needs of the modern patient - including more complex social interaction, better access to information through a multitude of sources, etc. The added complexity of the interactions in the health system where both patient and the doctor play a crucial role deserves much attention if we are aimed at reducing the inequality, socio-medical and ethical disparities.

Teaching methods	<p>The theoretical part of the lectures gives overview of the social dimension of the doctor-patient and institution-patient relationship, behavioural patterns (both patient and professional) and definitions of the patient safety, medical/pharmaceutical care, medication safety and their interrelation to the causes of socio-medical problems. The theoretical knowledge is illustrated by case studies.</p> <p>After introductory lectures students discuss the definitions based on questions distributed prior to the class.</p> <p>As part of the assessment, students are asked to write an essay describing a case/example for selected instruments or mechanisms for overcoming a certain socio-medical issue in health care practice.</p>
Specific recommendations for teachers	<ul style="list-style-type: none"> • ECTS: 0,25 • work under teacher supervision/individual students' work proportion: 40%/60%; • facilities: lecture room; • equipment: LCD projection equipment; • training materials: recommended readings or other related readings; • target audience: undergraduate and master degree students according to Bologna scheme
Assessment of Students	Multiple choice questionnaire, structured essay

SOCIO-MEDICAL ASPECTS AND ETHICAL DIMENSIONS OF THE HEALTH PRACTICE

Neda Milevska-Kostova, Doncho Donev

THEORETICAL BACKGROUND

History and context

The dramatic social and economic changes that have taken place in the past two decades in South Eastern Europe (SEE) countries, have caused the existing inequalities in health to grow even bigger, not only between but also within the countries in the region. Backed up with the national health statistics, which gives a stark illustration of the effect of economic crisis and reveals a growing health divide, the issue is recognized to deserve greater attention; the once strong and sole focus of the health services to offer better care, newer treatments and more effective drugs, in the contemporary society requires to be accompanied with the much wider scope of needs of the modern patient - including more complex social interaction, better access to information through a multitude of sources, etc. The added complexity of the interactions in the health system where both patient and the doctor play a crucial role deserves much attention if we are aimed at reducing the inequality, socio-medical and ethical disparities.

Defining socio-medical issues

According to definitions in some standard worldwide renowned dictionaries (1), the term socio-medical dimensions of health care practice refer to the relations of practicing medicine in the societal context. Under such definition, we can look at number of aspects, some of which are already defined in monetary terms: equity, equality, healthcare spending; in socio-legal terms: physician-patient relationship, institution-patient relationship, patients' rights; or which are still in developmental stage or at the level of concept: like patient safety, for example. Further below, we will look at each in the attempt to define the complex milieu of the interrelatedness of medicine and society, yet more focusing on the legal and social aspects. This, will, ultimately give us an idea of how to address problems that might occur at the crossroad between medicine as science (represented by the medical profession) and the subjects of society (represented by the patients and other users of medical services).

Equity

A key consideration in addressing the performance of any health care system, including those of the SEE countries to which this book is dedicated, is equity. Equity in health means that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically that no one should be disadvantaged from the achieving this potential, if it can be avoided (2). In terms of health care delivery it means that citizens get the care they need without consideration of their social status or other personal characteristics such as age, gender, ethnicity or place of residence (3). Equity addresses questions such as whether some groups in the society have better access to health care or better health benefits and outcomes than others (4). The term *inequity in health* refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust (2).

Equality

The equality in healthcare is usually associated with the economic and social equality in the society. It is true to some extent; as Wilkinson states “the greater the economic and social inequality within a society the lower the health outcomes” (5). Yet, there is another aspect of “equality of access” to healthcare, which should be considered as vital part of the medical care in each country. As Canadian Commissioner on Future of Healthcare in Canada in his report explains, the rapid growth of private magnetic resonance imaging (MRI) clinics, which permit people to purchase faster service and then use test results to “jump the queue” back into the public system for treatment, is a troubling case-in-point (3), and can disturb the balance of the system, offering lower possibilities to those that cannot afford private services, that are otherwise available under the insurance scheme). This becomes a fertile ground for flourishing the financial discrimination within the social-welfare healthcare systems.

Healthcare spending

Spending on health care does usually appear to make a difference in health outcomes. Health indicators such as life expectancy and infant mortality clearly show that problems are ameliorated when spending increases (6). A financially inefficient system, however, may use additional health resources to provide higher salaries to health care providers without a corresponding improvement in services (3); it may also lead to shift of health services demand from the free-of-charge public health services to private out-of-pocket paid services, which to a large extent instigates the financial discrimination between those that can and those that cannot afford the private payment for services, otherwise available under the basic insurance package. At the other end of the spectrum, there are those that due to poor accessibility cannot benefit from the health system, despite the fact that they may belong to the category that needs it most. Unfortunately, the available data on healthcare spending in some countries is recorded only for the public healthcare institutions (7), who give a much fragmented and highly unrealistic picture, while the private healthcare services are flourishing especially for the basic package of health services.

Physician-patient relationship

The sensitivity of this issue when it comes to the scope of socio-medical problems in healthcare delivery is obvious from its defining; it represents a relation of two parties that are equal in the mission to sustain, improve, promote one’s health condition, but are unequal in many other aspects, like specialist knowledge and medical information (information asymmetry), objectivity in approaching the problem and sobriety to make informed decision. This to a large extent explains the paternalistic roles very commonly taken in the physician-patient relationship, rather than the paternalistic concept of the health care system. Several countries reported a similar situation with the physician-patient relationship, in some occasions even expressed as “the father-physician taking care of the child-patient” (8).

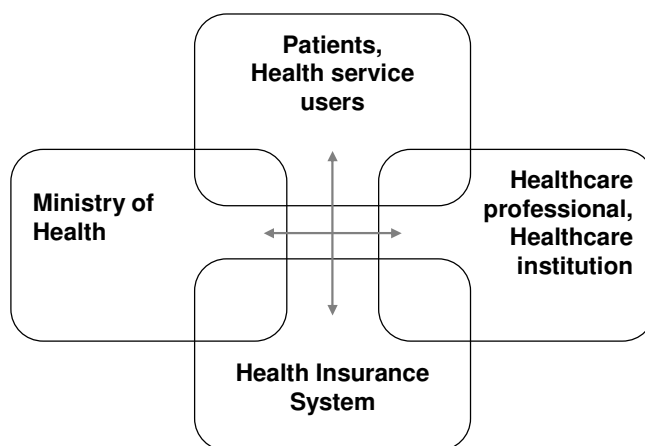


Figure 1. Relationships and flow of healthcare spending

Despite the benefits they have brought to the individual and the society, the medical advances in the areas of life-prolonging technology, prenatal diagnoses, organ transplantation and genetics have all had side effects of increasing the technological and decreasing the human aspects of medical care. These advances brought and enlarged the alienation between patients and physicians. At times, physicians forget or simply do not have time to be compassionate; they often perceive themselves as absolute authorities in judging patient needs due to their medical knowledge supremacy and they do not perceive the need to discuss diagnoses and proposed treatment with patients that in their opinion are not capable of making reasonable decisions. Thus the most common complaints of patients across the national milieus investigated are that in largest number of cases the physicians don't listen, don't take much time and don't explain or give a partial explanation in a difficult to understand (referring to the professional and specialized terms) language. At the same time if anything happens beyond the expected procedure, the physicians would in the first place "blame it on" the patient for non-compliance (8), whereas the patients would consider it to be the physician's mistake for any of the above reasons.

To this end, it is often difficult to quantify the influence, but the relationship between the physician and the patient should have its place in the model defining the socio-medical problems, at least on a qualitative level.

Institution-patient relationship

In many cases, the hospital visit and the patient's health are usually associated with the patient-physician relationship, to a large extent, besides the expertise, professionalism and ethical principles of the medical personnel. But, the preparedness and level of equipment of the healthcare setting plays crucial role in the outcome of certain intervention; this is another angle of the complex health systems' relations: patient-institution relationship. Most of national legislations are regulating the right of the patient to access to healthcare, but also the right to healthcare itself, to access to medications and technology (based on maximum availability in the system) – rights and conditions that cannot be regulated and met by the physician alone. In this sense, the need to include the patient-institution relationship into the equation for understanding and solving socio-medical problems is evident, and further more it can be quantified in monetary terms.

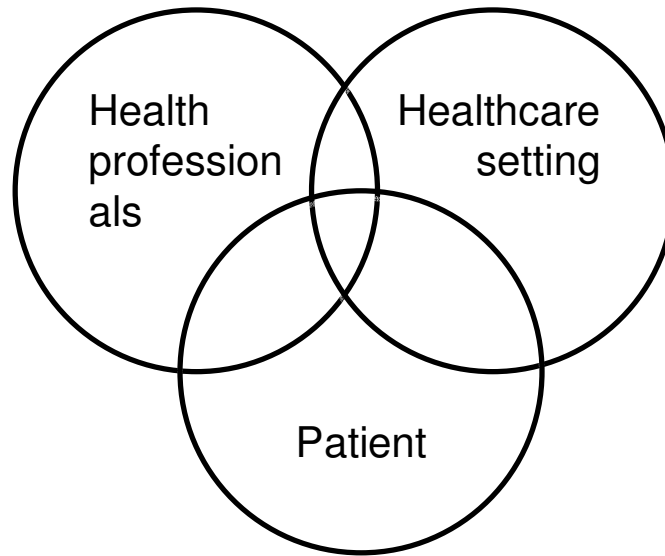


Figure 2. Interrelatedness of physician-patient-institution

Rights and responsibilities – patients vs. healthcare professionals

As in every relationship, patients and physicians in their interaction have both rights and responsibilities; as much as this might sound inhumane and too bureaucratic, in lot of cases these rights or responsibilities have been a driving force or inhibiting factor to proceeding with interventions much more than the substantial medical knowledge or practice (8). Despite the fact that both patients and physicians are on the same side of the healthcare system - with their mission being health condition improvement or life prolongation - the ethics of holding each of them responsible against the inequality of their positions explained above becomes a complex issue not only difficult to prove and measure, but also unpopular to convert into monetary value.

In each country, there are at least several mechanisms for addressing the violation of the rights or non-compliance with the responsibilities by patients or health professionals; ranging from health mediators, in-house (clinical) patients’ advocates, ombudsman, administrative and court procedures (civil and criminal). The level of their implementation or applicability is always questionable, for both technical and ethical reasons, such as lack of medical knowledge of judges or justifiable compassion with the peer physician in a case of unintentional medical error and adverse outcomes.

Thus, the intention is for the concept to go beyond the simplified version of “good guy-bad guy” situations but to rather look into the potentials of objectivising the cases and anonymization of malpractices (9), for future use of the case-based knowledge in extending the medical practice. This aspect is further elaborated under the section of *patient safety*.

Patient safety

The concept of patient safety happens to be a relatively recent initiative, as a response to the generally low level of awareness and knowledge about the frequency and magnitude of avoidable adverse outcomes in healthcare industry; the first serious approach to this issue was given in 1990s, when reports in several countries revealed a staggering number of malpractice patient injuries and deaths each year (10).

Patient safety is a serious concern in most developed and developing countries

alike. Recent studies consistently show, in an increasing number of countries, that health care errors occur in around 10% of hospitalizations (11). The concept of the patient safety is described with many operational definitions - each defined by the research context. In general, the term *patient safety* describes the tendency to provide conditions and interventions for patients in the healthcare settings that would enable and ensure the desirable outcome. The broadness of this concept embraces both medical and non-medical errors that can incur during the patient visit or stay at the healthcare setting.

Nevertheless, the scientific literature shows that the healthcare sector is a decade or more behind other high-risk industries in its attention to ensuring basic safety for its key players (both patients and health professionals) (12). Aviation for example, has focused extensively on building safe systems since World War II; between 1990 and 1994, the U.S. airline fatality rate was less than one-third the rate experienced in mid century (13). In 1998, there were no deaths in the United States in commercial aviation; in health care, preventable injuries from care have been estimated to affect between three to four percent of hospital patients (14,15).

Yet, the patient safety does not imply responsibility only on the physicians and healthcare settings - it involves other medical professionals, such as pharmacists (through their contact with the patients, education about use and abuse of medications, etc) and patients themselves - with their understanding of the procedures and willingness to comply with given instructions. Regardless if the advice is aimed at improved nutrition or regularity of taking medicines; both can equally affect the patient and his/her role in increasing own safety as patient.

Under the Luxembourgian presidency of EU, in April 2005, the European Commission DG for Health and Consumer Protection issued the Declaration "Patient Safety - Making it Happen!" widely known as the Luxemburg Declaration. The Declaration calls for active involvement of EU institutions, in establishment of EU forum to discuss issues regarding patient safety, in cooperation with other patient safety initiatives, like the WHO Alliance on Patient Safety etc. The Declaration recommends to the national authorities to establish national forums, to ensure full and free access to personal health information to patients, to optimize the use of new technologies, and above all to work towards creating a culture that focuses on learning from near misses and adverse events as opposed to concentrating on "blame and shame" and subsequent punishment (16).

Denmark became the first example of a country that introduced nation-wide mandatory reporting of medical errors and adverse outcomes. The Danish Act on Patient Safety (9) enacted by the Danish Parliament in 2003, sets the ground for obligatory reporting of adverse events by the frontline personnel to a national reporting system; the famous Article 6 of this Act (9), which reads "A health care professional reporting an adverse event shall not as a result of such reporting be subjected to disciplinary investigations or measures by the employing authority, supervisory reactions by the National Board of Health or criminal sanctions by the courts", is opening a space for professional yet sincere debate grounds for gathering, analyzing and communicating the knowledge of adverse events, in order to reduce the number of such events in the healthcare system. In January 2004 the national reporting system on adverse events in Denmark was set in place, obliging not only the frontline personnel to report, but also the hospital owners to act on the reports and the National Board of Health to communicate learning from the reports, after making data anonymous, and in that way lifting it to the meta analytical level. More details of this reporting system are available from the National Board of Health and Danish Society for Patient Safety (DSFP) (17, 18).

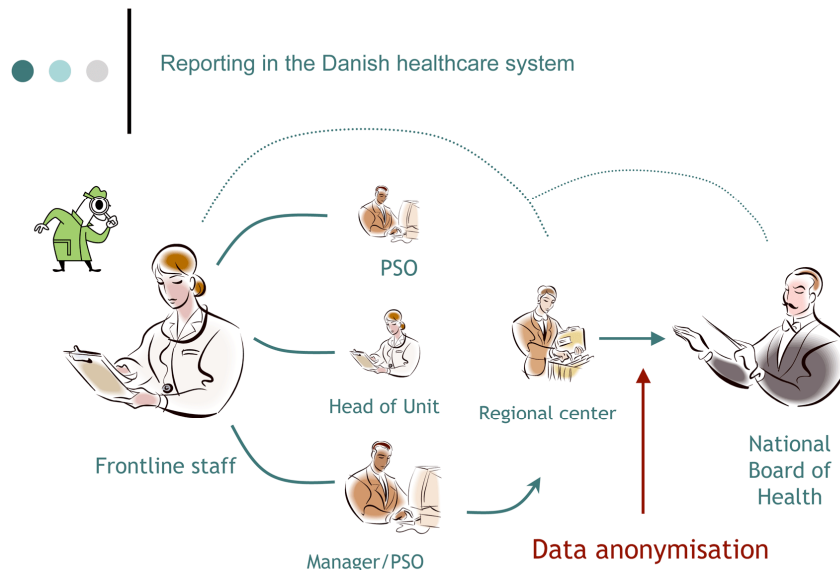


Figure 3. Adverse event reporting in the Danish healthcare system (18, modified)
(PSO = patient safety officer)

CASE STUDY: MEDIATION IN HEALTHCARE

For simple overcoming of the socio-medical problems in the health practice they can be negotiated and potentially resolved, with good will and without judicial intervention, by introduction of health mediators and patients' advocates who are taking up a role of a neutral middle-person in sensitive health-related issues. These forms have been more or less successfully adopted in Romania (health mediators) and Serbia (patients advocates), thus this case study is illustrating their existing and potentially expanding role in solving socio-medical problems for a wider range of health-related issues (including professional patterns of behaviour, adverse events and malpractice).

Romani health mediators in Romania

Roma Health Mediators (RHMs) are members of the Romani community who work with their communities, physicians, and national health care systems to improve Romani health, as attempt to challenge the health conditions of the 12 to 15 million Roma living in Western and Eastern Europe exhibit some of the region's worst health indicators (19). Infant mortality rates among Romani communities in the Czech and Slovak Republics and Hungary are about double the national average (20).

One of the most visible elements of the government strategies for addressing the health issue of Roma is introduction of the programs for Roma Health Mediators (RHM). RHM programs are meant to respond to the current situation and stereotyped conditions of the Romani population by selecting individuals from Romani communities to work as mediators who: (a) facilitate communication between Romani patients and physicians during medical consultations, (b) communicate with Romani communities on behalf of the public health system, (c) provide basic health education, and, (d) assist Roma in obtaining the health insurance or identity documents necessary to visit the doctor (19).

Although a similar concept in education was developed in France in 1986-87, the leading country in the introduction of this comprehensive concept to healthcare mediators

is Romania. As the statistics is showing that large percentage of Romani population in this country is not properly covered by health insurance, due to various reasons, such as traditional practices or lack of personal identification documents, the health status of this minority has been steadily showing a downwards trend, with different disease structure than the general population. The initiator of the RHM was the non-governmental organization CRISS (Roma Center for Social Intervention and Studies) which in 2000 has introduced it as pilot version through training health mediators to provide liaison between Roma families and mainstream public health services (20), funding it through international and domestic project schemes.

In August 2002, the Ministry of Family and Health passed an ordinance making Roma Health Mediator an official profession within the Romanian public health system (21). According to the ministry's ordinance, all mediators must be trained and certified by Romani CRISS. The Romani CRISS theoretical training covers communication, access to prevention and treatment services, the public health insurance system, and first aid. However, RHMs must not provide any medical services, as they are not qualified medical providers (19).

In addition to the standard curriculum, a small percentage of the mediators have also been trained by Romani CRISS to address discrimination. The training structure is somewhat flexible, and training in a long distance format is possible (19). Graduates of the theoretical training must complete a three-month on the job apprenticeship with a "qualified medical staff [person]" (21).

In 2002, the Ministry of Health and Family asked county public health departments and Romani organizations to send their suggestions regarding whether or not mediation was required, how many mediators were needed, and nominations for who should fill this role.

Approximately 200 RHMs now work throughout Romania. Geographic distribution is based on need as well as local level willingness to participate. RHMs are currently paid about €83 monthly, which is equivalent to a nurse's salary. They are supervised by local and national authorities, as well as informally by Romani CRISS. Each RHM is assigned to a local contact GP, who is based in a nearby health facility. The GP meets weekly with the RHM to discuss tasks completed and any problems. A representative of the Family and Social Assistance Section of the local county public health department has monthly meetings with each mediator to provide additional supervision and any required assistance (19).

The Family and Social Assistance Section should also reimburse RHMs for travel costs associated with their work. In terms of interactions with national agencies, the RHMs have four meetings per year with staff from the Ministry of Health's Department for the Health of Mother and Child, and must respond to an annual ministry questionnaire. A representative of Romani CRISS phones each mediator about every two months to discuss how work is progressing (19).

The concept also has its disadvantages and problems; despite the fact that local authorities had nominated them, some RHMs had problems being hired following the initial trainings. Moreover, many medical staff and county public health departments did not understand the role of the mediator, and required substantial support from Romani CRISS and the Ministry of Health and Family to cooperate effectively with the RHMs. However, this is certainly an initiative that can be expanded when it comes to addressing the health needs of the Romani population, and which can be adjusted and replicated for the general population in the rural areas.

Patients Advocates in healthcare settings in Serbia

The new Law on health protection (22) of the Republic of Serbia established a system for protection of patients' rights as a powerful tool for mediation and solving one of the largest categories of socio-medical problems in the healthcare practice.

The article 39 of the aforementioned Law (22), which regulates the right to complaint, is also stipulating the mandate and responsibilities of the patients' rights advocates ("zastitnici prava pacijenata"). Among other, the Law stipulates that the healthcare settings are responsible to provide conditions for work of the patients' rights advocates; the director is appointing the advocate from the employees of the healthcare setting, most usually the lawyer of the healthcare institution. Procedures are set for both oral and written complaint, with timeframes within which the patients' advocate has to respond to the complaint, in a form of: legal advice, opinion or information. The Law also regulates the format of the written complaint to be submitted when patient right has been violated.

The patients' rights advocate has obligation to submit written monthly report to the Director of the healthcare setting, and a six-month report to the Board of the healthcare institution and to the Ministry of Health.

Second level procedure includes complaint filed to the Ministry of Health of Serbia, after what, if the patient is not satisfied with the reply, and still believes that his/her rights have not been exercised and implemented, he/she or a member of their family can forward to using court procedures.

The main role of the patients' rights advocates is to mediate a dispute between the patient and the healthcare setting or healthcare professional in a peaceful and good will manner. Using this procedure, most cases of general misunderstanding or misinformation about rights and responsibilities can be resolved, thus avoiding extra burden on the judicial system in the country. Effective as it sounds, however, this system, already existing in some other developing and developed countries, has its own drawbacks, such as subjectivity of the advocate, who works for one of the sides for which he/she has to mediate.

EXERCISE

Task 1

Given the case study above, think about an initiative in your country for mediating socio-medical problems in the health practice; try to consider the advantages and drawbacks of the initiative.

Task 2

From your knowledge and practice, think about a mechanism of health mediation that might be applied for a particular health discipline (surgery, outpatient setting, etc.). Write a brief explanation of the idea, fitting it into the currently available medical and legal procedures of the chosen healthcare setting.

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