A Brief Bioethical Perspective on Work in the Field of Health

7

Gilberto A. Gamboa-Bernal

Abstract

Work in the field of health has been distorted over the years, with the emergence of new health systems that have made the delivery of services a real business. As a result, the field has lost not only the motivation with which it originated, but also the human quality of providing health care. It is not new to say that exercise of the medical profession is in crisis. The causes of this predicament can be found in policies and health systems that are poorly imitated, poorly administered, mismanaged, and poorly regulated. However, there is no denying the crisis is also due to the loss of the Hippocratic spirit that gave force and vitality to the medical profession from its beginning.

Several aspects of work in health and health care, namely, scientific and technical competence (knowledge and knowhow) and human skills (knowing "how to be"), are examined in this chapter, based on a brief look at the patients and the professionals who serve them. The author goes on to discuss three fields of professional activity where these competencies play out: the Hippocratic tradition, social responsibility, and constructive dialogue. In conclusion, and in light of the above, several initiatives and strategies to humanize health services are suggested. They involve example, communication, accompaniment, correction, purpose, and professionalism.

Keywords

Person • Health • Responsibility • Humanization • Professionalism • Dialogue

G.A. Gamboa-Bernal, MD, MSc, PhD
Universidad de La Sabana,
Cra. 43E 7D-14, Medellin 050022102, Colombia
e-mail: gilberto.gamboa@unisabana.edu.co

© Springer International Publishing AG 2017
P.Á. Gargiulo, H.L. Mesones-Arroyo (eds.), *Psychiatry and Neuroscience Update - Vol. II*,
DOI 10.1007/978-3-319-53126-7_7

Introduction

The topic in question could be examined by talking about specific situations in medical practice; however, illustrating this field of activity, which is also an art, would require a far longer chapter than this one. Other thoughts on how to resolve the problems in clinical practice are discussed but, before tackling them, it is important to say a few words about patients and the professionals who serve them.

Although some find it difficult to accept, embryology and biology provided an answer, some years ago, that is fundamental to understanding what it means to work with human beings in the perinatal and neonatal stages; namely, that patients are human beings [1]. We have to start there.

In the 1970s, that assertion cost French geneticist Jerome Lejeune the Nobel Prize in Medicine. As you will remember, it was he who discovered trisomy 21 in patients with Down's syndrome [2]. Dr. Natalia López Moratalla, in an article entitled "The Zygote of Our Species Is the Human Body" [3], combines scientific data in embryology and biochemistry with anthropological applications to show how the life cycle of a body, with its own character and individuation, begins with the fertilization of two gametes. It also answers the question of what makes the human genome human, and clearly identifies the competencies that each field of science has to study this reality.

With these two examples, we are talking about the anthropological and biological statute on the human embryo. They provide all the rationale that is needed to say, with certainty, that every member of the human species, from the dawn of its existence, is a personal, relational, and acting being, one who also has a legal status that demands respect and protection [4].

Patients are persons, some healthy, others with illnesses or malformations. They passively await care and attention in proportion to their degree of defenselessness but, above all, commensurate with the dignity they hold. These two characteristics, dignity and defenselessness, make patients very special, and condition the care and attention they should receive. In the face of dignity and defenselessness, one must act with respect, care, prudence, and a great deal of science.

Expertise in Health Work

Scientific and technical expertise is the first requirement for work in the field of health. To find meaning in professional practice, but particularly to provide good service, one must start with specific training that includes knowledge and knowhow. However, these are not the only aptitudes medical professionals need to develop. They also are required to deploy a range of other skills that must be at the core of those mentioned already, namely, human capabilities, competencies of being [5].

More than being a good doctor, one must try to be a good person. Patients are the first ones to recognize these qualities, followed by family members, parents or companions. Colleagues and support staff also know what kind of person they have at their side. And, since work in the field of health is usually as a team effort, personal relationships are very important, especially if the outcome of that work is to benefit the patient.

Characteristics of Professional Activity

All these capabilities in terms of being, knowledge, and knowhow are reflected in three areas of professional activity: the Hippocratic tradition, social responsibility, and constructive dialogue.

It is not new to say that exercise of the medical profession is in crisis [6]. The causes of this predicament can be found in policies and health systems that are poorly imitated, poorly administered, mismanaged, and poorly regulated. However, there is no denying the crisis is also due to loss of the Hippocratic spirit that gave force and vitality to the medical profession from its beginning [7].

There are now new factors in medical practice that tend to denature its basis, which is the doctor–patient relationship. Part of this concern facilitated the origin of bioethics. Potter saw how

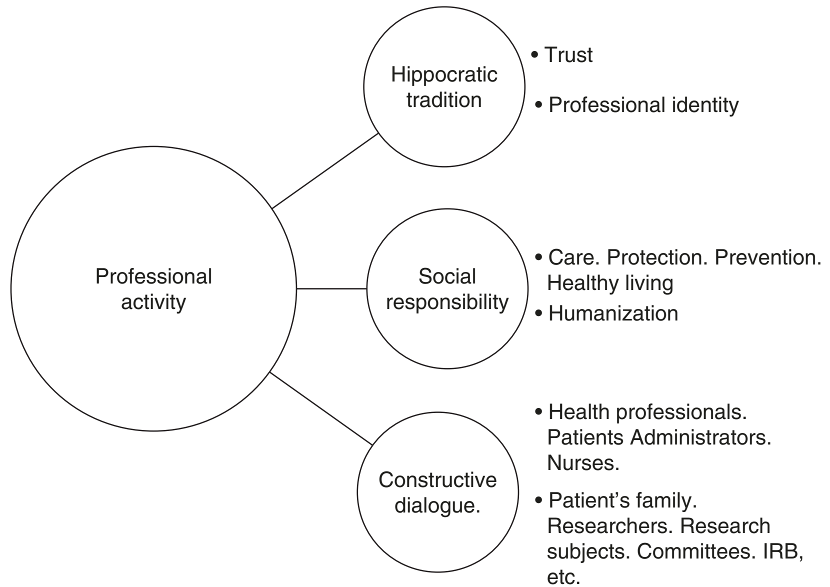

Fig. 7.1 Areas of professional activity

instrumentalization and techno-scientific advancement, when handled poorly, produced a gap that further removed physicians from their patients. It was not only a crisis of medical paternalism or old medical ethics, as claimed. It was the weakness of fundamental concepts inherent in modern globalization. For that reason, Potter proposed bioethics as a "bridge" between the humanities and the biosciences [8] (Fig. 7.1).

The Hippocratic tradition must not be lost. It is what safeguards professional identity and offers a core value such as trust, which is at the heart of medical practice. Thanks to that tradition, it is possible to give medical practice back its original force, which prompted practitioners to think first about the patient's welfare and then about administrative interests; in other words, to do patients no harm, as opposed to benefiting from them as possible subjects of research; to give them the best care, rather than abusing them through haste, paperwork, or procedures.

This is not to say that the Hippocratic tradition operates to the detriment of economic and administrative matters. This tradition will lead to more rational use of resources, getting the most out of them without waste, respecting times, meeting schedules, and being patient with administrative procedures.

The patient, however, will always be paramount. This is based on a comprehensive vision of patients and those who care for them, one that knows how to combine the patient's autonomy (or in the case of minors or the disabled, the autonomy of the parent or guardian) with that of health workers, preventing the imposition of patterns of action devoid of ethics and humanity. It is a holistic vision that knows how to exercise conscientious objection [9], when necessary, without allowing abuses by employers or contractors; one that knows how to apply a moderate form of paternalism that is a balm for the indifferent and aloof protection provided by health systems.

Only with professional practice supported by the Hippocratic tradition will it be possible to get past the frustration, discouragement and, frequently, the feeling of impotence in an environment that is hostile to humane and humanizing medical practice. Only with professional practice based on the Hippocratic tradition can the medical profession maintain its identity and repair or construct health systems on the basis of that identity, ones that genuinely contribute to the change found at the heart of the new notion of health [10], which goes beyond the concept formulated years ago by WHO.

The second characteristic of professional activity that merits comment is social responsibility. For the medical profession, social responsibility is derived from the people it serves, among other things. It is not at all poetic or lyrical to say that the present and the future are in the hands of health professionals, and how the present and future turn out depends on the care, skill, and competence with which patients are treated.

One of the practical applications of social responsibility is the ability professionals have to train the parents of their patients. Part of the education that new generations receive will depend on this. However, you cannot think that parents of patients only help them in medical topics. In addition to guidelines on care and protection, the physician also will give recommendations on prevention and healthy living to ensure a safe and positive course in life.

There is another front that warrants mention in relation to social responsibility. I am talking about the strategies that have been proposed in many health institutions to improve humanization [11]. Thanks to quality control offices or the concerns expressed by patients, their families, or the staff at these institutions, areas and situations have been detected where opportunities for improvement cannot wait.

It is often suggested that humanization can be achieved in one of two ways: through common sense and awareness. While common sense is extremely valuable and can explain many situations "*that aren't working out,*" it is not enough in itself to get to the cause, much less to propose applicable solutions to the problems it is able to detect.

The other way is to help staff members become "sensitive" to the need for humanization. This can be accomplished through "dynamics" and conferences designed to give people a "sense" of how they need to improve and why. Yet, this is not enough. Sensitivity is temporary, contingent, and variable; and what is built on that basis can change very easily, be forgotten, or cause fatigue that can chip away at efforts to humanize medical practice, making that goal fruitless.

There is a third option that allows for a better approach to the problem: raising consciousness. When reasons are taken into account, it is a different matter. If the objective is to humanize, you will want to enhance what is authentically human, both in personal and professional action. However, appreciation of what is authentically human depends on the conceptual framework being applied [12].

That conceptual basis can be found in humanism. However, the question is: What kind of humanism are we talking about? There are many versions in the history of human thought. Renaissance humanism, socialist humanism, existentialist and hermeneutic humanism, antihumanism and the new humanism or integral humanism are some examples.

It is not necessary to explain each of them, only to jot down the characteristics of humanism that seem to respond more to reality. The new humanism is based on the following propositions: man is a personal being, human uniqueness demands defense; it is essential to emerge from relativism and any sort of reductionism. In addition, it assumes that truth exists and can be known; the human person is free and capable of responsibility; freedom is connected with the individual good and the common good; the human person is worthy and deserving of respect; the human body is a human person (Fig. 7.2).

The points of reference used in person-centered bioethics are supported by those assumptions; namely, life is a fundamental value; the person is a relational and transcendent value; a holistic conception of the person is essential, a priority and complementary relationship must exist between the person, society and the environment; human love is a stable, exclusive, and enduring form of dedication (Fig. 7.3).

In short, social responsibility also translates into effective efforts that are made and maintained to bring about genuine and stable humanization of health services, based on adequate integral humanism.

Finally, the third characteristic is constructive dialogue. Ever since Plato's dialogue, this has been a tool of unique value to man. In the course of time, its use has proved to be crucial to human development and peace among people [13]. Dialogue also can deliver its best fruits in clinical practice, research, teaching, and social projection.

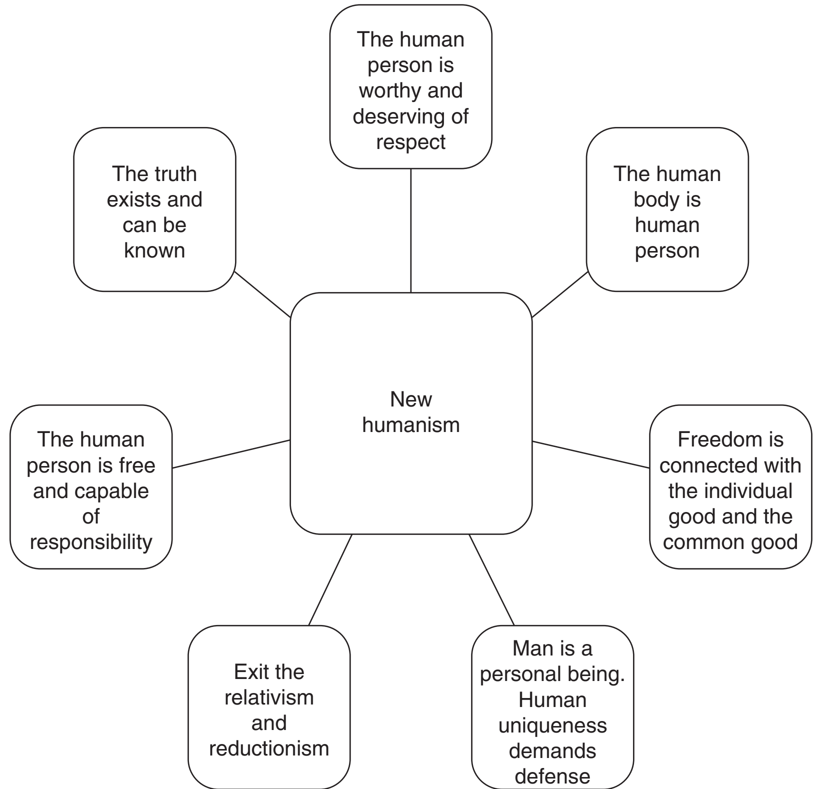

Fig. 7.2 The new humanism

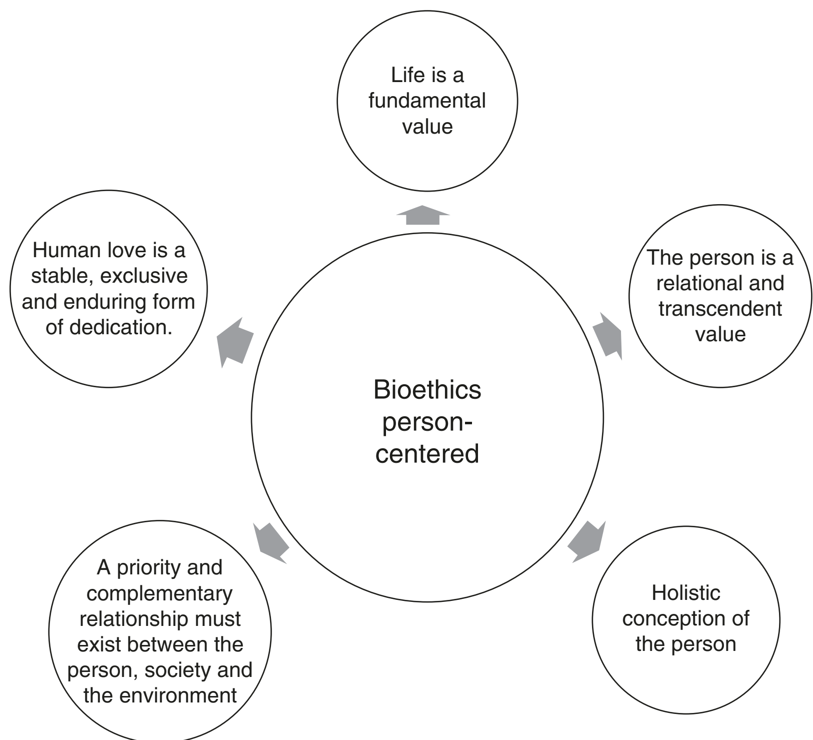

Fig. 7.3 Person-centered bioethics

In these areas, the exercise of dialogue is extremely important and it must be "constructive," since the point is to build, to add, and to propose the positive and good that can and should come from human action.

Dialogue has to play out at vastly different levels: dialogue between health professionals and their patients, among physicians themselves, to achieve real teamwork; between patients and doctors; between doctors and administrators, and doctors and nurses; between health service providers and the patient's family; between researchers and research subjects; within committees on bioethics; etc.

Humanizing Strategies

We can try to make these concepts more practical by combining the last two fields. In short, dialogue is needed to institute strategies that favor humanization (Fig. 7.4). The following are several possible humanizing strategies that require constructive dialogue.

- Example: while not acting to be seen by others, example is a major factor in change. Its influence has been known since ancient times. Julius Caesar's decision to separate from Pompei Sila, his second wife, when she became embroiled in a scandal perpetrated by Clodius during the festival of Bona Dea, is famous. He supported his decision by saying: "Caesar's wife must not only be virtuous, she also must seem to be so." We must set a good example in our personal lives and professional practice. Example is the result of coherence between what we think and what we do.

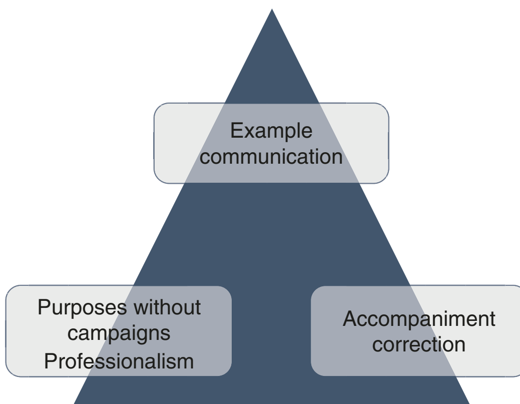

Fig. 7.4 Humanizing Strategies

- Communication: Marshall McLuhan is one of the pioneers and leading thinkers of the information society. Concepts such as "the global village", "the medium is the message," "we are what we see," or "we shape our tools, thereinafter our tools shape us" have made him a visionary in our globalized world [14]. He also argued that communication is an extension of the person. This is what makes it so important; it is crucial to know how to establish, maintain, and direct communication. The causes of many of the problems addressed in clinical bioethics committees at health care institutions stem from difficulties with communication. Therefore, strategies to improve communication will always be important if we want to advance in the process of humanization.
- Accompaniment: medical students and interns are not the only ones who need accompaniment to perform well. Prudence dictates it is always good to seek accompaniment, especially when problems are more complex, even if one has a great deal of experience. It helps a lot to have an outside opinion, frequently free of the passion and bias that can come with proximity to the problem. Time and again we need someone to help us when we can't see the forest for the trees. Loneliness is almost always a bad counselor. It is an inseparable companion of professionals in health and education, who move in a hostile and disorganized system, one that often is imbued with ideologies that are harmful to the human person, the family, and society, and where corruption has also spread its tentacles. This environment is not the most conducive to making decisions, but when professionals know they are accompanied and supported by their colleagues, the institution, and their immediate family, they are far more likely to work well, sometimes with genuine heroism.

- Correction: one of the finest expressions of charity is correcting someone who has made a mistake. Nevertheless, this practice is rare, not least of all because we work in an environment where selfishness and a culture of indifference prevail. Before proposing to help someone who has blundered, we often reject, ignore, or condemn them outright. It is crucial to promote a culture of joining in solidarity to help those who have blundered. This also would cure another disease of the medical profession: complicit silence. We must not perpetuate this culture of silence, which hushes up mistakes. If the goal is to humanize medical practice, we must take it upon ourselves to help those who have made mistakes by correcting them in a kindly, clear, and sincere way.
- Purposes without campaigns: as we have seen, an integral form of humanism is supported by human virtues [15]. Without them, professional practice does not go beyond the scope of what is technical or procedural: it seemingly is enough to "follow protocol". Campaigns not are the right vehicle to help build human virtues. These generic initiatives usually propose achieving a particular institutional value in a certain amount of time. However, it should be absolutely clear that situations or conditions are humanized not with values, but with virtues. And, how do you build virtues? You do so by helping to formulate specific purposes, setting achievable goals, and providing accompaniment (companionship, once again) to evaluate performance on the specific points that are slated for improvement. This task falls first and foremost to those who lead the work groups, and is based on two important assumptions: knowing one's subordinates and being close to what they do.
- Professionalism: health professionals in private practice and teachers in the academic community labor under the growing imperative that procedures be performed quickly and dictated, in many cases, by the economic interests of the agencies that have come to mediate in the health agent–patient–family relationship. We can longer assume neither that the circumstances of medical practice will stimulate an expression of professional virtues, nor that teachers can assume that students will see these qualities in action [16].

On the contrary, students might witness acts or omissions that damage this relationship and might adopt, for themselves, a standard that is not consistently professional. These constant encounters with unprofessional attitudes and behavior have jeopardized the standard of excellence that has characterized professionals in medicine, education, and research.

Professionalism is based on a service mentality, trust, altruism, accountability, excellence, duty, honor, integrity and respect for others. However, in the current environment of work in the health sciences, this notion is being challenged constantly and requires active and repeated reaffirmation from professionals to sustain it.

The key to practicing any medical specialty appropriately, from a bioethical perspective, is the ability to recognize and be conscious of the magnitude of the *dignity of each person*, so as to act accordingly. Above all, that action must be coherent: you must proceed according to what you think, which will always stem from what you are.

References

1. Pastor-García LM. Scientific evidence and bioethical discourse. Cuad. Bioét. 2009;XX(3):453–69.
2. Muñoz-Pérez B, Sarricolea-Errausquin ML. Dr. Lejeune: the educational challenge of bioethics 50 years later. Cuad. Bioét. 2009;XX(3):531–2.
3. López-Moratalla N. The zygote of our species is the human body. pers.bioét. 2010;14(2):120–40.
4. Steinbock B. Life before birth. The moral and legal status of embryos and fetuses. New York: Oxford University Press; 2011.
5. Barnett R. Learning for an unknown future. High Educ Res Dev. 2012;31(1):65–77.
6. Patiño-Restrepo JF. The health care in a model of commercial insurance. Rev Colomb Cir. 2011;26(1): 9–10.
7. Gómez-Fajardo CA. Notes on some ideas of the Constitutional Court. Iatreia. 2006;19(2):155–63.
8. Hottois G. Definir la bioéthique: retour aux sources. Rev Colomb Bio t. 2011;6(2):86–109.
9. Tomás y Garrido GM. (Coord.). Understanding conscientious objection. Murcia: San Antonio University Foundation; 2011.

10. Huber M, Knottnerus JA, Green L, Van der Horst H, Jadad A, et al. Should health how we define it? BMJ. 2011;343:D4163.
11. Sánchez-Naranjo JC. Humanization of health care, art and humor therapy. Rev Med Risaralda. 2013;19(2):154–7.
12. Gamboa-Bernal G. Philosophical anthropology as key of Bioethics. Rev Roman Bioethics. 2013;11(3):130–7.
13. Alfaro RM. A communication for another development. Lima: Calandria; 1993.
14. McLuhan E. McLuhan, then and now. Infoamérica. 2012;7-8:23–9.
15. González-Blasco P, Pinheiro TR, Rodríguez-Ulloa MF, Angulo-Calderón N. Medical ethics: an educational resource that facilitates learning. pers.bioét. 2009;13(2):114–27.
16. Wynia MK, Latham Jr SR, Kao AC. Medical professionalism in society. N Engl J Med. 1999;18: 1611–6.