



How the Practicing Physician Encounters Human Rights in Daily Clinical Situations

A. Rosiek; K. Leksowski

Volume 4, No. 1 (2013) | ISSN 2161-6590 (online)
DOI 10.5195/hcs.2013.110 | <http://hcs.pitt.edu>



New articles in this journal are licensed under a Creative Commons Attribution 3.0 United States License.



This journal is published by the [University Library System](#) of the [University of Pittsburgh](#) as part of its [D-Scribe Digital Publishing Program](#), and is cosponsored by the [University of Pittsburgh Press](#).

Abstract

Our study shows the awareness and application of the concept of human rights (understood as patient rights) in a hospital environment. We sought to determine whether such rights are respected, soliciting the opinion of patients and as to how it acts as a measure for whether service delivery is wholly effective in the context of the clinician-patient relation. Our research was undertaken to signal a contemporary need in service delivery: health personnel involved in the delivery of surgical services have much to learn from the practical applications of human rights principles and the essential role they must fulfill in research and advocacy in order to improve the availability of surgical care globally.

Human rights, medical ethics and empathy are parallel mechanisms working at the level of the patient-clinician relationship. This, in general, can influence the quality of care and communication for the better.

Our study was conducted in 2011 and lasted 6 months. The research sites were the public hospitals located in the Kujavian-Pomeranian region of Poland. There were two classes of hospitals: the first, had more than 400 beds (Group I) and the second one: above 400 beds (Group II). We solicited the opinion of 180 patients who had undergone laparoscopic cholecystectomy. The main planned outcome (hypothesis zero) of the study was that there were no differences between the two Groups of hospitals, and therefore no substantial variance in service delivery. The Mann-Whitney U test evidenced that judging by the significance level ($p > 0.05$), there is no basis for rejecting hypothesis zero.

Keywords: *patient care; human rights; medical ethics; service delivery*

How the Practicing Physician Encounters Human Rights in Daily Clinical Situations

A. Rosiek; K. Leksowski

1. Introduction

Medical practitioners have a key role to play in protecting, promoting and fulfilling the human rights of their patients, and consequently, of the wider community seeking to use health services. The organization, Physicians for Human Rights (PHR), for example, works closely with many human rights organizations the world over and likewise The American College of Physicians has an active human rights committee, proven by its authorship of the Ethics Manual, which is now in its internationally hailed sixth edition. Likewise, medical organizations (specifically the Regional Chamber of Physicians and Nurses) in Poland are also becoming more active in this area, marking an upturn in the consciousness of the clinician-patient relation, one that is all too often taken for granted, and consequently, all too often misunderstood.

The broad definition of human rights is arguably given by Amnesty International (2009) which describes human rights advocates as individuals or groups of people promoting and protecting human rights through peaceful and non-violent means. Such advocates carry professional status and concordant social responsibility, and examples include judges, lawyers, religious leaders, and educators. To this we can remember the Declaration on Human Rights Defenders, where the United Nations calls upon professionals to uphold human rights and freedoms (Article 3 and Article 25) within their professional decision-making and active capacities. But the promotion of human rights is also in keeping with the medical professional code of medical ethics. Peel, for example, states in his *Human Rights and Ethics* that ‘human rights and medical ethics are complementary’ (Peel, 2005, p.172). The Universal declaration of Human Rights has been instrumental in protecting human dignity in international law policy, providing a moral grounding for the improvement of standards of care on the basis of basic, shared responsibilities towards in life. This, moreover, allots important guidance to legal, social and ethical issues where a concept of the personal and fundamental dignity of all human beings implies that patients have rights, and that although such a public is commonly perceived to constitute a homogenous indistinct group, rights may vary depending on country, continent, jurisdiction and also upon prevailing cultural and social norms, respectively so. Different models of the patient--clinician relationship can thus take on a different form of formality and linguistic, communicative intimacy signalling that an opportunity exists to compare the clinical setting of human rights in everyday clinical practice – a landscape of human need and concordant assistance, one, which cannot be simplified. With this, we can also signal that a growing international consensus exists underlining the patient’s fundamental right to privacy and to the confidentiality of their medical information: a patient indeed has the right to refuse treatment, and also to be informed about the respective risks a medical procedure or medication may carry.

The abuse of human rights in clinical contexts and situations is a worldwide problem, demanding the attention of clinicians and the reevaluation of the consciousness defining the ethical presence of the clinical personage. As a member of the World Medical Association (WMA), the Polish Medical Association is committed to realizing the

mission of the WMA—upholding the highest possible standards of ethical behavior and care, at all times (Kao, 2004). Although, there is some distance to go before the aspirations of the "human rights" declarations (Universal Declaration of Human Rights, 2004), conventions (European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2004) and treaties (International Covenant on Economic, Social and Cultural Rights, 2004) are fully realized in clinical consciousness, physicians need to be conscious, pragmatically so, of the special responsibility they have been allotted to defend the human rights of patients – this, a responsibility grounded in medical heritage and its vocation of caring for the sick and suffering.

The issue of human rights in the context of patient care can be facilitated through asking how the practicing physician encounters human rights issues in daily clinical situations. Our research, which was conducted in Polish surgery clinics on laparoscopic cholecystectomy patients, highlights basic everyday problems related to human rights in a public hospital, if not basic everyday problems which haunt human communication. Here, we can identify two basic demands:

1. The need to understanding the physician's role as an advocate for human rights in surgery clinics
2. The need to identifying ways in which physicians can participate in providing health care for patients (e.g. after undergoing laparoscopic cholecystectomy).

Our study addresses these two perennial demands in detail where the respect of patient's rights by physicians and medical staff is assessed from the service user point of view. By focusing on two such fundamental patient needs means that questions of emotive connection, emotional attunement and empathy can be raised within a pragmatic situation not merely as a necessity, but as a fundamental dimension to the effective delivery of patient care. To be "attuned" and "in resonance" moreover, is not a uniquely professional skill, but a part and parcel of human communication - this arguably a field which solicited the energies of phenomenological philosophers (Martin Heidegger; Max Scheler), rather than mainstream clinicians. Such philosophies of communication and empathy eventually had a degree of impact on the clinical practice and research of psychiatry albeit historically localized and geographically rare. In our day, however, for both the clinician and health service user, the state of affairs has become one where a stoic, uncomplicated approach to the clinician-patient relation is necessary and where empathy as a basic factor to human communication, is a fundamental reality to the clinical encounter. We suggest that structurally, there are three main ways in which physicians can base their emotional responses to improve medical care and ethical service delivery: ***The physician must be attentive to, and identify, what is human and significant in healthcare provision***

The physician should seek to be 'emotionally focused, attentive to the patient's anxieties, fear and doubts. He/she should inform the patient about treatment and the guarantees for the patient's mental and physical wellbeing and safety. What's more, the physician should seek to preserve the patient's privacy and dignity, this, forming mutual trust. ***The awareness should be that empathy facilitates trust building and can directly influence therapy.***

Physicians engage empathetically not only by paying attention to what a patient actually says, but also by (automatically) paying heed to the patient's non-verbal style: vocal tones, body language and gestures. Doctors who are more attuned with the non-verbal methods of communication with a patient's style of being will enable the patient to feel more secure. Building the emotional connection with patients also facilitates trust and enhances the therapeutic process during the patient's hospital stay. ***Empathy makes a physician's work more satisfying leading to professional, as well as therapeutic contentment.***

Empathy enhances patients-clinician communication, trust, and therefore improves treatment effectiveness and ultimately, satisfaction. Yet, that empathy depends on emotiveness means that a consciousness, or mindfulness of emotions is necessary, otherwise emotiveness may indeed be a barrier to empathy. Yet another hurdle is that many physicians still do not see a patient's emotional needs as core aspects of illness and care. Often a physician will become irritated or agitate, this, limiting mutual dialogue and the existential communication facilitating empathetic understanding. Working under the pressure of time is also invoked as a serious barrier to (1) to the clinician *listening* and (2) to the patient *voicing and expressing*.

Surgical interventions are increasingly important to public health and must be included in contemporary discussions on health and human rights. The number of diseases requiring surgical interventions known to avert disability and death, along with cost effectiveness of the intervention, are evidence that certain surgical procedures such as cancer surgery, organ transplant surgery and also general surgery procedures, should be prioritized for delivery in all countries, and that the status of these specific procedures must be elevated from a mere "importance" to an "essential element" of the right to health. This said the current disparities in global surgical care are questionable and at times practically unacceptable. Owing to this disparity, short- and long-term plans to improve access to surgical care in these clinical environments are necessary measures and intrinsic mechanisms to effective delivery. As a starting point, this includes the critical appraisal and action in areas of the world's surgical workforce,; the integration of surgical services in ongoing health policy initiatives, and the consensus on (public)health indicators that can be used to measure progress. What's more, health care personnel, as a working team involved in the delivery of surgical services, have much to learn from the practical applications of human rights principles and the essential role they must fulfill in research and advocacy to improve the availability for surgical care globally.

II. Method

Our research was conducted in six health care units within the Kujavian-Pomeranian province. These units were divided into two groups: Group I: three hospitals with the number of beds above 400, and Group II: three hospitals with the number of beds below 400. The research included 180 patients: 30 from each hospital. Research was conducted in public surgery clinics in Poland. In each category 90 patients were asked to answer a survey. They were asked to assess the doctor's work with regard to patient rights and the consistency of medical information provided. The patients were also asked if their dignity and privacy had been respected, and also how well the doctors communicated with them. The patients evaluated the difference between the expected service and that received during their stay at a hospital. A Servqual qualitative method was adopted owing to the qualitative parameters of research collation . The originality of this method is to show that the perceived quality of service is the result of a comparison of service both expected and received. this, measuring any possible differences that exist between the quality perceived by a patient and service expected. Such a service quality framework can also signal the steps undertaken to improve the quality of health care service and their implementation in a particular medical facility by comparing patient's expectations and patient's perceptions of the service.. The difference between the value desired by a patient in particular areas and the value perceived consequently indicates a weakness in the service delivery of an organization. Research results were consequently analyzed statistically where the authors used non-parametric statistical tests of Spearman, Kruskal-Wallis and the Mann-Whitney U test. All patients underwent laparoscopic cholecystectomy surgery, where the average time of hospital stay was 3 days.

Results

The basic hypothesis – hypothesis zero– is that there is no difference between the two sample groups (Group I and Group II). In other words, all the patients treated, in both of hospitals, expected the same service delivery during their stay (protection of privacy, information about their rights, and a high quality of hospital care).

III. Human Rights as Patient Rights in Medical Surgery Clinics (MSCs)

The respect of patient confidentiality is a central factor to the patient-clinician relationship in which nursing staff are also privy to sensitive information and central in the delivery of humane and nondiscriminatory treatment. The research indicated that each patient was informed about their rights by medical staff, and their level of satisfaction.

Group	Group I		Group II		Sum	
	Number	%	Number	%	number	%
-4	9	10,0	1	1,1	10	5,6
-3	4	4,4	2	2,2	6	3,3
-2	5	5,6	1	1,1	6	3,3
-1	14	15,6	14	15,6	28	15,6
0	41	45,6	65	72,2	106	58,9
1	13	14,4	7	7,8	20	11,1
2	4	4,4	0	0,0	4	2,2

Table I: communication of patient rights

Table 1 evidences that there were no differences between the expectations and the actual state in the majority of Group II – (72,2%). In Group I more patients expressed satisfaction– 17 (18,8%).

Rank Sum Group I	Rank Sum Group II	U	Z	level p	Z Corrected	level p	N weighted. Group I	N weighted Group II
7834,0	8456,0	3739,0	-0,88975	0,37360	-1,00079	0,31693	90	90

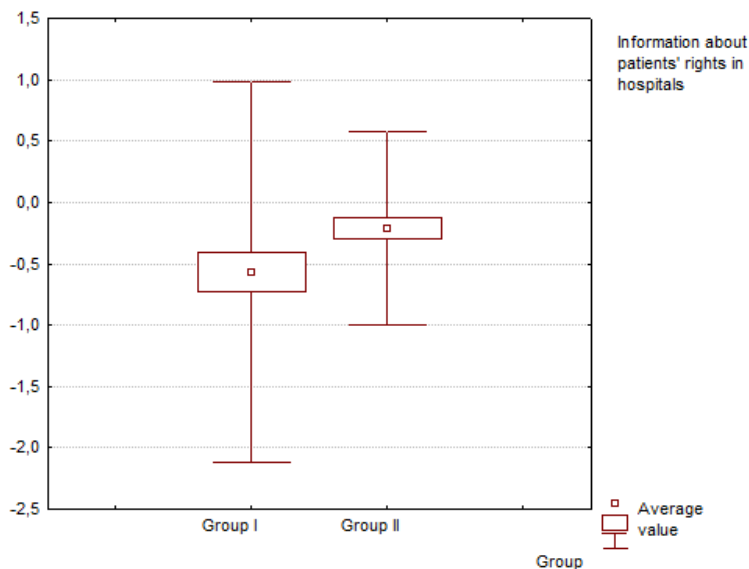
Table II: Differences between both Groups – information about patients' rights

The Mann-Whitney U test revealed that, judging by the significance level ($p > 0.05$) there is no basis for rejecting hypothesis zero. The Groups do not display a significant difference in terms of the communication of information.

Table III: Average assessment in researched groups – information about patients' rights.

GROUP	Average	SD
Group I	-0,57	1,55101
Group II	-0,21	0,78604
Both groups	-0,39	1,23898

Figure 1: Average assessment of information distribution



The communication of patient rights was better evaluated in Group II. Despite the fact that in both groups the expectations were higher than the actual state, the difference in the average assessment was 0.36. The main reason for the expressed dissatisfaction of surgical in-patients was the general lack of information provided. Most people accepted that individuals have a right to personal autonomy and control over what is done to their bodies. Such a right is firmly rooted in common law doctrines, including the self-defense privilege (Alexander JA 2012, Amnesty International 2009, Institute of Medicine 2001) and the informed-consent standards (Geneva Convention 2004). Likewise it is recognized as a constitutional right to refuse medical treatment (Geneva Convention 2004, Institute of Medicine 2001). This said, more often than not, the right to refuse is part of common popular reason.

Our results indicate certain important points namely, that the patient-clinician relation influences and changes patient behavior, and tantamountly, patient attitude towards then received service care. Empowered and better informed patients are active participants in their care, and a physician who encourages and supports this activation facilitates a more equitable, and collaborative partnership. Indeed, although healthcare focuses on individual wellness or freedom, pathological speaking, "public health" is concerned with promoting the optimal

health of the population as a whole (Burris, 1997). More concretely, public health seeks not only the aggregation of individual satisfaction but, rather, the common good (Lawrence, 2004) such as a patient's rights. Accordingly, individual rights are constantly in tension with communitarian interests which may or may not conflict with service providers, particularly in the context of health provision and medical intervention (Wendy, 2007). In this aspect, physicians in their capacity as medic and provider are advocates of human rights in public healthcare systems. The development of modern public health in the context of human rights, concordantly requires the analysis of current policy effort and its effectiveness in the promotion of value-based health care through consumer choice and through the protection of the basic rights of patients. This means that although there are differences in legislation, administration and procedures in the health care administration of different countries, patients should receive a treatment that is consistent with his/her rights and dignity. Equitable access to high quality medical care, ensuring patient privacy and confidentiality, informing patients and obtaining their agreement before medical intervention, and also providing a safe clinical environment during medical procedure are the main determinants of the new role surgical physicians occupy – one of assistance and advocacy. The Universal Declaration of Human Rights (2004) has been instrumental in guaranteeing and positioning human dignity in international law discourse, providing a legal and moral basis for improving the standards of care and giving important guidance on social, legal and ethical issues. There still remains a great deal of work to be done to clarify the relationship between human rights in clinical and socio-medical contexts, including and in this aspect understanding the physicians' role and the new relationship between patients and doctors in hospital settings is a contemporary necessity. The new role of doctors as medic-advocate and a new professional style and communicative dynamic signals that the degree of information imparted to patients is more today, than previously practiced. Doctors are faced with the need to see patients as service users and service consumers who have constitutionally reserved rights to health care and equitable treatment.

Rights to privacy and dignity of patients undergoing surgery

In the public health care arena there is continuous debate in hospitals about how to best conceive the patient-clinician relationship, without falling into paternalism or alienation. There is also growing international consensus in health sectors that all patients have a fundamental right to privacy, confidentiality of their medical information and have a right to consent to or refuse of surgical treatment. This fact and the continuously changing legislation in the public healthcare sector create a new role for the clinician as an advocate of human rights in everyday clinical practice/s. On the other hand, the creation of effective patient- protection laws relies on how public healthcare integrates scientific advance within an ethical, social, legal and medical paradigm. And with this new personage of the medic comes the consequence changes in the medical and political environments defining the public healthcare sector.

Group	Group I		Group II		Sum	
	No.	%	No.	%	No.	%
-4	0	0,0	1	1,1	1	0,6
-3	1	1,1	0	0,0	1	0,6
-2	2	2,2	0	0,0	2	1,1
-1	12	13,3	11	12,2	23	12,8

0	49	54,4	67	74,4	116	64,4
1	21	23,3	11	12,2	32	17,8
2	5	5,6	0	0,0	5	2,7

Table IV Guarantees of privacy and dignity preservation (differentials)

Table IV evidences that there is no difference between patient expectations and the nature of service provided. The majority of Group II – 67 patients (74.4%) – did not indicate differences between their expectations of respecting their privacy and dignity, and their perception of this issue. In Group I more people stated they were satisfied with the way in which their rights to privacy and dignity were handled by the respective hospital.

Rank sum Group I	Rank sum Group II	U	Z	level p	Z Corrected	level p	N weighted Group I	N weighted Group II
8630,0	7660,0	3565,0	1,38756	0,16527	1,62999	0,10310	90	90

Table V: Differences in sample groups – guarantees of privacy and dignity preservation

The U Mann-Whitney test showed that judging by the significance level ($p > 0.05$) there is no basis for rejecting hypothesis zero. The sample groups in Table V are not significantly different in their assesment of privacy and dignity preservation.

Table VI Average assessment in the researched groups – guarantees of privacy and dignity preservation

GROUP	Average	SD
Group I	0,13	0,87666
Group II	-0,04	0,65190
Both groups	0,04	0,77548

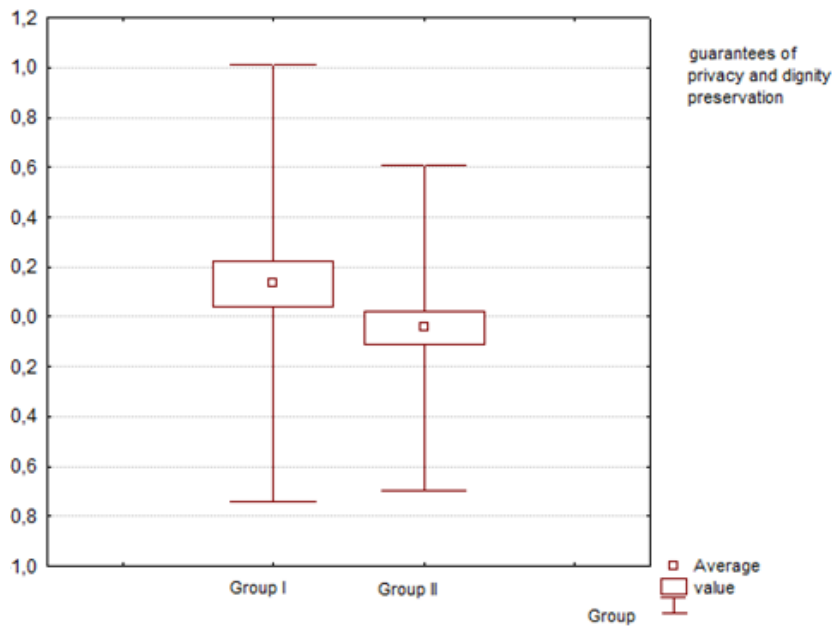


Figure 2: Average assessment of guarantees of privacy and dignity preservation

differing knowledge between doctors and patients (Starr 1982), and expressed through traditionally passive patient roles and dominant physician roles (Charles, Whelan, Gafin 1999). This traditionally passive role is contradictory to the new role of the doctor in society, which has been postulated since 1973 by Keith Hodgkin (p.895). The lack of cooperation in the patient-physician relationship usually results in a lack of involvement and both the changing historical environments of patient-centred care and its consequent philosophies requires new methods in the initial development of clinical guidelines that provide a framework for everyday clinical practice (Wersch and Eccels 2001), this, affirming that the patient is more active in treatment processes, particularly those requiring stay in hospital surgery wards. Likewise, the clinician's role should focus on the delivery of complex and respectful treatment, hallmarked by consistent information exchange. Our study shows that the preservation of dignity and the guarantees of privacy are the primary steps in affirming a more responsible role of health care. Patients who feel that they are treated fairly by their doctors, regardless of their personal characteristics, tend to be more motivated to relate to their physician, and consequently to the treatment process. Thus patients believe that they have an important role in their healthcare process as individuals (the assessment of dignity is higher in this group of patients (Group I). Indeed, patients prefer treatment that they perceive as free of bias or free of ethnic, socioeconomic, demographic and gender variables. Patients also prefer to be taken into consideration when it comes to treatment decisions and they prefer strong interaction with their doctor.

IV. Discussion

The results of our research study indicate that the development of modern public health care necessitates necessary changes. The physician is as an advocate of human rights, and the new relationship between patients and doctors which is defined by the degree of interaction and assertion. Likewise, the practicing physician encounters human rights in daily clinical situations, and can be instrumental in the process of redefining roles and relationships. Respect for human rights in clinical practice was better assessed by patients when the physician listened carefully, where patients are affirmed as partners in the treatment process, considered a decision -maker. Indeed, treating patients with respect and dignity helps to develop a partnership which contributes to health status and healthcare

In Group I the expectations turned out to be lower than the actual state while in Group II the expectations were higher with a difference of 0.17. The main reason for the negative feelings of patients staying at surgical wards in Group II was precisely the relationship with medical staff. Lower guarantees of privacy and dignity preservation in Group II signals a power differential between patients and their doctors, which is deeply engrained in the culture of medicine composed of

quality processes. And as Berry et al. (2008) and Lubetkin et al. (2010) affirm, the patients–physician relationship may impact not only treatment processes but also eventual well-being. Thus, the clinician who treats his/her patients fairly, that is, equitably, and as partners, will also see his/her patients become more active agents in treatment and its results. Understanding a doctor’s role in the patient–clinician relationship and their association with human rights is instrumental in contributing to patient health and to the patient perception of clinical work. The role of the patient–clinician relationship and the level of activation among individual patients has also been examined by Alexander et al. (2012) whose research confirms that while talking about clinical situations, treatment processes and the new patient–clinician relationship, one has also to be mindful of fair treatment which is guaranteed by the Constitution in various countries and is in agreement with WHO guidelines. This means, that human rights in medical contexts encompass myriad factors: fair treatment; the guarantees of privacy; informing patients about their rights to hospital treatment and care, and also nondiscriminatory treatment. Such factors also include patient communication, the role and degree of empathy and the medical staff’s competency to meet the emotional needs of patients.

Doctors are taking a more patient-centered approach to their work in order to understand the depth and impact of a patients’ illness and to not only identify possible psychosocial causes of diseases but to understand the patients’ biographical history and disposition: beliefs, priorities and preferences for treatment. This approach is also postulated by other authors such as Mead and Bower (2000), who argue that the medical task requires a doctor to listen to the voice of his/her patient, facilitating and encouraging an active involvement in communication of his or her beliefs, feelings and other psychosocial aspects. This is in telling contrast to the more common modes of clinical communication strictly adhering to an objectively “disease-centered model” in terms of what has been referred to as the voice of medicine (Mishler, 1984, p.464).

Such differences in communication style highlight the need for the cultivation of communication skills but also a necessity to flag differences in clinical attitude to the medical task at hand. The new relationship between doctors and patients, which is more interactive, shifts towards the philosophy of patient–centered care and shared treatment decisions. Interactive relationship, good communication and shared decision-making is being developed to provide patients with information they want to receive, this, supporting individual treatment choices and supporting the new role of doctors who should be advocates of human rights in public healthcare processes.

Informing the patient about treatment during his/her hospital stay is a guarantee for the patient’s mental and physical wellbeing, patient safety climate and the increase in patient satisfaction. Over several past decades, the informed consent doctrine has become a staple of the Polish health care system, creating a monumental shift in the way medicine is practiced, and indeed thought out. For much of medical history, the Hippocratic Oath to “do no harm” meant that doctors paternalistically determined what they believed to be the appropriate course of treatment for their patients (Garrison, Schneider 2003; Roe and McMurray, 2009). Now, instead of simply following the will of their doctors, patients generally prefer to take a more active role in their health care processes, deciding which treatments, if any, are most appropriate for their individual circumstances (Roe and McMurray, 2009; Berg et al, 2001, p.26-27). As Professor Robert Post Noted: “when physicians speak to us as our personal doctors, they must assume a fiduciary obligation faithfully and expertly to communicate the considered knowledge of the ‘medical community’”(Post 2007, p.939; Roe and McMurray 2009, p.3). Ideally, the process is one that promotes the type of thoughtful and effective communication between a patient and his or her physician that ultimately allows the patient to realistically and objectively balance the risks and benefits of a proposed healthcare in hospital ward (Roe and McMurray, 2009 p. 2).

In the Polish health care system’s reform programs, the ‘quality communication’ concept involves the two dimensions of the technical and interpersonal. The former looks for achieving better results through the conduct and application of health care and scientific research. The latter comes from concerted efforts to increase respect for patients as human beings and improve their satisfaction with the health care services they receive. Consequently,

health care leaders and managers have developed a heightened awareness of the importance of the moral dimension of health care service provision. This has resulted in a rapid proliferation of professional codes of ethics, codes of conduct for health professionals and patients' rights documents, and assessment of the quality of care as a necessity for each hospital. Honesty and sensitivity and the so called "human approach" are main determinants of performance quality in hospital environments where verbal communication (especially informing patients about treatment and drug therapy) provided during hospitalization, is important both from the patient's and quality assurance point of view.

Regardless of advances in information technology, medical care will continue to involve direct communication between individuals (Miller et al. 2001, p.123) and patient education is one way to prevent medical errors (Sulzer-Azaroff and Austin, 2000, p.20) in hospital practices. When patients know the questions to ask and feel they can effectively communicate with caregivers, they are providing prompts to activate safe health care behaviors. Effective communication between the empowered patient and receptive caregiver not only helps alleviate patient concern about experiencing a negative outcome (Sulzer-Azaroff and Austin, 2000 p.23), but also adds a patient-centered, customized set of cues to prompt the occurrence of critical safety-related behaviors.

V. Conclusion

Empathy, competence of the medical staff, how information is communicated and shared with patients are all elements influencing a patient's assessment of service received. . A similar position on this issue is presented by other researchers who found that the more medical staff is willing to express empathy, the better the patients assess their competence and, consequently, patients are more satisfied with their hospital stay and the course of treatment (Birhanu et al. 2010). Meeting the emotional needs of patients is therefore an important area of medical care that should be provided to patients treated surgically. Others have suggested that the capacity for empathy in people in general can serve as a foundation for building interpersonal relationships that have a buffering effect against stress and can be an essential step in healthcare resolution (Kremer & Dietzen, 1991). Patient involvement in treatment decisions and also empathic interpersonal engagement in the clinical environment thus can lead to greater patient satisfaction and effective health care delivery within hospital settings (Moore, Adler, & Robertson, 2000; Zachariae et al 2003). What's more, patient satisfaction with hospital treatment, including surgery, is built up through interpersonal relationships (doctor-patient, nurse-patient), proper communication, diagnostic information patient rights and pharmacological treatment, all of which impact upon the experience of hospital stay Well-managed hospitals, constantly wanting to improve their image, must pay attention to the quality of service, the efficiency of operations and the maximization of efforts to secure full satisfaction of the patient by respecting the patients' right to dignity preservation and privacy. Such actions are the way to founding a modern, positive image of hospital care not only in the eyes of patients, but of the public at large.

Investing in surgical services is advisable for all sectors in medicine as it could help to ensure the upholding of human rights in everyday hospital practice despite the fact that the researched parameters related to human rights are not statistically significant when it comes to patient opinion. Such parameters are however important when it comes to the assessment of teamwork in surgery wards, especially in terms of communication, care quality in surgery wards, and in terms of the basic human rights advocacy. Patients seek empathy from their physicians and seek to be co-partners in the evolution and decision making of treatment paths. However, the function of empathy doesn't end with doctors labelling patients' emotional states, but is to do with recognizing what and how a patient feels and how a patient wants to experience hospital stay. This can, more generally, influence quality of care and patient-clinician communication, this defining the cl Empathy has, as its goal, mutual understanding and the

preservation of another's dignity: human rights, medical ethics and empathy are thus parallel dimensions to clinical reality working at the level of the patient-clinician relationship which in turn places a duty on the state and on healthcare providers to comply with minimum standards in each hospital.

Our study puts forward that there are certain functions which need to be realized in hospital clinics in order for the concept of high quality standards to become a concrete and practical reality. And where patients need to be informed with regards to their rights, so too do new doctors need to learn how to speak to patients and how to provide a supportive service in surgical clinics. It would be beneficial to establish broader definitions of medical ethics or create new international communication codes in terms of the clinician-patient communication, and the fundamental human rights this edifies. What is needed are procedures for implementing, monitoring, and enforcing existing standards and codes, as well as an increased awareness by the medical community of its human rights obligations. Additionally paying attention to patients' rights influences the culture of patient safety can contribute to the perception and recognition of safety in surgical wards. The best way to achieve this would be to make "medicine and human rights" a significant part of the ethics curriculum in medical schools.

The objective of the first stage of implementing a culture of patient safety is to create a strong platform for hospitals through the implementation of public programs promoting a better clinician-patient relation as well as better education and training for staff to increase the level of relationship commitment with patients. Medical staff and hospital managers should be taught how to build strong relationship skills in order to facilitate and establish patient commitment, which is now a modern necessity to the medical market. Strong competition in this area of medical services creates new roles for doctors to be advocates of human rights and necessitates the medical staff to learn new skills and how to function as a team in hospital wards. More advanced skills, both in communication with patients and in recognizing and responding to the emotional needs of patients, should be used to build patient loyalty to a hospital, as a brand.

The objective of a proposed second stage is to create the positive image of a hospital and surgery ward in which the preservation of patients' rights to privacy and dignity is of utmost importance. Launching awareness programs for all hospital staff, educating on the importance of a relationship between patients and medical staff in the aspect of human rights, should consequently be a standard practice in hospitals.

The limitations of our study must be recognized, however. Firstly, there were few studies researching how human rights are recognized in hospital practices and the assessment of how well such rights are respected from the patients' point of view. This and other related identifying factors used in our study could suffer from lack of validity and reliability, but it is nevertheless interesting to look at the results of this study with the prospect of increasing competition among hospitals on the market and the changes (new roles) this brings. Secondly, the results of our study benefit from the patients' point of view and the analysis contained herein can be interpreted in many ways. Future studies can perhaps benefit from using other analytic techniques, for example, the clinician's point-of-view, as well as other medical staff, thus shedding greater light on what precisely is encountered on a daily basis and how human rights are interpreted by those who hold responsibility for patient care and the evolution of clinical cases.

References

Alexander JA, Hearld LR, Mittler JN, Harvey J. Patient-physician role relationships and patient activation among individuals with chronic illness, Health Services Research, June, 2012

Amnesty International. Human rights defenders. <http://www.amnesty.org/en/human-rights-defenders/background> (accessed 13 March 2009).

- Barry CA et al. *Patient's unvoiced agendas in general practice consultations: qualitative study*. British Medical Journal, 2000, 320:1245-1050
- Bendaputi, N.M., Berry, L L. Frey, K.A., Parish, J.T. (2006). Patients' perspectives on ideal physician behavior. Mayo Clinic Proceedings, 81, 338-344
- Berg J W, Appelbaum PS, PARKER LS and LIDZ CH W, Informed Consent: Legal Theory and Clinical Practice, 2001, 2d edition, 26-27.
- Berry LL et al. Patients' commitment to their physician and why it matters. Annals of Family Medicine 6 (1): 6-13, 2008.
- Birhanu Z, Assefa T, Woldie M, Morankar S. *Determinants of satisfaction with health care provider interactions at health centres In central Ethiopia: a cross sectional study*, BMC Health Service Research 2010, 10:78, 1-12
- Burris S, The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism, 87 AM. J. PUB. HEALTH 1997, 1607-1608.
- Charles, C., T. Whelan, and A. Gafni. 1999. "What Do We Mean by Partnership in Making Decisions about Treatment?" British Medical Journal 319: 780-2
- Charon, R. Narrative Medicine: A model for empathy, reflection, profession, and trust. Journal of American Medical Association, 2001, 286, 1897-1902.
- S M Lukhozi, MB BCh, Dip Forensic Med (Clinical), PG Dip Applied Ethics for Professionals, Certificate in Medicine & Law, MFFLM (London) Clinical Forensic Medical Officer, Mamelodi Medico-Legal Crisis Centre, Clinical forensic medicine and human rights – doctors as human rights defenders , December 2009, Vol. 2, No.2
- Council of Europe. *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*. Accessed August 31, 2004.
- Garrison M, Schneider CE. For years, medical paternalism--the belief that doctors should make decisions for patients--ruled.", The law of bioethics: Individual autonomy and social regulation 41, 2003.
- General Assembly Resolution A/RES/53/144. Declaration on Human Rights Defenders, adopted 1998. <http://www.ohchr.org/english/issues/defenders/declaration.htm> (accessed 23 April 2009).
- Geneva Convention. *Convention (III) Relative to the Treatment of Prisoners of War*. Geneva, 12 August 1949. Accessed August 31, 2004. <http://www.refworld.org/docid/3ae6b36c8.html>
- Hodgkin K, The role of the doctor in society, Proc R Soc Med. 1973 September; 66(9):893-896
- Institute of Medicine 2001. Crossing the Quality Chasm: A new health system for 21st century. Washington, DC: National Academy Press.
- Kao Audiey C. Medicine and Human Rights, *Virtual Mentor*, September 2004, Volume 6, Number 9.
- Kremer, J. F., & Dietzen, L. L. (1991). Two approaches to teaching accurate empathy to undergraduates: Teacher-intensive and self-directed. Journal of College Student Development, 32, 69-75
- Lawrence O. Gostin, *Health of the People: The Highest Law?*, 32 J.L. MED. & ETHICS, 2004, 509:510
- Lubetkin EI, Lu W H, Gold M R. Levels and Correlates of Patient Activation in Health Center Settings: Building Strategies for Improving Health Outcomes. Journal of Health Care for the Poor and Underserved, 2010, 21

(3):796:808.

Mead N, Bower P. *Patient-centredness: a conceptual framework and review of empirical literature*. Social Science and Medicine 2000, 51:1087-1100

Mishler EG. *The discourse of medicine, dialectics of medical interviews*. Ablex Publishing Corporation, Nordwood, NJ, 1984.

Miller MR, Elixhauser A, Zhan C, et al. Patient safety indicators: Using administrative data to identify potential patient-safety concerns. *Health Serv. Res.* 2001; 36: 110-32.

Moore, P. J., Adler, N. E., & Robertson, P.A. (2000). Medical malpractice: The effect of doctor-patient relations on medical patient perceptions and malpractice intentions. *Western Journal of Medicine*, 173, 244-250

Peel M. Human rights and medical ethics. *J R Soc Med* 2005; 98: 171-173.

Post R, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 977.

Roe, McMurray “*Not-so-informed consent: using the doctor-patient relationship to promote state-supported outcomes*”, *Case Western Reserve Law Review*, September, 2009.

Sulzer-Azaroff B, Austin J. Does BBS work? Behavior-based safety and injury reduction: A survey of evidence. *Prof Saf.* 2000; 45: 19-24.

Starr P. *The Social Transformation of American Medicine*, New York: Basic Books, 1982.

United Nations. *Universal Declaration of Human Rights*. Accessed August 31, 2004.

United Nations. *International Covenant on Civil and Political Rights*. Accessed August 31, 2004.

United Nations. *International Covenant on Economic, Social and Cultural Rights*. Accessed August 31, 2004

Weeks L.E, *The public's right to health: when patient rights threaten the commons*, *Washington University Law Review*, October, 2009.

Wendy E. Parmet, *Public Health and Constitutional Law: Recognizing the Relationship* 10 *J. Health Care L & Policy*, 2007 13, p 24.

Wersch van A, Eccles M. *Involvement of costumers in the development of evidence based clinical guidelines: practical experiences from the North of England evidence based guideline development programme*. *Quality and Safety in Health Care*, 2001, 10:10-16

World Medical Association. *Declaration of Tokyo*. Accessed August 31, 2004.

Zachariae, R., Pedersen, C.G., Jensen, A.B., Ehrnrooth, E., Rossen, P.B., & von der Maase, H. (2003). Association of perceived physician communication style with patient satisfaction, distress, cancer-related self efficacy, and perceived control over the disease. *British Journal of Cancer*, 88, 658-665.