ITS

Health Care is a System of Measures for the Improvement, Preservation and Restoration of Health

Siniša Franjić[1*]

[1] Independent Researcher, Osijek, Croatia

Email Address

sinisa.franjic@gmail.com (Siniša Franjić)
*Correspondence: sinisa.franjic@gmail.com

Abstract:

Health care is a system of state, group and individual measures for the improvement, preservation and restoration of health. The goal of health care is the promotion, ie improvement of health, prevention of diseases, timely detection of diseases, effective treatment and rehabilitation. Health care is organized on three levels, such as primary, secondary and tertiary health care. Health care is divided into consultative health care, hospital treatment, specialist health care and outpatient treatment. Health crises, an aging population, rising expectations regarding the quality of services and technological advances call into question the sustainability and resilience of health systems. These factors point to the need for structural adjustments and reforms to improve public health and increase the efficiency, resilience and sustainability of health systems, while guaranteeing equal access to quality services.

1. Introduction

In most societies, the majority of rules, including legal ones, affecting citizens' lives have grown out of custom and usage, and are part of their heritage [1]. Legal rules normally go through an assimilation process, having been influenced by whatever socioeconomic, moral and other factors indirectly shape a particular society's ethics or rules of human behaviour. This includes its cultural and religious beliefs as well as those of its neighbouring societies, who may also influence it through social and political interaction. Given that man is not merely a thinking being, to counter the argument of some philosophers such as Descartes (1596-1650), human beings can be shown to be also moral beings. They are capable of discerning right from wrong, arguablyaccording to the way in which they were bought up. There are no general moral standards of behaviour that are acceptable to all internationally: they vary from society to society since there is indeed no such thing as universal morality.

In order to understand care, one may start by attempting to devise a general definition of this term [2]. Such a definition of care must necessarily be broad if it is

to cover as many important aspects of the phenomenon as possible. Care in healthcare comprises many elements including the physical interactions between care providers and patients, the observation of hygiene requirements and the completion of paperwork. Joan Tronto 1 and Bernice Fisher have offered an influential definition that classifies as care all activities that help to "maintain, continue and repair 'our' world so that we can live in it as well as possible".

This definition can be fruitfully adapted to the healthcare context by replacing the term "activity" with "action", which specifically indicates goal-directedness and intentionality. Healthcare activities are triggered by patient needs and requests; they follow professional obligations, and are shaped by institutional demands. Thus, activities in this field are usually goal-directed, which is to say they are actions rather than activities. In the same vein, the verbs "maintain, continue, repair" may be changed to "maintain, improve, restore". While the first list describes the relations between people and all manner of entities, the second is tailored to actions that are directed towards humans and human health.

2. Diagnosis

When someone is diagnosed with cancer or some other life-threatening illness, the most common response is shock [3]. Initially they may describe a feeling of numbness, where the reality of the situation has yet to be absorbed. This may last for hours, days or in some cases for weeks. Naturally this is a time of emotional turmoil; early reactions may be anger, guilt, anxiety or sadness. How each patient copes with these emotions is a highly individual matter. As time goes on, the reality of the situation becomes apparent and the patient may become distressed and emotionally vulnerable. As the information is assimilated, it is important to allow the patient the opportunity to talk about his or her complex feelings. A skilled professional, such as the community palliative care clinical nurse specialist, may be able to encourage patients to disclose their initial worries or fears, to give them time to make sense of the news that has just been delivered.

All individuals experience losses throughout their lives, but when bad news is given, the way it is delivered can assist or prevent patients in working through their grieving process. Depending on how this news is conveyed, it may leave the patient feeling not only angry but also resentful towards the doctor. The shock, fear and devastation of hearing bad news may mean that information is just not being absorbed. Unfortunately, so many of these encounters take place in a busy outpatient clinic and patients have limited time to assimilate the information and ask appropriate questions before they are ushered out of the room. This leaves the patient not only shocked, particularly if the diagnosis had not been suspected, but also unable to remember most of the consultation beyond the word cancer. Therefore, they have no clear understanding of treatment options, likely outcomes, or indeed when they are to be seen again.

For some patients, the diagnosis itself may leave them bewildered; they may never have heard about the disease the doctor is talking about, for example motor neurone disease. The diagnosis is bound to raise further questions, perhaps in relation to treatments, prognosis or more practical issues, for example transport to and from the hospital for treatments. In situations of stress, such as receiving bad news, research has shown that short-term memory and concentration become poor and people have difficulty absorbing new information. As a result, there may be an urgent need for

ITS

further advice and rechecking of information already given, as well as supportive care to address the psychological distress associated with the diagnosis.

3. Finance

The moral argument that care should be provided at whatever cqst is not realistic [1]. In financial terms, the standard practice involving the internal market within the National Health Service (NHS) is that money should follow the patient. It is accepted that, when planning the delivery of care, the limited resources argument should be taken into account while working within the constraints of the law. The borders of morality and benevolence, doing good for the client and what the health care worker or carer could do for the client are boundless. In practice, the reality of the matter is that the moral argument cannot often win the day. From the point of view of the client, the question is how far the issue of morality should determine the kinds of law, and the quality of care and how it is delivered. NHS Trusts have to accept that resources are limited, and managers have to prioritise. There may be times when harsh decisions have to be taken as Trusts must live up to their financial responsibilities (that is, to deliver care within budget) and accountability. Financial management decisions sometimes conflict with ethical considerations when decisions are taken in rationing care. When that situation occurs, it is sometimes unrealistic for the law to be expected to intervene where resources are not limitless. Professionals should be guided by the supposition that, in a given situation, they will pave acted in the patient's best interests given the constraints of available resources, and will have acted in accordance with legal requirements, professional rules and local policies.

However, moral values cannot be taken for granted when applying the law, as legal systems of different societies can often be seen to conflict, although morality seems to have a more universal appeal. This conflict has been the cause of religious strife and the basis of crusades both in the ancient and the modern senses. Most religions see it as their responsibility to teach morality. In Christian societies, of which the UK is one, laws have been substantially influenced by religion in areas such as family law, property law and the law of succession, in addition to canon (Church) law itself. One of the reasons for this influence is historical. Monks were among the few learned people who could read and write. The influence of the Church as property owners, administrators and owners of estates during the developmental feudal period was extensive. If one poses the question of what the essence of law is, there is no direct answer, only the fact that the law is seen as a system or body of rules that are prescribed by an authority of some kind in order to regulate human behaviour. It is also important that the effects of making laws are to have sanctions, or those laws will be ineffective. As to the question of what would happen to a group of individuals or a society that was not subject to any rules or laws, the answer is that there would be chaos, with survival of the fittest, who would thrive at the expense of the weakest members of that society. One could argue that this is a realistic situation. The difference that the law makes, however, is that it sees all people as equal. A useful definition of the law is 'Those rules which the courts will enforce'. Once one has established what law is, the view that all persons are equal before the eyes of the law must be qualified by the reality that individuals have certain competing rights and obligations that the law can enforce.

4. ADRT

An ADRT (advance decision to refuse treatment) is considered valid if it [4]:

• Is written by an individual aged 18 or over who had the capacity to make, understand, and communicate the decision when it was made.

• Has clearly specified which treatments they wish to refuse.

• Has explained the circumstances in which they wish to refuse them.

• Is signed by the individual and by a witness if he or she wants to refuse life-sustaining treatment.

• The individual has made the advance decision of their own accord, without any harassment by anyone else.

• The individual has not said or done anything that would contradict the advance decision since it was made.

Some proformas of ADRTs are available online, and the National Health Service (NHS) Improving Quality has published guidance in collaboration with the National Council for Palliative Care.

However, significant problems with ADRTs have been raised. There is no national registry for ADRTs, and so finding whether a patient has one can be difficult. Some general practitioners (GPs) are not aware of the legal constraints on validity, and some lawyers are not aware of the details of medical treatments, so that, of the few ADRTs that are written, many are not valid. A simple wish not to have cardiopulmonary resuscitation (CPR) attempted, for example, may not be considered valid if the circumstances in which the arrest happened are not documented. To be legally binding, it would have to be written: 'should my heart stop, I would not want any attempts at resuscitation, in any circumstance. I understand that this is a refusal of life-sustaining treatment' and then have it dated and signed. But this kind of ADRT may force people into extremes they did not mean to instruct; what about a patient who is choking? So then someone might write: 'I do not wish to have resuscitation attempted unless there is a clear reversible cause'—but then is hyperkalaemia a clear reversible cause? Would you wait until you knew the potassium before stopping CPR?

One approach to this problem is to ensure that an 'advance statement' coexists with the ADRT. While patients do not have the right to request treatments, they can write about their treatment preferences (e.g. 'I would like to die at home if possible' or 'I would like all treatments to prolong life to be considered' or 'quality of life is the most important thing for me: please only give me treatments if you think I have a good chance of retaining my mental functions'). Providing treating clinicians with an 'advance statement' alongside an ADRT allows them to interpret the ADRT for the circumstances that exist. A new charity, 'Advance Decisions Assistance', has mocked up some appropriately legally and medically worded ADRTs and combined them with 'values statements' to go alongside them, to aid patients in understanding what might help ensure their wishes are respected.

5. Long-Term Care

The term long-term care conjures up many images; few of them are felicitous [5]. Long-term care seems to hang like a pall covering the inevitable coffin that awaits us all. Surprisingly, in our culture it is less death than long-term care that strikes us as so

ITS

repugnant. This reaction may represent a profound psychological defense against death, to be sure, but its immediate effect is to place long- term care center stage in an unfavorable light. The images of long-term care are images of frailty and despair, loneliness and destitution, and above all a profound sense of loss, a loss not only of things, but of who and what we are. These attitudes undoubtedly reflect society's perceptions of the institutions that are often thought to be the main providers of long-term care, namely, nursing homes. Anthropologists and sociologists regard nursing homes as anything but humane. They are frequently seen as places of exploitation (of staff as well as of residents). They stimulate either moral outrage or revulsion. These reactions are shaped by latent image: a blabbering, incoherent, disheveled elder strapped into a gerichair, withdrawn or beckoning for attention, but invariably ignored by staff who, without emotion, expression, or enthusiasm, perfunctorily perform the onerous tasks of daily bed and body work that are made even more difficult by the niggling demands of residents. The image is coupled with the olfactory assault of urine, excrement, and myriad other unpleasant odors that suffuse drab corridors or insipid sitting rooms where residents sit transfixed, each in his or her own world. There are also disturbing sounds of people moaning from down the hall, crying out, one elder scolding another harshly, others weeping in protest. No wonder that the pall of long-term care is as feared as the coffin it covers! Long-term care seems suffused with a terrifying absence, the absence of a meaningful sense of control, dignity, or identity. It is an appalling state of living death, somewhere just this side of madness.

Like many taken-for-granted beliefs, the nursing home-dominated image of long-term care is in its general form brutally apt, but it harbors latent meanings that require careful exegesis and qualification. For one thing, not all long-term care is institutional. Despite perceptions to the contrary, only 4.3 percent of those over the age of 65 live in institutions, a percentage that rises dramatically with age, ranging from 1.1 percent for those aged 65–74 years to 4.5 percent for those aged 75–84 years and 19 percent for those aged 85 and above. Twenty-five percent of those in institutions will spend at least 12 months there, and at least 10 percent will be patients for 5 years or more. The chance of being in a geriatric facility significantly increases with age.

6. Palliative Care

Caring for seriously ill patients within their own homes can prove difficult and challenging to the health professionals involved; especially when the illness is progressing and there are the added complexities of distressing symptoms, emotional issues to address and family members to support [3]. However, given the choice and a supportive family, most patients would want to be nursed at home during their illness and to die at home. The aim of palliative care in the home is to have a well-supported family and ensure the patient is comfortable and able to deal with his or her approaching death. The patient may require assistance to manage not only physical, psychological, social and spiritual needs, but also legal and financial issues that may have to be addressed. This requires the skills of many professionals working together as a team to achieve the desired outcome.

Multidisciplinary team working lies at the heart of palliative care and involves many individuals working together with a common goal. Functioning as a team, the professionals can provide continuous and integrated supportive care. Today's patients and their families have increasingly high expectations of the health care services and what professionals should offer. Therefore, when the needs of the patient and family require ongoing visits from a number of disciplines, optimal care is given when the

health care providers collaborate as a coordinated team. As such, the palliative care team requires excellent communication skills, an understanding of each other's abilities and an acceptance of 'blurred' role boundaries. This approach will support most patients and their families with a sense of security, consistency and comfort.

Modern palliative care promotes aggressive symptom management at all stages of treatment for a serious illness, from early disease treatment through end-of-life care [6]. According to the American Academy of Hospice and Palliative Medicine, "The goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs, and practices". This concept has been echoed by the Institute of Medicine, which also notes that "Palliative care in this broad sense is not restricted to those who are dying. It attends closely to the emotional, spiritual, and practical needs and goals of patients and those close to them".

Viewed from this context, it is clear that palliative care is a cornerstone not just of end-of-life care but also of chronic disease management. After all, diseases such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), arthritis, and Alzheimer disease are largely incurable, but much can be done to help the patient, and the goal of treatment is not only to extend life (a curative care principle) but also to maximize comfort, function, and quality of life. The difference at the end of life (i.e., in very advanced, terminal disease states) is that palliative care principles become paramount, and prolongation of length of life becomes much less important than quality of life.

7. Disparities

Ethnic and racial minorities manifest significantly poorer health status than their white counterparts [7]. Health disparities are defined by the National Institutes of Health as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." Cardiovascular disease, cancer, and diabetes mellitus are the most commonly reported health disparities, followed by cerebrovascular diseases, unintentional injuries, and HIV/AIDS. Assessing these differences requires that a wide variety of factors, including age, gender, nationality, family of origin, religiosity, education, income, geographic location, race or ethnicity, sexual orientation, and disability, be considered.

Healthcare disparities are defined by the Institute of Medicine (IOM) as "differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention." Causes of healthcare disparities most often relate to quality and include provider-patient relationships, provider bias and discrimination, and patient variables such as mistrust of the healthcare system and refusal of treatment. Although disparities in health and healthcare can be inextricably tied to one another, distinguishing between them increases our understanding of the complexity of the problem.

8. Morality

In the UK, there is a basic presumption that all persons are equal before the eyes of the law and that the primary aim of the law is to protect its citizens and promote fairness [1]. It is fair to say there are areas of consensus in which most societies accept

that an action, for example one person intentionally killing another, is wrong. However, morality and the law are concerned with what a specific society views as right or wrong. The place of morals in society is to set acceptable standards of behaviour. The purpose of the law is to ensure fairness so that the weaker members of society are not compromised. In presenting evidence in any given case, the court must at times look to morals for guidance, as they are the fabric of our society. The court may question whether a defendant/defender's behaviour in a given situation matched that of the 'reasonable' man. The law is there not to apply purely the standards of the lawyers, but to look at the morals of the society where it developed.

When carers are faced with ethical choices or problems that cannot be resolved immediately, they may look to the law; similarly, registered professionals may consult their code of professional conduct, or local policies and guidelines, for the behaviour expected of them. In some situations, however, it is possible that they may face dilemmas that they cannot resolve. In the UK, the traditional paternalistic view of care allowed the professional, in particular the doctor, not only to prescribe, but also to dictate care in the patient's interests. On the other hand, the spirit of the NHS and Community Care Act 1990 means that, to a large extent, patient autonomy should be the guiding factor when prescribing and providing care in the community, and discharge plans should be made accordingly. This means that clients have a right to lead an independent life at home and to determine their destiny within reasonable limits. In practice, the multidisciplinary team of professionals should work towards that goal in partnership with the client. The term 'professional' applies to both registered professionals and other paid carers who give care both in establishments and in the client's own home.

9. Ethics

Modern philosophy links the definitions of morality and ethics [8]. In the simplest forms, morality is the difference between right and wrong, while ethics represents the critical study of morality. Individuals choose from a variety of sources of moral authority, such as religion, cultural norms, politics, and law. As such, persons may regard situations or objects differently, based on the value systems espoused by their source of moral guidance. Ethics represents the cognitive evaluation of a principle or situation, acknowledging the fact that individuals possess different moral backgrounds. Ethical dilemmas arise when there is a conflict of values between persons arguing for competing moral imperatives – when people cannot agree on what is right and what is wrong.

Medical ethics is a discipline that studies differences in value systems as they apply to clinical situations. Medical ethics is most commonly taught through classroom discussion, as a means to familiarize providers with common ethical principles. Applied health care ethics is the practical extension of such discussion, recognizing that like all clinical decision-making, ethical dilemmas require action. The word "applied" then refers to the reality that physicians mediate ethical dilemmas and make tough decisions every day. They are not philosophers, but practitioners of medical philosophy.

Most American physicians guide their ethical decision-making from duty-based concepts known as the "principles of biomedical ethics." These principles include respect for autonomy, non- malfeasance, beneficence and justice. Respect for autonomy is demonstrated when the patient is given the ability to exhibit self-

governance, or self-determination. Patients should be allowed to make choices regarding their own health care. Non-malfeasance is loosely translated into the statement "do no harm." Physicians have an ethical obligation to limit the risks of poor outcomes that may result from diagnostic or therapeutic interventions. Beneficence in health care refers to the fundamental challenge to optimize a patient's condition and well-being; this may be through treatment of disease or provision of comfort care. Justice refers to the fair and equal treatment of patients, both in access to and quality of health care. Justice is also manifest through systems and institutional ethics, which in today's marketplace must respond to the reality of limited health care resources.

10. Law

As well as being under a duty not to harm, doctors also have a strong ethical and legal duty to respect the individual autonomy of their patients [9]. This so-called principle of respect for individual autonomy is arguably the most central ethical principle in modern medical ethics. It requires health care professionals to respect the authentic choices of their patients about their medical treatment. This means that if the decision regarding treatment is made by a patient who has the requisite mental capacity to be able to make a decision about their treatment and the relevant information and freedom to make this choice, the decision must be respected by health care professionals, even if it seems foolish or unwise to others. The reason why respect for individual autonomy is seen as so fundamental, ethically (and legally) speaking, is that it enables individuals to have control over their own lives. Indeed, this ability to be in control of our own lives is seen to be more important than being protected from the possible harmful consequences of our choices. It is this ethical principle of respect for individual autonomy that underpins the law on consent to treatment in most jurisdictions, making it a battery to treat without or against a competent patient's consent to this treatment. Thus, so long as a patient demonstrates that they have the requisite mental capacity, are not unduly influenced and have and understand the relevant information, their choices to refuse even lifesaving treatment must be respected.

However, if it can be shown that a patient does not have the requisite mental capacity to provide a valid consent to treatment or refusal of treatment, then the principle of respect for individual autonomy no longer requires that we respect their decisions. This ethical principle only requires that health care professionals respect authentic decisions – that is, decisions that we believe the patient has the mental capacity, information, freedom, and so on, to make. Those who do not have the requisite capacity to make decisions about their treatment – for example, young children, unconscious individuals, individuals whose capacity to process information has been compromised by a psychiatric illness – should be treated in what is considered to be their best interests, in order to protect them from harm.

11. Conclusions

The goal of health care is to help people stay productive and satisfied for the rest of their lives. People's life expectancy is being extended as a reflection of the quality of health care and a standard of living. The healthcare team alone is not enough to provide a complete service. Commitment to work and giving of oneself with a humanitarian echo are the main characteristics of a healthcare team. Every contact with the user is looking for a way to help and guide him. Health advances and the

improvement of medical techniques have contributed to improving the quality of human life for those who need it most. The warm word of health workers greatly contributes to reducing moments of crisis and feelings of helplessness and abandonment.

Conflicts of Interest

The author declares that there is no conflict of interest regarding the publication of this article.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

References

[1] Fletcher, L.; Buka, P. A Legal Framework for Caring - An Introduction To Law And Ethics In Health Care, Macmillan Press, Basingstoke, UK, 1999; pp. 1-4.

[2] Krause, F.; Boldt, J. Understanding Care: Introductory Remarks in Krause, F.; Boldt, J. (eds):, Care in Healthcare - Reflections on Theory and Practice, Palgrave Macmillan, Springer International Publishing AG, Cham, Switzerland, 2018; pp. 3.

[3] Aitken, A.M. Community Palliative Care - The Role of the Clinical Nurse Specialist, John Wiley & Sons Ltd, Chichester, UK, 2009; pp. 40-42.

[4] Fritz, Z. End of Life in Sturgess, J.; Duane, D.; Ley, R. (eds):, A Medic's Guide to Essential Legal Matters, Oxford University Press, Oxford, UK, 2019; pp. 77-84.

[5] Agich, G.J. Dependence and Autonomy in Old Age - An Ethical Framework for Long-term Care. Cambridge University Press, Cambridge, UK, 2003; pp. 2-3.

[6] Vandekieft, G.K. "Palliative and End-of-Life Care" in Sloane, P. D.; Slatt, L. M.; Ebell, M. H.; Smith, M. A.; Power, D. V.; Viera, A. J. (eds):, Essentials of Family Medicine, Sixth Edition, Lippincott Williams & Wilkins, Wolters Kluwer, Philadelphia, USA, 2012; pp. 283.

[7] South-Paul, J.E.; Lewis, E.L. Health & Healthcare Disparities in South-Paul, J. E.; Matheny, S. C.; Lewis, E. L. (eds):, CURRENT Diagnosis & Treatment in Family Medicine, Fourth Edition, McGraw-Hill Education, New York, USA, 2015; pp. 678.

[8] Gisondi, M.A. Ethics and end-of-life issues in Mahadevan, S. V.; Garmel, G. M. (eds):, An Introduction to Clinical Emergency Medicine, Cambridge University Press, Cambridge, UK, 2005; pp. 653.

[9] Smith, R.C. "Body Integrity Identity Disorder: a problem of perception?" in Alghrani, A.; Bennett, R.; Ost, S. (eds):, Bioethics, Medicine and the Criminal Law - Volume 1, The Criminal Law and Bioethical Conflict Walking the Tightrope, Cambridge University Press, Cambridge, UK, 2013; pp. 76.