



PREFACE

In connection with the COVID-19 pandemic, recent years have raised new questions and posed new challenges for the medical community, making us all come to realize that medicine is a fundamentally human field – and for that reason also a fundamentally ethical one. Sanitary restrictions and the mass scale of the pandemic made it necessary to isolate patients, to minimize their contact with relatives, and often to objectify the relationship between the medical team and the patient. It soon became evident that there was a need for serious reflection on the ways in which healthcare professionals function, as well as on the axiological context of the medical staff–patient relationship. These events showed how important a role – in the face of so many and new factors conducive to treating patients as mere units posing various sorts of accounting, technical, or scientific problems to be solved – can be played by the humanization of medicine. At the foundation of humanization as both a concept and as a practice lies concern for the welfare of the patient, understood as their effective diagnosis and treatment in the context of respect for their dignity, rights, and autonomy.

Explicit efforts to strengthen the link between medical science and humanism became a growing phenomenon in the later decades of the twentieth century, motivated by a desire to “humanize” medicine in the face of and in opposition to the various “dehumanizing” factors that have detached medicine from its historical roots. These factors include the privatization of medical practice, the growing role of business and finance in medicine, the fragmentation of the patient experience, the shortening of appointment durations, and also the ever-growing use of technology as a substitute for human interaction (Thibault, 2019).

Key elements of a more humanistic approach to medicine – such as respect for the dignity, uniqueness, individuality, and indeed the humanity

of the patient – are quintessential to human existence: each patient is a unique person with his or her own values, unique expectations and life experiences, shaping his or her identity and style of relationships with others. A patient's individuality can be disrupted by the experience of illness. Severe illness violates one's sense of dignity due to functional changes, diminished control over one's own body and day-to-day activities. In response to these phenomena, medical professionals can work to support patients' dignity by developing an understanding of how the experience of illness and the conditions of care affect the patient's life, by responding empathetically and acknowledging the patient's suffering, while at the same time highlighting the patient's own resources. Beach et al. (2005) found that treating patients with respect for their dignity is associated with higher patient satisfaction and adherence to the recommended treatment.

Medical professionals inevitably face three basic issues. First, they are confronted daily with pain, illness, and death in human experience. Second, they must be prepared to come into contact with the diverse manifestations of human ideas, with the profoundly human quest for happiness, pleasure, and prosperity, even immortality. Therefore, as González Quirós (2013) has pointed out, to think about medicine is to think about humanity and its problems, and this cannot be done by limiting medical thinking only to what science can tell us with certainty.

One crucial aspect of medical care that is focused on people and their humanity is the holistic approach – invoked more often by healthcare professionals, who are more familiar with it, than by patients and their caregivers – which calls for the patient to be perceived in terms of their functioning in the bio-psycho-social and spiritual dimensions. This approach recognizes that the mind has a strong influence on the body and that it is necessary to provide an effective form of care, that is, one that deals with both body and mind (Floyd, 2001). As early as 1996, a World Health Organization (WHO) study group recognized that the way to approach health holistically and support personalized medicine is to provide patients with integrated care, in which all elements of the healthcare system play a complementary role in ensuring patient well-being.

Humanizing medicine is not just about politeness or “being nice” (Silverman et al., 2021). Based on showing respect, nurturing the dignity of the patient, and building a partnership with him or her, it requires involving the patient in the process of diagnosis and treatment, and jointly setting goals and developing realistic plans to improve their health. Although it originated back in antiquity, the humanization of medicine does not stand in opposition to technological advances or evidence-based medicine.

These three elements must work together to comprise a medicine that is universal, interdisciplinary, and complete.

One prerequisite for the successful humanization of medicine is effective clinical communication. Its quality determines not only the patient's satisfaction and whether he or she will follow the recommendations of healthcare professionals, but also the extent to which it is possible to build a proper, authentic relationship with the patient. It is worth remembering that the communication skills of healthcare workers and patients include not only the ability to use words appropriately, i.e. not just the content of communication. Also extremely important are the skills involved in the process of communication, i.e. non-verbal communication, meaning all the elements related to how healthcare professionals build a relationship with the patient, the way they organize and give structure to the communication. A final element of communication skills involves perceptions – that is, what healthcare professionals themselves think and feel. It concerns the decisions they make; their clinical reasoning and problem-solving abilities; their attitudes; their personal capacity for empathy, attentiveness, honesty and flexibility; their awareness of what they feel and think about the patient, the disease and other issues that may affect them; their awareness of their own self-image and self-confidence, as well as their biased behavior or resilience to distraction (Silverman et al., 2021).

An important contribution towards shaping the humanization of medicine was made by the late Prof. Kazimierz Imielinski, MD, who devoted a great deal of his career to spreading the idea – for which he received 56 honorary doctorates and two nominations for the Nobel Peace Prize. In the 1990s, many publications were produced and numerous scientific conferences were devoted to the humanization of medicine. Further continuing Prof. Imielinski's lifework, together with the Polish Ministry of Health and the Medical Research Agency, we organized the 1st Congress on Humanization of Medicine at the University of Warsaw in 2022. In conjunction with the event, a letter of intent was signed by representatives of the aforementioned institutions, which emphasized the need for interdisciplinary cooperation to promote the idea of humanism in medical science.

This book-length report is one outcome of the research project entitled "Humanization of the treatment process and clinical communication between patients and medical personnel before and during the COVID-19 pandemic," implemented from May 2021 to June 2023. The report begins with a comprehensive theoretical section (Part I) outlining the broader context for the presentation of empirical findings. The main part of the report then discusses the results of two interrelated studies: one was

a quantitative survey conducted in 2022 among healthcare employees and patients at healthcare units (the “Survey at Healthcare Facilities”), with questionnaires completed by 2303 healthcare employees and 1572 patients at a random selection of 114 hospitals and clinics from all of Poland’s provinces (voivodships), the other was a survey included a sample of 2050 adult Poles (the “Patient Population Survey”), representative for the Polish population, registered on the survey panel, including only individuals who had received treatment in the last 24 months for either emergency conditions or chronic diseases. The surveys conducted are therefore unique in their nationwide coverage, in capturing the context of the COVID-19 pandemic, and in offering the opportunity to compare different professional groups of healthcare workers (498 physicians; 1216 nurses, 166 paramedics, and 423 representatives of other medical and non-medical professions). They also allow comparison of different groups of healthcare professionals and patients distinguished by gender, age, place of residence, level of education, professional and family situation. Many of the indicators are related in this report to various factors of social differentiation.

Part II of the book then presents the assumptions and methods of the two main surveys, as well as pilot work. The main surveys were preceded by pilot interviews with medical professionals and patients and questionnaire work, including the selection of measurement scales and adaptation of the new tools described further for this project (BAT-12, PTSD-8). Many of the questions developed by the team for this project can be considered prototypes of new research tools.

The preliminary results of the study were presented at the “1st Congress on the Humanization of Medicine” held at the University of Warsaw in June 2022, just a month after the study itself was completed. Part III of this book-length report presents more detailed results of the quantitative survey, broken down into seven chapters. Each chapter follows a uniform structure: giving the theoretical background, a description of the tools used, the results obtained and their summary, plus an indication of practical implications and recommended directions for further analysis.

Within Part III of this book (presenting the results), Chapter 1 focuses on how the term “humanization of medicine” is understood and defined by healthcare workers and patients, and on identifying barriers to good communication and to fostering good patient–staff relationships. Chapter 2 of the results section then discusses aspects of the work of healthcare personnel during the COVID-19 pandemic and the degree of mental burden they faced during this period. Special attention was paid to the phenomenon of professional burnout and symptoms of post-traumatic stress.

The objective of Chapter 3 of the results section is to assess what impeded patients from obtaining treatment during the COVID-19 pandemic period and to identify the negative and positive effects of this period. Attention is paid to the reevaluation of one's own values – a phenomenon typical of crisis periods – as expressed in a shift in patient attitudes towards significant values in life.

Chapter 4 focuses on assessing selected aspects of the physical and psychosocial health of the two main groups of respondents. Much attention is paid to the reported severity of stress and sleep disorders. The importance of social support as a stress-reducing factor is also addressed. Chapter 5, in turn, discusses selected consequences of living in a pandemic, linked to behavioral factors. Changes in the reported prevalence of use of alcohol, tobacco, selected groups of drugs or psychoactive substances on the part of healthcare workers during this period are presented. For patients in the population-based sample, findings on reported changes in body weight over the last 3 and 12 months are presented.

Chapter 6 deals with a problem rarely addressed in empirical studies: patients' awareness of their rights, as guaranteed by relevant legislation. Respondents also reported how well, from their perspective, they felt that eleven key patients' rights are actually complied with at healthcare facilities.

The results section then concludes with Chapter 7, which deals with public perceptions of clinical trials. Patients in the population-based sample described factors that could be conducive to their deciding to participate in a clinical trial (or to opt out) in the future. These included factors related to the protocol and organization of the study, factors related to communication and the relationship with the doctor (which strongly ties this thematic area to the concept of this entire report), and a block of questions about expected benefits and risks.

Overall, the results described in the report may be instructive and useful for education modules dealing with the humanization of medicine at medical schools – which, it can be hoped, will result in an improved patient care system once successive crops of graduates enter the healthcare workforce. However, as the findings presented herein partly help to illustrate, such educational efforts promoting the humanization of medicine should in fact be two-track, also including current and future patients. And so, all initiatives to develop and shape health literacy are worthy of support, from integrating these issues into the health education provided in schools to teaching and strengthening patient co-responsibility in the treatment process.

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