PRESERVING TRUST IN THE PHYSICIAN-PATIENT RELATIONSHIP AND ADDRESSING MORAL INJURY OF PHYSICIANS

JADRANKA BUTUROVIĆ PONIKVAR[1,2]

[1]*Department of Nephrology, University Medical Center Ljubljana, Slovenia*
[2]*Department of Medical Ethics, Faculty of Medicine, University of Ljubljana, Slovenia*

Abstract

In recent decades, which have brought about dramatic changes in medicine, the relationship of trust between patients and doctors has come under severe pressure. In parallel with the increasing needs and complexity of patients who demand more individual time from their physicians (including the explanatory duty required by law), the administrative burden of the latter is increasing. The performance metrics of individual physicians has either already been introduced or is planned to be introduced, forcing physicians into the "production line" of healthcare services. Although physicians represent a small percentage of all employees in the healthcare enterprise, generally less than 10 %, they are the main target of performance metrics in healthcare. The administrative burden and metrics approach are enhanced by the corporatization of healthcare systems, both in private as well as public healthcare organizations.

Patients and physicians are no longer the main figures in medical decision making, as many other individuals and entities have since joined, described as "strangers at the bedside" in a book by Professor David Rothman. They include bioethicists, lawyers, court rulings, economists, psychologists, civil society, and activists. The introduction of artificial intelligence into healthcare and its role in medical decision making will be assessed in the near and distant future.

Patients do not want to be part of a healthcare production line. They want a human touch from their physician, whom they trust to fight for and protect their best interests, their health, and their lives. Patients need this trustful relationship at least as much as medications and healthcare services. Physicians want and need the same. A trustful relationship between patient and physician has been the core value of medicine for thousands of years, and should be protected and consolidated for the future. Our duty as physicians is the fight to sustain it in the challenging times ahead.

Key words: **trust, physician – patient relationship, moral injury**

Address for correspondence: **Jadranka Buturović Ponikvar**
jadranka.buturovic@kclj.si
jadranka.buturovic@mf.uni-lj.si

INTRODUCTION

Trust between patient and physician has been a critical component of their relationship for thousands of years. It is precious and beneficial to both patient and physician, and an important component of the success of medical treatment.

During the past decades that have brought dramatic changes in medicine, this relationship has been under huge pressure. Patients and physicians are no longer the main figures in medical decision making, as many others have since joined. The evolution of this process has been described in the book "Strangers at the bedside: A history of how bioethics and health law has transformed medical decision making", published in 1991 and authored by David J. Rothman, Professor of Social Medicine and Professor of History at Columbia University (1). Not only bioethicists and lawyers, but many other outsiders have since joined patients and physicians in making medical decisions, e.g., insurers, economists, psychologists, sociologists, civil society, activists, emerging artificial intelligence... (2,3)

In parallel with the increasing needs and complexity of patients who demand more individual time from their physicians (including the explanatory duty required by law), the administrative burden of physicians is increasing. The performance metrics of individual physicians has either already been introduced or is planned to be introduced, forcing physicians into the "production line" of healthcare services.

Although physicians represent a small percentage of all employees in the healthcare enterprise (for example, at the Mayo Clinic less than < 10 % of 76,000 employees are physicians), they are usually the main target of performance metrics. The administrative burden and metrics approach have been enhanced by the corporatization of healthcare systems (4, 6).

The introduction of artificial intelligence into healthcare and its role in medical decision making will be assessed in the near and distant future. Although the expectations of benefits from artificial intelligence in healthcare are extremely high, one should not overlook the unfulfilled benefit expectations from information technology in healthcare (2). As Dean and Talbot wrote in their paper, "massive information technology investments, which promised efficiency for healthcare providers, have instead delivered a triple blow: they have diverted capital resources that might have been used to hire additional caregivers, diverted the time and attention of those already engaged in patient care, and done little to improve patient outcomes (7)."

Last but not least, legalizing euthanasia and assisted suicide in an increasing number of high-income countries, together with the ensuing pressure on physicians to be involved in the termination of their patients' lives, are only adding to the already existing pressure, hyper-responsibility and moral injury of physicians (8, 9). All these issues are the reason why trust in the patient-physician relationship is now being challenged more than ever.

Moral stress and moral injury in physicians

On June 15, 2023 a paper by Eyal Press was published in the NY Times under the title "Moral Crisis of the American Doctors: The corporatization of healthcare has changed the practice of medicine, causing many physicians to be alienated from their work" (10). Press was inspired by psychiatrist Wendy Dean, who reported a high suicide rate among physicians, even higher than among active military servicemen, and focused on moral injury in physicians, which had originally been described by psychiatrist Jonathan Shay from his experience in treating Vietnam war veterans (11, 12).

After talking with a number of physicians, Press reported that the major causes of stress were a lack of time to talk with and care for patients, the high administrative burden of electronic medical records, battling with insurers about whether individuals with a serious illness would be preapproved for medications, and performance metrics forcing physicians to reduce their already insufficient time for direct contact with patients. RVU (relative value units) metrics were introduced to calculate individual physician reimbursements. Physicians were said to resemble "laborers in Amazon warehouses, productivity tracked on an hourly basis and being pressured by management to work faster". The author was especially surprised by the fact that physicians were not prepared to talk in public, being aware that some of their colleagues had been fired after speaking about safety concerns in their healthcare practice (9).

The most critical situations were in emergency departments, where understaffed workplaces have become reality through corporatization and profit-oriented healthcare practices. Emergency physicians were outsourced and could be fired without due process, especially after having publicly addressed their incapability to provide safe healthcare services. Physicians were pushed to discharge Medicare and Medicaid patients, rewarded to prescribe desirable (from the reimbursement point of view) diagnostic and therapeutic services over talking and listening to patients. Through such pressures, physicians could be turned into instruments of patient betrayal (9). All these pressures may be among the reasons why physicians are increasingly thinking of leaving their institutions or profession (13).

Moral injury describes the challenge of simultaneously knowing what kind of care patients need, but being unable to provide it due to constraints that are beyond an individual's control (6). Moral injury is critically different from burnout. It is not the physician that is "broken" and needs help to increase resiliency, it is the system that is broken; yoga, wellness, and other strategies aiming to ameliorate burnout in individual physicians cannot help in ameliorating moral injury (6).

It should not be overlooked that the healthcare system in the U.S. is much more complex and different in many components from the healthcare systems in Europe and Slovenia. Some problems of the U.S. healthcare system are not (yet) present in European countries. However, it is wise to follow what is occurring in the U.S., because their practices may influence and be adopted (with more or less delay) in the healthcare practices of other countries. Lessons learned from problems and failures in the U.S. healthcare system may be useful in trying to avoid generating even more problems in our healthcare systems than are already present today.

Decreasing authority of physicians in the healthcare system in parallel with hyper-responsibility

A recent criminal case in the United Kingdom illustrates that a similar corporatization management atmosphere as described in private healthcare corporations is also present in public hospitals (NHS – National Healthcare Service). In August 2023, a 33-year-old nurse, Lucy Ledby, was sentenced to life in prison after killing seven newborns and causing severe injury to others in a northern England NHS hospital (14). She carried out the killings and caused the injuries by injecting air, applying insulin shots, or overfeeding babies. The striking details in this process were that on several occasions senior physicians had warned the hospital management about the nurse in question after having observed unexpected newborn deaths on her shift only, and had asked the management to investigate and call the police. Despite the warnings, the hospital management did not act. On the contrary, they used procedures to punish those who had raised safety concerns, as witnessed by a lead consultant of the Neonatal Unit, Dr. Stephen Brearey, who had raised concerns about the nurse in October 2015 (15). Being threatened with disciplinary measures, the physicians were forced to undergo mediation and apologize to the nurse, while she was transferred to the Quality Department of the hospital.

Physicians' involvement in controversial practices

Physicians themselves, especially when involved in ethically controversial practices (like euthanasia or mutilating surgery in minors with gender dysphoria), may contribute to jeopardizing the trusting patient-physician relationship.

The explosion of euthanasia cases in Canada, which legalized euthanasia and assisted suicide in June 2016, may serve as an example of a slippery slope with physicians involved. By the end of 2022, as many as 44,958 euthanasia procedures had been performed in Canada, with more than a 30 % annual increase over previous years. It was reported that 1,745 Canadian physicians (out of 96,020, i.e., 1.8 %) were engaged as euthanasia providers in 2022 (16). One of them celebrated his first 100 euthanized patients in a medical journal (17). It is not surprising that fear of physicians may have subsequently developed in patients, as illustrated by the tattoo "Do not euthanize me" on the shoulder of a woman in her 80s from Calgary, Canada – the first tattoo in her life (18). Who is this tattoo meant for? Physicians? Without physicians involved, the explosion of euthanasia cases in Canada would not have been possible. Although only a minority of physicians were involved in providing euthanasia, the shadow may fall on the whole profession.

Another controversial aspect of modern medicine are the mutilating and sterilizing interventions in minors with transgender dysphoria. A number of patients who had been admitted for these interventions at a young age and later regretted them ("transgender regret") claimed that doctors had failed them, that they were the victims of invalid informed consent based on lack of evidence, and of activist-driven rather than evidence-based medicine. Such patients have lectured physicians, saying "you need a really, really good evidence base in place if you're going straight to an invasive treatment that is going to cause permanent damage to your body" (19).

On April 14, 2023 Elon Musk made the following statement on X (previously Twitter): "Any parent or doctor who sterilizes a child before they are a consenting adult should go to prison for life" (20). Support for this statement was impressive. What should not be overlooked is the fact that only the parents and doctors were considered responsible. No one mentioned bioethicists, psychologists, lawyers, insurers, sociologists, activists, politicians, or society as having a role in or share of the responsibility for these practices, although they were all involved, directly or indirectly.

Recently, a paper on gender-affirming chest reconstruction (mainly bilateral mastectomy) among adolescents in the U.S. showed a steep rise in the number of these procedures, including girls as young as 12 years (21). The policy of reimbursement from insurers may also be associated with such an increase of these procedures.

On the other hand, physicians had to struggle to provide routine treatment for a child with a serious, progressive, and debilitating disease, navigating through unnecessary hospitalizations (and inducing further suffering to the child) just to help in getting treatment as soon as possible, along with battling insurers and an increasingly complex administration on the way to helping and healing a suffering child (22).

Without physicians' involvement, some controversial practices would not have been possible – not only euthanasia or mutilating gender-affirming surgery as adopted in some high-income countries, but also illegal organ transplantations performed by highly trained physicians (23).

Social values can change

However, social values can change. What is considered acceptable, ethical, and desirable by society today may become a crime against humanity tomorrow. This already happened in the 20th century, when the philosophy of eugenics and "life unworthy of living" was widely accepted by society. In such times, all armchair "strangers at the bedside" may disappear, leaving physicians as the only ones responsible for performing services once required by society.

Physicians should always keep this in mind and never betray their core values and mission of healing (and not killing), never harm their patients, or fail to protect the weak and vulnerable.

Autonomy, paternalism, and conscientious objection

In medicine, like generally in life, the right balance is critical for finding the optimal solution and making the optimal decision. However, the weight given to the principle of "autonomy" is increasingly becoming too disproportionate in medical decision making. Wise interference or suggestions from physicians in the best interest of the patient may be stigmatized and condemned as "paternalism" (24).

In an increasing number of countries, a patient's request that the physician terminate their life or perform mutilating and irreversible surgery, even by a minor desiring to change gender, is considered ethical. All is done in the context of respecting the patient's autonomy, yet neglecting the fact that, for example, brain maturation in minors is not completed, or that the patient may change his/her mind in the future, or that "sickness is the biggest thief of autonomy" (25).

However, the four main principles of bioethics: respecting autonomy, non-maleficence, beneficence, and justice, should have equal weight, as pointed out by the fathers of bioethics, Bechaump and Childress, in their paper published in 2019, 40 years after the first edition of their landmark book "Principles of biomedical ethics", published in 1979 (26). "...respect for autonomy is always relevant as a prima facie principle, along with other prima facie principles, but it has no more or less weight than the others in the abstract..... and we never use an a priori ranking of principles and rights...."(26)

Utilitarian bioethicists claim that physicians should not have the right to conscientious objection. They argue that society (and not physicians) defines the framework of a physician's profession, thus physicians who do not provide the healthcare services requested by society in a specific period should be punished by revocation of their professional license and other mechanisms of law: ".... Doctors are first and foremost providers of healthcare services. Society has every right to determine what kind of services they ought to deliver...." (27-29)

It should be kept in mind that philosophers and bioethicists do not bear responsibility for their positions and arguments, or for the consequences of their doings. Frequently, the more eccentric or even morbid their positions are, the more glory and citations they may receive. For instance, Wilkinson and Savulescu have suggested that organ donation in a euthanasia candidate should be started while the person is still alive, thus procuring their organs while the heart is still beating. The heart should be the last organ to be removed, and with this act euthanasia would be performed (30). Of course, he himself would not be personally involved in such procedures. He would let physicians do the job he proposed, while physicians would be responsible for and live with the consequences of such actions.

Young physicians are particularly vulnerable when exercising conscientious objections and need support form senior colleagues. Being in a subordinate position in the medical hierarchy, they may be exposed to significant harms: either compromising their moral integrity or compromising their careers by objecting to being involved in euthanasia (31).

Physicians are selected, trained, and capable of being resilient under huge pressure

Physicians are selected and trained to become resilient in the course of their medical school studies, which have been among the most demanding areas of study for centuries. Physicians are trained to be responsible for their actions. They are trained for and used to making the most difficult life or death decisions under huge pressure and within limited time, any time of the day or night.

Doctors are trained for and used to taking responsibility for their actions and decisions. They put their signatures on and authorize various documents many times each day. And every one of these many thousands of documents may become crucial evidence in a court of law. The physician's responsibility will be the same regardless of the time available to create such documents, whether it is three minutes or three hours.

Physicians are used to being under continuous supervision, and may face threatening litigations, media exposure, or physical assault.

As Talbot and Dean claim in their contribution on moral injury: "Physicians are smart, tough, durable, resourceful people. If there were a way to MacGyver themselves out of this situation by working harder, smarter, or differently, they would have done it already." (10).

I strongly believe that, regardless of all the dramatic and many unfavorable changes in modern healthcare, the majority of physicians in most medical fields are capable of preserving a deeply intimate and trustful relationship with their patients, fighting together with them for their health and life, and respecting the autonomy of each individual patient as a unique person.

Professional organizations, medical institutions, and healthcare systems can aid physicians

Intensive education on medical ethics should be provided during the medical studies. Professional organizations should intensify education aimed to assist physicians in navigating ethical dilemmas through case studies, discussions, and workshops for practical ethical decision-making advice. Policies and guidelines delineating ethical practices and procedures should be established to aid physicians in understanding their duties and the standards expected of them, thus mitigating moral uncertainty. Education in medical and criminal law focused on a physicians's legal obligations and responsibility is also important. Professional organizations should systematically advocate for changes in healthcare policies, to support ethical practices and address the root causes of moral distress and injury of physicians and healthcare professionals.

Medical institutions should offer access to ethics consultants or committees for guidance on challenging ethical decisions, providing personalized advice and support. They should encourage open communication within healthcare teams and between physicians and patients, to address ethical concerns promptly and foster collaborative decision-making. They should acknowledge the emotional toll of ethical dilemmas on physicians and help them manage stress and moral injury. They should promote an organizational culture that values ethical decision-making and the moral integrity of healthcare professionals, and create a safe environment for discussing ethical concerns.

By formulating and implementing these strategies, healthcare organizations can ensure that physicians are adequately supported to face moral and ethical challenges, leading to improved patient care and a healthier working environment for physicians.

Final thoughts

During the past decades which have seen dramatic changes in medicine, the trusting patient-physician relationship has been under huge pressure. In parallel with the increasing needs and complexity of patients, the administrative burden of physicians is expanding, and the performance metrics force physicians into the "production line" of healthcare services.

The introduction of artificial intelligence into healthcare and its role in medical decision making will be assessed in the near and distant future. Although expectations of the benefits of artificial intelligence in healthcare are extremely high, one should not overlook the unfulfilled benefit expectations from information technology in healthcare, which resulted in high costs, unconvincing improvement in patients' outcomes, an increased administrative burden, and a reduction of the already insufficient time physicians can devote to talking and listening to patients.

Patients do not want to be part of a healthcare production line. They want a human touch from their physician, whom they trust to protect their best interests, their health, and their lives. Patients need this trustful relationship at least as much as medications and healthcare services. Physicians want and need the same. A trustful relationship between patient and physician has been the core value of medicine for thousands of years, and should be protected and consolidated for the future. It is the physicians' duty to fight to sustain it in the challenging times ahead.

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REFERENCES

1. David J. Rothman. Strangers at the bedside. A history how law and bioethics transformed medical decision-making. Copyright 1991 Ó byBasic Books (a Member of the Perseous Books Group). Printed in the United States of America. ISBN 0-465-08210-6. CIP 90-55598

2. Jiang, L.Y., Liu, X.C., Nejatian, N.P. et al. Health system-scale language models are all-purpose prediction engines. Nature 2023; 619: 357–362. https://doi.org/10.1038/s41586-023-06160-y

3. Buturović Ponikvar J. Ohranitev in utrditev zaupanja med bolnikom in zdravnikom v času dramatičnih sprememb v medicini. / Preserving and consolidating patient-physician trust in an era of dramatic changes in medicine. (in Slovenian) In: XII. Konferenca slovenskih zdravnikov iz sveta in Slovenije. Slovenski svetovni kongres /Slovenian World Congress. 5. in 6. oktober 2023. Zdravniška zbornica Ljubljana. E-zbornik. Pp. 32-34

4. Mayo Clinic, Wikipedia, accessed at URL on January 3, 2024 https://en.wikipedia.org/wiki/Mayo_Clinic#:~:text=Mayo%20Clinic%20is%20a%20nonprofit,health%20staff%2C%20as%20of%202022

5. Hover AR. Observations on corporatization of healthcare systems in America. Missouri Medicine, 2022; 119: 2 (March/April): 93-97

6. The Mismeasure of all things? Case studies. Medicine. In: Muller JZ.The Tyrrany of Metrics. Princeton University Press 2018, ISBN 978-0-691-18495-2. Pp. 103-122

7. Dean W, Talbot S, Dean A. Reframing clinician distress: moral injury not burnout. Fed Pract 2019 Sep; 36(9): 400–402. PMCID: PMC6752815. PMID: 31571807

8. Legality of euthanasia. Accessed at URL on January ?, 2024 https://en.wikipedia.org/wiki/Legality_of_euthanasia

9. Talbot SG, Dean W. Moral injury: the problem facing physicians. Accessed at URL on January 6, 2024 https://www.physicianspractice.com/view/moral-injury-the-problem-facing-physicians

10. Press E. The Moral Crisis of America's Doctors. The corporatization of healthcare has changed the practice of medicine, causing many physicians to feel alienated from their work. NY Times, June 15, 2023, Accessed from URL on January 1, 2024 https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html

11. Talbot SG, Dean W. Physicians are not burning out, they are suffering moral injury. Accessed at URL on January 6, 2024 https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/

12. Shay, J. Moral injury. Psychoanalytic Psychology, 2014; 31, 182–191. https://doi.org/10.1037/a0036090

13. Ligibel JA, Goularte M, Berliner JI, Bird SB, Brazeau CMLR, Rowe SG, Stewart MT, Trockel MT. Well-being parameters and intention to leave current institution among academic physicians. JAMA Network Open; 6 (12): e2347894. doi:10.1001/jamanetworkopen.2023.47894

14. https://www.bbc.com/news/uk-66573067

15. https://www.bbc.com/news/uk-england-merseyside-66668023

16. Fourth Annual Report on Medical Assistance in Dying in Canada 2022. Published in October 2023. Accessed at URL on January 6, 2024 https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html

17. Ashe GP. A unique milestone. Can Med Assoc J 2021; 193 (10, March 08),E345-E346. DOI: https://doi.org/10.1503/cmaj.202569

18. https://ca.news.yahoo.com/calgary-granny-gets-dont-euthanize-me-tattooed-as-sign-of-faith-173549275.html

19. Ault A. Doctors have failed them, say those with transgender regret. Accessed at URL on January 6, 2024 https://www.medscape.com/viewarticle/970223

20. https://twitter.com/elonmusk/status/1646824088940232704?lang=en , Accessed at URL on January 6, 2023

21. Karan Das R, Perdikis G, Al Kassis S, Drolet BC. Gender-affirming chest reconstructiion among transgender and gender-diverse adolescents in the US from 2016 to 2019. JAMA Pediatr 2023 Jan 1;177(1):89-90. doi: 10.1001/jamapediatrics.2022.3595.

22. Erlandson E, Ramirez C, Dean W. Medicine shouldn't be that hard: The intersection of physician moral injury and patients healthcare experience in pediatric complex care. J Pediatr Rehab Med: An interdisciplinary approach through the lifespan 16: (2023) 443-447. doi: 10.3233/PRM-230027

23. Shimazono Y. The state of international organ trade: a provisional picture based on integration of available data.

Bull World Health Organ 2007; 85: 955-962. doi: 10.2471/blt.06.039370.

24. Caplan AL. Why autonomy needs help? J Med Ethics May 2014; vol. 40, 5: 301-302. doi:10.1136/medethics-2012-100492

25. Cassel EJ. Consent or obedience? Power and authority in medicine. N Engl J Med 2005; Jan 27;352:328-30. doi: 10.1056/NEJMp048188

26. Beuchamp T, Childress J. Principles of biomedical ethics: marking its fortieth anniversary. Am J Bioethics; 2019; 19 (11): 9-12, DOI: 10.1080/15265161.2019.16654024

27. Savulescu J. Conscientious objection in medicine. Br Med J 2006; 332: 294-297. doi: 10.1136/bmj.332.7536.294

28. Savulescu J, Schuklenk U. Doctors have no right to refuse medical assistance in dying, abortion or contraception. Bioethics 2017; 31: 3: 162-170. doi: 10.1111/bioe.12288

29. Schuklenk U. Conscientious objection in medicine: private ideological convictions must not supercede public service obligations. Bioethics, 2015 Jun;29(5):ii-iii. doi: 10.1111/bioe.12167.

30. Wilkinson D, Savulescu J. Should we allow organ donation euthanasia? Alternatives for maximizing number and quality of organs for transplantation. Biethics Bioethics. 2012 Jan; 26(1): 32–48. doi: 10.1111/j.1467-8519.2010.01811.x

31. McDougall RJ, White BP, Ko D, Keogh L, Willmott R. Junior doctors and coscientious objection to voluntary assisted dying: ethical complexity in practice: J Med Ethics 2022; 48: 517-521. doi: 10.1136/medethics-2020-107125

SAŽETAK

OČUVANJE POVJERENJA U ODNOSU IZMEĐU LIJEČNIKA I PACIJENTA I MORALNA OZLJEDA U LIJEČNIKA

J. BUTUROVIĆ PONIKVAR[1, 2]

[1]Odjel za nefrologiju, Sveučilišni medicinski centar Ljubljana, Slovenija
[2]Odjel za medicinsku etiku, Medicinski fakultet, Sveučilište u Ljubljani, Slovenija

Povjerenje između pacijenta i liječnika posljednjih je desetljeća pod velikim pritiskom, zbog dramatičnih promjena u medicini. Usporedo sa sve većim potrebama i složenošću pacijenata koji zahtijevaju od liječnika da svakome od njih posvete više vremena (uključujući dužnost objašnjavanja propisanu zakonom), povećava se administrativni teret liječnika, a mjerenje produktivnosti pojedinih liječnika je ili već uvedeno ili se planira uvesti, tjerajući liječnike u „proizvodnu liniju" zdravstvenih usluga. Iako liječnici predstavljaju mali postotak svih zaposlenika u zdravstvenom poduzeću, tj. obično manje od 10 %, oni su glavna meta mjerenja produktivnosti u zdravstvu. Administrativno opterećenje i metrički pristup povećavaju se procesom korporativnosti zdravstvenih sustava, kako u privatnim, tako i u javnim zdravstvenim organizacijama.

Pacijenti i liječnici više nisu jedine osobe koje sudjeluju u donošenju medicinskih odluka, jer su se pridružili mnogi drugi. U knjizi profesora Davida Rothmana opisani su kao «stranci pored (bolesničkog) kreveta«. Među njima su bioetičari, pravnici, ekonomisti, psiholozi, civilno društvo, aktivisti. Uvođenje umjetne inteligencije u zdravstvo i njezina uloga u donošenju medicinskih odluka ocjenjivat će se u bližoj i daljoj budućnosti.

Pacijenti ne žele biti dio proizvodne linije zdravstvenih usluga. Oni žele humani kontakt sa svojim liječnikom, za kojeg vjeruju da će se boriti za njih i štititi njihov najbolji interes, zdravlje i živote. Očuvanje odnosa međusobnog povjerenja sa svojim liječnikom pacijentima je potrebno jednako kao i lijekovi i zdravstvene usluge.

Liječnici to također žele i trebaju. Odnos povjerenja između pacijenta i liječnika temeljna je vrijednost medicine tisućama godina i potrebno ga je zaštititi i učvrstiti i ubuduće. Naša dužnost kao liječnika jest boriti se da ga sačuvamo u izazovnim vremenima koja su pred nama.

Ključne riječi: povjerenje, odnos liječnik – pacijent, moralna ozljeda

Autor za korespondenciju: Jadranka Buturović Ponikvar
jadranka.buturovic@kclj.si
jadranka.buturovic@mf.uni-lj.si