PART

I

THEORETICAL FOUNDATIONS FOR THE PROJECT

1.
Research background

1.1. Theoretical concepts underpinning the humanization of medicine

More than two thousand years ago, Hippocrates laid down a set of basic ethical principles that have been held up and respected ever since. Since Hippocrates' times, medical practice has rested upon the foundation of doctors' deep commitment to selflessly help patients and their families (Roubille et al., 2021).

One prominent Polish historian of medicine has written this inspiring passage on the issue of humanism in medical practice:

> The patient comes to us with their pain, bitterness, suffering, and anxiety, and cries out for help. This, of course, is rarely a cry in the literal sense. It takes on various forms of expression. It may be a torrent of words to relieve their anxiety, or petrified facial features that thinly conceal distrust of the doctor. And the patient tells the story. We must listen, hear the story out. From time to time asking a question to help them continue their train of thought, to pin down an important detail, or to clarify the chronology. For the storyteller, this story is the primary thing. And the listener should remember that one of these stories will someday become his own, one of these diseases will someday befall the doctor. (Szczeklik, 2003, p. 12)

Humanism is believed to form a universal ethical structure that is based on such virtues as fidelity, trust, kindness, intellectual honesty, courage, compassion and truthfulness. These virtues should represent the standard by which the healthcare system is organized.

The Humanization of Medicine

The humanization of medicine is a theory and a set of practices aimed at adapting diagnosis and treatment to the needs and capabilities of the human patient and his or her environment, emphasizing the importance of personalizing the treatment process. It is based on scientific evidence, on advances in knowledge, and on activities that focus on a philosophy of thinking about the human being, taking into account respect, the dignity of autonomy and the rights of the patient, while supporting the needs of healthcare professionals. Thus, a holistic view of the role of the human being in the treatment process, along with his psychosocial, cultural, social, legal, and economic circumstances, is crucial for the proper implementation of the tasks associated with the humanization of medicine. In both theory and practice, it stretches beyond ethics and the theory of patients' rights and is a concept broader than clinical communication and medical communication. It is an interdisciplinary, autonomous field of knowledge and a multifaceted area of activity.

(Izdebski, 2022, p. 5)

Maintaining and continuously improving human relations, in medicine and beyond, is the responsibility of doctors and other medical personnel – in terms of raising the level of health services and the quality of medical care. The overarching idea of humanism is to recognize the human being as the highest value, and with his or her welfare, as well as respect for his or her dignity, rights and autonomy, seen as the essence. These ideas have been pursued by the Polish Academy of Medicine and the Albert Schweitzer World Academy of Medicine founded and led by Prof. Kazimierz Imielinski.

The basic elements of humanization and dehumanization in relation to medical care can be summed up in eight dimensions (Table 1). This classification should not be interpreted in terms of alternatives; rather, in each case it represents a certain continuum (Todres et al., 2009).

Table 1. Conceptual framework of the dimensions of humanization

Forms of humanization	Forms of dehumanization
empowerment	objectification
agency	passivity
uniqueness	being likened to others
acting jointly	isolation
imparting sense	loss of meaning
respect for personal experience	detachment from personal experience
cultural context	detachment from the cultural context
holistic approach to health	biomedical approach to health

(from Todres et al., 2009)

The humanization of medicine is of significant importance for the direct outcome of the treatment process and for communication with the patient, and its task is to build a broadly-construed medical culture, including by strengthening the authority of the medical profession and better comprehension of the needs and rights of the patient. This approach contributes to:

- understanding the health situation of the patient while taking into account their individual needs in the context of their family, the social and economic situation in which they find themselves, and respecting their autonomy and rights,
- building mutual trust and the commitment of both parties to the therapy process and to proper communication within the treatment team,
- improving patient–staff and staff–staff communication,
- achieving close cooperation between the patient and medical personnel, resulting in compliance with therapeutic recommendations and shared responsibility for the recovery process,
- raising patient awareness by providing information on new diagnostic and therapeutic options.

Busch et al. (2019) have highlighted these "key points for decision makers" in term of policies bearing upon the humanization of medicine:

- Respect for patient's dignity, uniqueness, individuality, and humanity, as well as adequate working conditions and sufficient human and material resources are the most discussed key elements of humanization of care according to the different areas explored (i.e., relational, organizational, and structural, respectively).

- The key elements identified are expected to help patients, caregivers, healthcare providers, and institutions in implementing humanized care.
- Future studies fully examining implementation strategies of humanized care and quantitatively testing their effectiveness are warranted. (Busch et al., 2019: 461)

Humanization takes into account not only the patient, but also the system involved in the care process (i.e., patients, patient caregivers, healthcare providers, policy makers) and their interactions (Figure 1). This approach aims to humanize the entire healthcare system by focusing on relational as well as organizational and structural aspects of healthcare, encompassing all medical tasks and procedures.

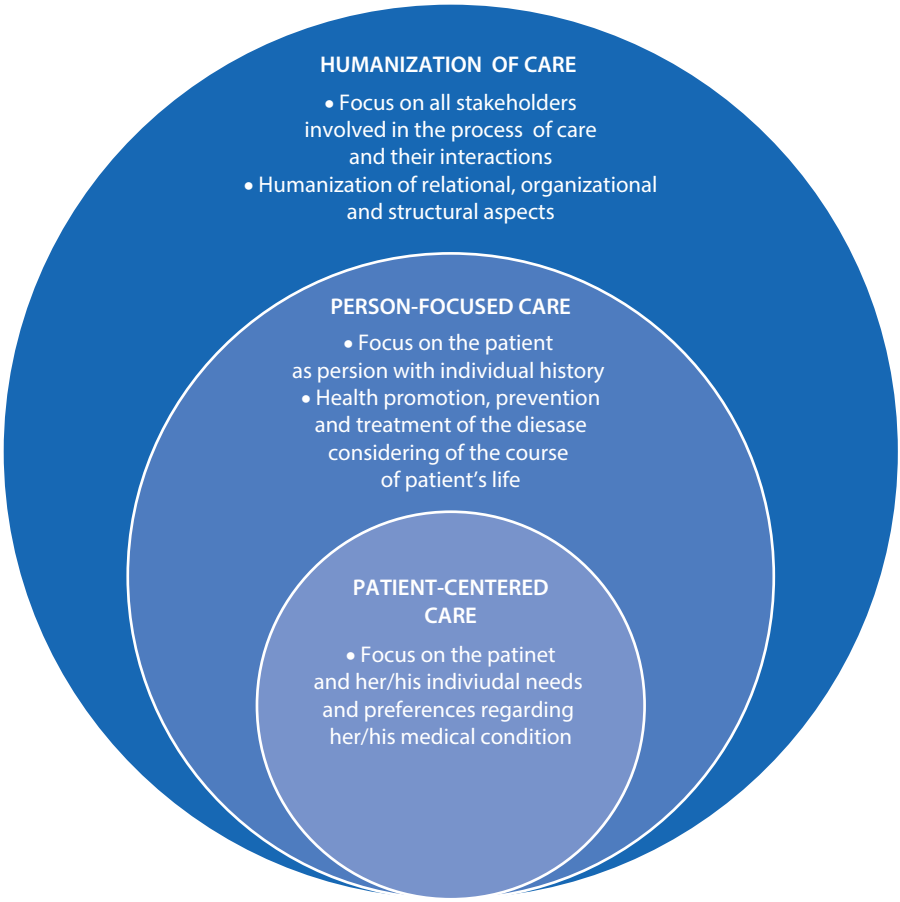

Figure 1. Development of the humanization of medicine
(from Busch et al., 2019: 462)

1.2. Theoretical models of the doctor–patient relationship in healthcare

In the sociology of medicine, Talcott Parsons' theory of social roles and Eliot Freidson's theory of conflict are most often invoked to elucidate the doctor–patient relationship. Both concepts recognize a certain asymmetry in the doctor–patient relationship: the doctor plays an authoritarian and dominant role, while the patient plays a passive role, and communication is usually one-way. Treatment decisions are made by the doctor, who focuses solely on the biological dimension of the disease, ignoring the patient's needs and emotions. It follows from this that the doctor–patient relationship is dynamic. Conflict may also result from a patient questioning a doctor's knowledge and skills, as well as doctors' subjective treatment of patients. Models of the doctor–patient relationship are presented in Table 2.

Table 2. Models of the doctor–patient relationship according to Szasz and Hollender (1965), Chmielewska-Ignatowicz (2017)

Model	Activity– Passivity Model	Guidance-Cooperation Model	Mutual Participation Mode
Physician's role	totally active, decisive	an active, dominant initiator – the doctor has the necessary knowledge and skills to carry out the treatment process	an active partner – the doctor has objective and detailed knowledge of treatment modalities, making diagnoses and prognoses, designing the treatment process
Patient's role	totally passive – the patient is the recipient of medical recommendations	an active, limited co-cooperator – the patient will comply with the doctor's recommendations because he does not have enough knowledge to take responsibility for the treatment process	an active partner – the patient has subjective knowledge of his or her own behavior and wellbeing
Clinical application	in life-threatening situations, when patient has limited awareness	in acute infectious processes, etc. that last a short time and usually resolve on their own	in chronic diseases in which conditions are long-term and require reorganization of various aspects of life

Related to the idea of humanization in medicine are approaches to medical care that value the centrality of the patient, known as PCO (patient-centered outcomes) or PCC (patient-centered care). However, note that in order to support patient-centered care, healthcare professionals must first identify barriers and facilitators to both patient-centered care and communication, given their interconnectedness in clinical interactions (Kwame, Petrucka, 2021). Attempts have been made to develop conceptual models that incorporate core areas of analysis (Hudon et al., 2011). One model, for instance, includes 4 dimensions: (1) the patient's illness and experience of illness; (2) the patient's whole person (the biopsychosocial perspective), (3) common ground (the sharing of power and responsibility), and (4) the patient–doctor relationship (also in the dimension of therapeutic covenants). On the other hand, in a model tailored to pediatric patients, attention is paid to such areas as respect and dignity, information sharing, participation, partnership and cooperation, and negotiation. The authors of publications proposing models of humanization in medicine emphasize that the conceptualization phase should precede the creation of tools (Tripodi et al., 2017) The Institute of Medicine (IOM) in the United States emphasizes that providing patient-centered care means respecting and responding to the individual patient's care-related needs, preferences, and values in all clinical decisions (Institute of Medicine, 2001). As Ostrowska (2020) points out, by definition the roles of doctor and patient entail a certain asymmetry and predominance of the former over the latter; moreover, the patient represents himself or herself, whereas the doctor has the prestige of medical knowledge and the treating institution behind him or her. The above considerations offer an important starting point for examining the relationship between medical personnel and the patient.

2.
The medical staff–patient relationship

2.1. Transformations of the doctor–patient relationship

For many years, the medical profession has recognized the importance of communication and relationship skills as part of professional competence. These skills are rooted in the multidimensional biopsychosocial

concept of health, as envisioned by the World Health Organization (WHO, 1948).

The doctor–patient relationship has been transformed over the years. This relationship used to be mainly between a patient seeking help and a doctor whose decisions were to be carried out by the patient. In this paternalistic model of the doctor–patient relationship, the doctor uses his/her skills to choose the necessary interventions and treatments that are most likely to restore the patient's health or alleviate his pain. Any information provided to the patient is intended to encourage the patient to consent to the doctor's decisions. This description of an asymmetrical or unbalanced interaction between doctor and patient has been challenged in recent years. Critics have proposed a more active, autonomous, and thus patient-centered approach that advocates greater mutual participation. This patient-centered approach has been described as one in which "the doctor tries to enter the patient's world, to look at the disease through the patient's eyes," and has become the dominant model in clinical practice today (Kaba & Sooriakumaran, 2007).

2.2. Importance of interpersonal relationships in healthcare institutions

In healthcare institutions, trust and communication are understood as kinds of "tools" towards achieving better patient care and satisfaction. Indeed, there is a need for a certain degree of trust in order to build a relationship in which sincere communication can flourish. The quality of patient interaction is positively related to patient trust and satisfaction, which are direct or indirect measures of the quality of healthcare services (Birkhaueret al., 2017; Anhanget al., 2014; Tsaiet al., 2015; Isaac et al. 2010; Jhaet al., 2008).

Trust has been shown to have a positive impact on patient functioning in areas such as adherence to prescribed medications, perceived satisfaction, and higher rates of treatment continuation (Hallet al., 2001; Zolnierek & DiMatteo, 2009; Baker et al., 2003). Patients with greater trust in their doctor tend to have more favorable health behaviors, fewer symptoms, and are more satisfied with their treatment. Healthcare professionals need to persuade their patients to share information, undergo tests, and take chemical substances in the form of medications, and trust undoubtedly plays an important role in order for all of these activities to occur with less stress and anxiety. Trust is something that needs to be cultivated and earned, and having good communication skills helps build that trust between doctor and patient.

Moreover, doctors' ability to communicate with patients by expressing acceptance, empathy and support (Epstein, 2007) seems to contribute to a better doctor–patient relationship and greater satisfaction with the consultation (Pollak et al., 2010). In addition, patients' perceived empathy has a positive impact on their psychological wellbeing: when doctors empathically acknowledge patients' feelings and encourage them to pursue their treatment goals, patients show reduced symptoms of anxiety and increased trust in doctors' recommendations (Zwingmann et al., 2017).

On the other hand, note that the relationship between medical personnel and patients may be less well-regarded due to a lack of channels for handling complaints and an enforceable system of patients' rights, due to misunderstandings or to unrealistically high expectations on the part of patients themselves regarding treatment outcomes. Ignoring the patient relationship can put significant strain on both providers and patients, leading to unresolved problems and tensions, as well as ethical issues (Borovecki et al., 2005).

Trust between doctor and patient, in addition to its ability to lay the groundwork for a lasting relationship and shape the behavior of both partners, also itself has therapeutic value. Krot and Rudawska (2013) posit that trust in a doctor is the result of the interpenetration and overlapping of two levels: trust on the macro scale and the meso scale. Macro-scale trust can be viewed as the context in which the dimensions of institutional trust are "nested," whereas meso-scale (institutional) trust is viewed through the prism of three dimensions: benevolence, competence, and reliability (Krot & Rudawska, 2013).

The important fact remains that the doctor–patient relationship is often based on a established scenario, without taking into account the patient's life situation, and with service performance indictors and the level of technical sophistication often being more important factors than who the patient is.

Table 3 presents recommendations for optimizing the patient-provider relationship, as an important contribution to relationship-building considerations.

The traditional model of the patient portrays him or her as a body passively subject to internal and external forces, whereas in line with the concept of humanization, the patient should instead be empowered. Therefore, as one of the ways to provide society with better and more optimal health services, it is important for providers to understand and realize the importance of trust and communication in their relationships with patients (Chandra et al., 2018).

Table 3. Indications for optimizing the patient-provider relationship

Recommendation	Examples
Listen actively	Listen without interrupting, focus on what is said and construct questions based on what you have heard.
Understand the patient's agenda	Several questions can elicit the patient's agenda: • What brought you here today? • What do you think you have? • What worries, or concerns do you have? • What do you feel I can do for you?
Empathize	Empathy involves seeing the patient's perspective, being nonjudgmental, understanding the patient's feelings, and communicating that understanding. An empathic statement is "I can understand how difficult it is to manage your pain."
Validate	Validation means you understand the patient's perspective, but you may not necessarily agree. A validating statement would be "I can see you are frustrated when people say this is due to stress, and you know it's real."
Set realistic goals	Chronic illness means symptom management, not cure "I understand how much you want these symptoms to go away, but you've had them for years. If we can reduce your symptoms by 30% over the next several months, would that help?"
Educate	Education is an iterative process: • Identify what the patient understands • Address any misunderstandings • Offer information consistent with the patient's frame of reference • Check the patient's understanding
Reassure	Reassurance is provided based on the available data and not prematurely. This involves identifying the patient's concerns, validating them, and responding to the specific concerns
Negotiate	Patient-centered care is a partnership. The physician offers choices, and the patient makes a choice. For example, the physician can suggest treatments "A" and "B," indicating the possible benefits and adverse effects.
Encourage patient responsiblity	With chronic illness, the clinical outcome is better when the patient takes responsibility for care. Rather than say "How is your pain"? one can say, "How are you managing with your pain"?
Be there	One cannot always anticipate what will come up in the clinical visit; providing support and a listening ear is indispensable.

(from Drossman et al., 2021; Drossman & Ruddy, 2021)

Furthermore, it should be emphasized that the practice of medicine and its embodiment in the clinical encounter between patient and doctor is fundamentally a moral activity that stems from the imperative to care for patients and alleviate suffering. The relationship between the patient and healthcare professionals is based on trust, which gives rise to the ethical responsibility of medical personnel to put the patient's well-being above their own interest and to act for the benefit of the patient.

3.
Clinical communication

3.1. Communication in clinical practice

Effective doctor–patient communication has a positive impact not only on clinical outcomes, but also on patients' experience of care. Understanding the importance of one's own communication skills in relationships with patients and their families can help improve a physician's skills, and ultimately increase both patient and doctor satisfaction. Note that there is a significant correlation between patient satisfaction and clinicians' communication skills (devoting adequate time to the patient's visit, explaining the diagnosis and treatment procedures). In addition, doctors' therapeutic skills, their friendly disposition, respect for patients' feelings and attentive listening have been found to exhibit a significant correlation with patient satisfaction (Eveleigh et al., 2012).

Because the concepts of doctor–patient relationship and patient-centered consultation are multifaceted, understanding and teaching them is difficult. It has been noted that using metaphorical language is a tool that can be useful in such situations:

> We could say that the 'good' doctor-patient relationship is a process where an 'alliance' is created: a process in which the doctor adapts to the rhythm of the patient and little by little can help him move towards healthier scenarios; that is, detect 'what dance the patient dances' and like a good dancer, take a step back, another forward, dancing and pacing with the patient. But there is not a single type of 'good' or 'adequate' doctor-patient relationship; there is not 'a single dance that the patient dances'. (Turabian, 2018)

However, shared decision-making is not always the norm in hospital care. Although doctors explain treatment plans, many hospitalized pa-