Health communication between theory and medical practice: the case of Romania

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ABSTRACT

The positive correlations between communication in the healthcare domain, the quality of health services and the satisfaction extent of their beneficiaries are demonstrated in the present study. Considering the positive effects, upon patients, of communication in the healthcare field, the study aims at offering new data on the dynamics of the theories and practices of communication in this domain, special stress being laid on the fact that at least for East Europe, in Romania, all these aspects represent a real emergency, caused by the alarmingly increased dissatisfaction and distrust of Romanians in the public healthcare system. Accordingly, the study attempts to enrich the existing knowledge and understanding of the new directions of the communication theories and practices in the healthcare field. The scope of the research is a multiple one: providing a general perspective upon the already justified and validated theoretical and practical grounds that may renew the communicational attitudes manifested in the direct health providers-beneficiaries interactions; launching discussions among the specialists of the field as to the possibilities, opportunities, and efficiency of such theories' and practices' application in the actual underfunded health systems; rendering aware and more responsible the young specialists entering the domain, for building up their own style of communication, while convincing the policymakers to pay more attention – when elaborating their public health strategies – to the importance of communication, which may assure a higher quality of the healthcare services.

KEYWORDS:

Healthcare communication, medical humanities, interdisciplinarity, people-centred medicine.

INTRODUCTION

In the last 30 years, the researches and studies dedicated to health communication have witnessed an unprecedented advance. The constant preoccupations of the specialists and practitioners in medicine, communication sciences, philosophy, ethics, public health for the development and improvement of the theoretical and practical applications in healthcare communication contributed to increasing the quality of public health services (1). In this respect, physician-patient communication is viewed as the main mechanism that may equally contribute to improving patient's health and medical care (2). Based on this assertion, the present study aims at elucidating and at substantiating the role of communication in medical fields, by an interdisciplinary methodology focused on a common public health and social paradigm, while also considering the contexts within which the processes are developing, as well as the degree of difficulty of communication's content. Equally, the study will provide arguments for consolidating the median position of the theories and strategies of communication, known as playing a double role: negotiating the distance between physician and patient, on one side, and the one between the medical theory and practice, on the other. Once accepted, the idea that communication in healthcare systems may occupy such a privileged position will orientate medical practice along its humanistic direction. Such an attitude is possible by simply leaving aside the simplistic conceptualizations of the communication theories, incapable of going beyond an "administrative" - type communication, namely of merely collecting basic information about the patient: name, age, etc., and by abandoning the communication models usually applied when selling and promoting pharmaceutical

products. Such models make use of persuasive or rewarding strategies which, from an ethical perspective, are situated on the narrow border between morality and immorality. Application of such typologies in the physician-patient communication, which was the case of the Romanian space immediately after the fall of the communist regime, is undoubtedly a special situation, more so than that, even if only partially applied, the intensity of such models is still and easily traceable in everyday practice. From this perspective, in the Romanian space, communication within the health system at all its levels, starting from prevention, from interprofessional communication and collaboration, up to the physician-patient communication, favorized, as a direct consequence of the influence of the above-mentioned model, an intense development of rhetoric elements, to the detriment of the logical or ethical ones. In Romania, acceptance of the "sale or seller" communication pattern was favorized by the fall of the communist regime. At the global level, the specialists in communication in the healthcare system (3) referred to the same period, taking the year 1989 as a reference, as to one in which communication in the health system began its development as an independent discipline, by an increased number of published studies and researches dedicated to the domain. This interest on communication both in the public space and in the health domain was manifested in Romania quite late, as a consequence of the socio-political-economic climate. The attempts made at synchronization with the dynamics of the investigations devoted to communication, performed at the international level, occurred at the beginning of the 2000's. However, the process was rapid, so that several disciplines of the communication sciences, physician-patient

communication strategies included, entered the curricula of the Romanian universities. Even so, along with more than 15 years, the Romanian public health system did not improve. Underfunding of the system and doctors' migration (4) represent other acute aspects of the public health system in Romania, to which one should add patients' negative perception on the quality of the health services provided here (5,6).

The present research, aimed at sketching an integrated theoretical perspective on the physician-patient communication within the context of communication and also on the difficulties here manifested, shall first discuss the results obtained through the application of the new strategies and micro strategies of physician-patient communication, especially those reconfiguring the new, people-centered paradigm within which medicine advances. Such recent approaches demonstrated clinically and statistically their contribution to the improvement of the quality of health services and of patients' satisfaction, in parallels with the decrease of the costs involved (1,2,7). On the other side, application of the same strategies also evidenced the effects an incorrect communication with the patients may induce, namely "discontinuity of care, compromise of patient safety, patient dissatisfaction and inefficient use of valuable resources, both in unnecessary investigations and physician work time, as well as economic consequences" (8). Also, in this study, the expression *people-centered* involves "adopting the perspectives of individuals, carers, families and communities as participants in, and beneficiaries of trusted health systems that are organized around the comprehensive needs of people, rather than individual diseases, and that respect social preferences" (9). All these soft shifts of accent from the health system towards the person,

from the typologies of the diseases towards the suffering subject, considered in the medical practice according to the newly introduced health policies require, at another level, equally qualitative modifications of the communication patterns, strategies, and micro strategies. This creates the need of re-theorizing, re-sizing and re-constructing the paradigm of communication in the medical domain, a necessity backed up, on one side, by the practical progress of medicine, by an extended access of the patient to information about his/her disease and treatment, provided by other sources than those offered by the physician, on the other. The new, *people-centered* turn of the communication in the health system, rebuilt with elements taken over – as the present investigation proposes – from the philosophy of communication, from ethics, theories of argumentation, logic, and epistemology, might lead to the humanistic opening the medicine of today needs for its general evolution, and not only at national level.

FROM THEORY TO MEDICAL PRACTICE BY THE PASSAGE OPENED BY MEDICAL HUMANITIES

The main issue of medicine practice is shifting from the theories which actually are the essence of what one calls the *science of medicine* to the practical application of such theoretical knowledge. The present study tries to demonstrate that, in medicine, this transition from theory to practice or from practice to theory depends, to a considerable extent, on communication. Development of certain communication theories adapted to the field of medicine and sketching of specific communication techniques and strategies in public health: prevention, information, public education, on one side, and interprofessional communication, and that between the provider of medical services and beneficiaries, on the other, might assure the

transfer of information from the objective zone of knowledge towards the subjective/situated knowledge (10), as well as the effects of this type of knowledge upon the milieu within which medicine acts as a science. In such a context, *situated knowledge* may be understood, on one side, as knowledge of disease through its experiencing in one's own body, or as empirical knowledge, namely observance of the characteristic manifestations and of its evolution, and the stages of treatment, either as a specialist in medicine or as a next-of-kin of the suffering person. In the advance of the humanistic perspective in medicine, situated knowledge should contribute decisively to the development of objective knowledge. As the amalgamation of the two types of knowledge - objective *versus* subjective - is impossible (11), we believe that the two dimensions may be integrated through communication. In proposing such an exercise, a series of premises are to be considered. Epistemologically, once accepted that medicine is characterized by a fundamental, never-to-be-solved duality, being concomitantly a science and an art, we shall approach this situation first from an interdisciplinary perspective. Another reason for which this perspective imposes itself as a methodology refers to the epistemological assertion of the present study, namely that application of theoretical knowledge to medical practice, as terms *epistamai* and *technai* (science and art) (12, 13) suggest that this might be possible in cases in which interactions among individuals occur only through communication. As any practical activity means "not only the making of whatever one can make; it is also choice and decision possibilities" (13), according to the new paradigm, in which medicine advances as a *people-centered/ patient-centered* discipline (9, 14), physician's practical options and his

decisions should have in view patient's choices and decisions, as well.

Methodologically, placing in the same plan of theoretical knowledge and of situated knowledge, derived from medical practice and communication within an interdisciplinary background, would bring about several benefits. Thus, an integrated perspective upon communication in public health domains would be achieved. From the – equally theoretical and practical - the perspective of ethics, epistemology and philosophy of communication, communication in healthcare fields might improve both its theoretical basis and the practice of communication with the patients, by leaving aside the traditional, pathologized forms of communication, at least at the level of the physician-patient communication registered in Romania. Its introduction among the other medical sciences, *e.g.* clinical medicine, diabetology, psychiatry, would add value to medical practice and provide new ways for correcting some complex situations of communication, with a high degree of unpredictability

THEORY AND PRACTICE: DIFFICULTIES AND TENSIONS IN HEALTHCARE COMMUNICATION

Suffering, fear, shame when faced with one's own helplessness and decay, hope, love, the concern for the dear ones, manifested in cases of various diseases, transform the human experience, adding to one's profound humanity. In such an extreme human experience, the patient develops a relationship with the physician, with the providers of health services, with the healthcare systems, with their legislative and administrative components. Such meetings are essential, as they may offer hope and trust, they may help the suffering one to prepare to live with his own suffering, to control it, or to manage the end of his life. According to a humanistic

approach, this might be a definition of what includes the expression "healthcare communication". In an even narrower perspective, healthcare communication is the meeting between two persons who talk about health, malady, life, death - viewed from inside a hospital. Once such simple definitions are accepted, healthcare communication appears rather as a theorized practice, which permanently involves the need of readapting the same communication principles to new contexts. A repetitive mechanism which evidences the differences it thus created. Transposed to the level of physician-patient interaction, the paradoxical effect of repetition and of difference evidences beyond any doubt that the dialogue is a heterogeneous one, impossibly to be compared among either physicians or hospitals. Such a situation creates major barriers in medical communication (16). Apart from good command over the medical knowledge in his domain, for granting high-quality services to his patients, a doctor should also master the inter-human dialogue. The benefits brought about by a correct physician-patient communication may considerably add to the satisfaction of the latter (17), and equally of the former one (18). Also, positive psychological effects resulting from a proper physician-patient dialogue has been registered, capable of improving the mental health, the tolerance capacity and the life quality of both partners (19). Especially important for the Romanian space is the absence of any policy capable of supporting and financing directly people's education as to an efficient and qualitative communication with the physicians and with all health services providers.

Adverse preventable events have negative effects upon the medical result, such as prolonged suffering, patient's dissatisfaction, enormous annual costs for medical assistance

(20). Patients who could not develop a good communication with the physician have, on average, 3 times more chances to face an adverse preventable event (21). Consequently, going beyond the communication barriers in the physician-patient relation are essential for attaining increased efficiency of the medical services and lower annual costs in the field. Most part of the communication difficulties are caused, in Romania, by the fact that the population is not educated and informed as to the role of patients, on one side, and by the lack of an extensive training of healthcare providers (physicians, nurses, hospital attendants, administrative staff) in the art of communication.

A cross-sectional study performed in the Cluj county suggests that, on average, the population has only minimum, inadequate and marginal medical knowledge (22), which is also the case at national level, especially in rural areas, a situation which increases the risks of mortality and morbidity. At the same time, the lack of basic medical knowledge prevents the patient from developing a homogeneous dialogue with the physician. In such situations, the patient is not part of the dialogue, as he cannot be viewed as an active participant. Based on a transversal analysis in Romania, out of the 84 physician-patient interactions they had in the study, it was determined that the interaction was overall insufficient on average (23). Special mention is made regarding the lack of support towards the patient when expressing his/her fears and questions, lack of adaptation to his/her language and level of understanding (involving adaptation of the medical jargon). Even if, organically, these elements of communication are not part of a physician's professional knowledge, they are essential for an efficient treatment of the patients, so that communication abilities should be here included. It is already known the fact that the

Romanian medical universities have introduced communication as a discipline of study for future specialists, however, no current methods are applied for current doctors in this domain as most of them did not have this discipline in their university curricula.

Even if the Romanian health system changed its structure, comparatively with that of the communist period, the last 25 years had no impact upon modification of medical staff's mentality as to the manner of approach towards the patients. Many physicians and nurses still have a paternalistic outlook, according to which it is not important to explain to the patients the procedure or treatment to be applied (24). Such paternalistic attitudes generate patient's dissatisfaction. According to the epidemiological studies performed (25), the first two causes that have induced dissatisfaction are the barriers of communication and the lack of esteem of the medical staff for the patient. To change this situation, more efforts should be made in Romania for educating and developing the inter-human communication abilities of actual and future physicians. Stress should be also laid on the health education of the population. This type of long-term interventions may diminish the tension still present in physician-patient communication, reduce considerably the national level of morbidity and mortality, while attenuating the medical costs in the health system.

In a patient-centered medical process, all persons involved should equally contribute to the decision-making process. Under such circumstances, patients should not be passive, but active, expressing their fears, ask questions and observing the medical advice they receive (26). A patient should have an equal power in decision-making, since the treatment is not only a result of passive consumption. During the medical treatment, the patient must be proactive, endure, leave aside certain comfort habits, and act as the most important member of the medical team (27). A change in this healthcare paradigm is to treat the patient as a customer and not as a participant to the discussion, which is the result of the asymmetry in the physician-patient relation. Lacking medical education, the patient experiences a higher pressure in assuming the responsibility of the decision in the same manner as the specialists of the field (28).

Quite frequently, in Romania, the medical staff does not involve the patient in the health services applied (24), not considering him/her an active participant in the curing process, yet only a passive presence. If co-opting the patient to the decision-making of the treatment, he/she may become more aware of the possible options at hand and may decide the best path to be followed. Under certain circumstances, this may also include refusal of the treatment. Table 1 illustrates the manner in which the physician might adapt his approach for offering a qualitative medical service, in which the patient is viewed as having an equal contribution.

Table 1. Essential elements of a common physician-patient decision making.	
1.	Full defining and explaining the medical issue
2.	Presentation of options
3.	Discussing benefits and disadvantages
4.	Establishment of patient's values and preferences
5.	Discussing patient's self-efficiency capacities
6.	Presentation of the known situation and offering of recommendations

7.	Checking and elucidating the patient's correct understanding of the medical situation
8.	Making or rejecting certain decisions
9.	Organization of future monitorization

(26)

According to the ideas of L. Millenson, what differentiates the patient-centered treatment is the fact that the medical decisions taken are based on the collaboration with the patient, and not only on physician's ideas. Accordingly, the physician is expected to share his position, even if this is uncomfortable to him (29).

What is mostly needed in Romania of today is a change in the current policies of healthcare and medical services offering, which might considerably increase the quality of the health system, patients' satisfaction, and their decision-making power. Table 2 lists the essential practices that should be implemented for assuring a modern health system in Romania.

Table 2. Necessary practices for the implementation of patient-centered treatments.	
1	Constant access to medical care
2	Patient's involvement in medical care activity
3	Clinical information supporting a high-quality medical care
4	Coordination of medical care
5	Constant consideration of patients' feed-back
6	Publicly valid information about the medical practices
7	Complex and integrated care offered by the medical supplier

(30)

CONCLUSIONS

In the public health field, communication appears as a basic element which assures the practical application of medicine as a science. Even if characterized by a different register *vs* medicine, a good physician-patient communication – of the type described in the present study – has the effect of a therapeutical procedure. As healthcare providers are not the exclusive representatives of this relation, patients, in their turn, have the responsibility of being active partners in the physician-patient equation. Within the context considered in the present investigation, namely the case of Romania, both elements of the equation: healthcare providers and patients, have their weak points. In the first case, only part of the physicians, mainly those with ages under 40 years, might have attended adequate communication training courses. As to the patients, most of them do not have a minimum medical education, so that their coopting in making decisions about the treatment remains only a working hypothesis.

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REFERENCES

1. Ha, J. F., & Longnecker, N. (2010). Doctor-patient communication: a review. *The Ochsner journal*, 10(1), 38–43.
2. Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R, Buffone N, Lofton S, Wallace M, Goode L, Langdon L. (2004). Participants in the American Academy on Physician and Patient's Conference on Education and Evaluation of Competence in Communication and Interpersonal Skills. *Acad Med.*, 79(6):495-507.
3. Thompson LT, Dorsey MA, Miller IK, Parrot R (eds.). (2003). *Handbook of Health*

- Communication. Lawrence Erlbaum Associates, Publishers Mahwah: New Jersey, London.
4. Stafford, N. (2014). Romanian health system is in crisis as doctors leave for better working life. *BMJ*, 348(jan22 2), g430–g430. doi:10.1136/bmj.g430.
 5. Tereanu, C., Ghelase, M. S., Sampietro, G., Furtunescu, F. L., Dragoescu, A., Molnar, A., Dragomir, M. I. (2017). Measuring Patient Safety Culture in Romania Using the Hospital Survey on Patient Safety Culture (HSOPSC). *Current health sciences journal*, 43(1): 31–40. doi:10.12865/CHSJ.43.01.05
 6. Murgu, A., Boldureanu, G. Pricop, C.L., Vodă, I.A., Costuleanu, L.C. (2017). The Quality of the Healthcare Services in Romania in Comparison with EU. An approach from the perspective of patient, doctor and hospital management. *Bulletin of Integrative Psychiatry*, 3 (74):15 – 27.
 7. DiMatteo M. R. (1998). The role of the physician in the emerging health care environment. *The Western journal of medicine*, 168(5), 328–333.
 8. Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., ... Vogelaers, D. (2015). Communication in healthcare: a narrative review of the literature and practical recommendations. *International journal of clinical practice*, 69(11): 1257–1267. doi:10.1111/ijcp.12686.
 9. World Health Organization. (2018). Improving the quality of health services, tools and resources. Turning recommendations into practice. Geneva, Licence: CCBY-NC-SA3.0IGO available at: <http://apps.who.int/iris>
 10. Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies*, 14(3): 575-599. doi:10.2307/3178066.
 11. Nagel, T. (2009). *Perspectiva de nicăieri*. Traducere Bogdan Lepădatu, Editura Vellant: București.
 12. Saunders J. (2000). The practice of clinical medicine as an art and as a science. *Medical Humanities*, 26:18-22.
 13. Gadamer, G.H. (1996). *The enigma of health. The art of healing in a scientific age*. Translated by Jason Gaiger and Nicholas Walker, Stanford University Press: Stanford, California.
 14. Epstein, M.R., Street, L. R. Jr. (2011). The Values and Value of Patient-Centered Care. *Ann Fam Med*, 11 9:100-103; doi:10.1370/afm.1239
 15. Pricop, C.L., (2016). Repetition and difference in doctor – patient interaction. *Bulletin of Integrative Psychiatry*, 3: 63 – 71.
 16. Hurtig, R. R., Alper, R. M., & Berkowitz, B. (2018). The cost of not addressing the communication barriers faced by hospitalized patients. *Perspectives of the ASHA special interest groups*, 3(12): 99–112. doi:10.1044/persp3.SIG12.99.
 17. Biglu, M. H., Nateq, F., Ghojzadeh, M., & Asgharzadeh, A. (2017). Communication Skills of Physicians and Patients' Satisfaction. *Materia socio-medica*, 29(3): 192–195. doi:10.5455/msm.2017.29.192-195.
 18. Ranjan, P., Kumari, A., & Chakrawarty, A. (2015). How can Doctors Improve their Communication Skills?. *Journal of clinical and diagnostic research: JCDR*. 9(3): JE01–JE4. doi:10.7860/JCDR/2015/12072.5712.
 19. Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ : Canadian Medical Association journal - journal de l'Association medicale canadienne*, 152(9): 1423–1433.
 20. David G, Gunnarsson CL, Waters HC, Horblyuk R, Kaplan HS. (2013). Economic measurement of medical errors using a hospital claims database. *Value in Health*. 16:305–310. doi: 10.1016/j.jval.2012.11.010.
 21. Bartlett, G., Blais, R., Tamblyn, R., Clermont, R. J., & MacGibbon, B. (2008). Impact of patient communication problems on the risk of preventable adverse events in acute care settings. *CMAJ : Canadian Medical Association journal - journal de l'Association medicale canadienne*. 178(12): 1555–1562. doi:10.1503/cmaj.070690.
 22. Blaga, O. & Brînzaniuc, A. & Sirlincan, E. & Baba, C. & Cherecheș, R. (2013). Assessing health literacy in rural settings: A pilot study in rural areas of Cluj County, Romania. *Global health promotion*. 20. 10.1177/1757975913502686.
 23. Ildikó, A., Ábráma, Z., Ceanaa, D., Sebesia, S., Fărcau D., Gáspárik, A. (2014). Shortages of doctor-patient communication. Teaching patients to communicate effectively. *Procedia - Social and Behavioral Sciences* 142: 376 – 379.

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24. Popa, D., Druguş, D., Leaşu, F., Azoicăi, D., Repanovici, A., & Rogozea, L. M. (2017). Patients' perceptions of healthcare professionalism-a Romanian experience. BMC health services research. 17(1): 463, doi:10.1186/s12913-017-2412-z
25. Pichert JW, Miller CS, Hollo AH, Gauld-Jaeger J, Federspiel CF, Hickson GB. (1998). What health professionals can do to identify and resolve patient dissatisfaction. (6):303-12.
26. Légaré, F., Adekpedjou, R., Stacey, D., Turcotte, S., Kryworuchko, J., Graham, I. D., Donner-Banzhoff, N. (2018). Interventions for increasing the use of shared decision making by healthcare professionals. The Cochrane database of systematic reviews, 7(7): CD006732.
27. Mol, A. (2008). The Logic of Care: Health and the Problem of Patient Choice, London: Culture Unbound: Journal of Current Cultural Research. 4: 533-535.
28. Deber, R. B., Kraetschmer, N., Urowitz, S., & Sharpe, N. (2005). Patient, consumer, client, or customer: what do people want to be called?. Health expectations : an international journal of public participation in health care and health policy, 8(4): 345–351.
29. Millenson M. L. (2014). New roles and rules for patient-centered care. Journal of general internal medicine, 29(7): 979–980. doi:10.1007/s11606-014-2788-y
30. Davis, K., Schoenbaum, S. C., & Audet, A. M. (2005). A 2020 vision of patient-centered primary care. Journal of general internal medicine, 20(10): 953–957. doi:10.1111/j.1525-1497.2005.0178.x

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