University of Economics and Innovation in Lublin

Communication competences of medical and health professionals

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1. Theoretical perspective

1.1. Philosophical and psychological sources of communication with patient

Communication with patients considered on the plane of medical sciences or other exact sciences has its deepest source in human philosophy, and within this philosophy, in the philosophy of dialogue. Martin Buber is the classical author of philosophy of dialogue, therefore, the theoretical perspective should originate from the presentation of his conceptualization of dialogue (later communication), concepts and persons of a specific drama which takes place in subject-to-subject communication < I and Thou >.

The term 'Grundwort', i.e. a fundamental word coming 'from the bottom of the soul' is among the central categories of Martin Buber's philosophy[1, 2].

Buber claims that the word comes from God. This divinity is expressed mainly in the feeling of love contained in words. Despite common thought, not intellectuals, or according to other approach, deeply religious but primitive peoples can use the word with dignity. In contemporary times, words, according to Buber, have lost their past sense, because they were deprived of love and became just empty sounds. It was long forgotten that in the past they were 'images of emotions'. In primitive cultures, objects do not obscure the real presence of man. Buber rightly contends that this fundamental instrument of dialogue should return to its original state [3, 4].

The following categories are the relationships < I – Thou > and < I – It >, and < inter-human sphere >. The relationships < I – Thou > and < I – It > are additionally specified as < Person > and < Individuum >, and the whole is comprised within < the life of dialogue >. In all relations of the < I >, the < Word > is a type of a research method applied by the subject with respect to any being. When < I > wants to cognize the surrounding reality, directs the questions exclusively to objects and, in such a kind of cognition, even < Thou > is approached instrumentally. In this conceptualization, things and man are considered in their externality. According to Buber, such cognition provides knowledge of individual qualities of reality, and

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1 Buber M. Ja i Ty. Wybór pism filozoficznych. Instytut Wydawnictwa PAX, Warszawa 1990, 43, 47, 59.

2 Buber M. Opowieści rabbiego Nachmana. Paryż 1983, 16–18.

3 Buczyńska-Garewicz H. Martin Buber i dylematy subiektywności. Znak, Kraków 1980, 7.

4 Buber M. Między osobą a osobą. Społeczne i międzyludzkie. [in:] Ja i Ty. Wybór pism filozoficznych, PAX, Warszawa 1992, 138–139.

simultaneously does not provide the image of the being as a unity. Objects are cognizable only by the differences which we notice between them[5] .

Cognition, for which a man should strive, should be of an overall character. Only such cognition is considered important by Buber. Partial, aspect-oriented cognition may give a false result while composing individual qualities [6].

In order to change the relationship < I – It > into < I – Thou >, one should maintain a passive attitude in scientific understanding, no concepts, experiments or schemes reach the whole. To the question 'What, therefore, do we know about < Thou >?' Buber answers: all or nothing, because nothing partial is known about < Thou> [7].

There are three spheres through which we can recreate the world in ourselves:

1. Living in accord with nature – we have such a reflection of the world as animals do without awareness, why is it so?'
2. Living with others – we acquire the reflection of the world and education by communicating with other people,
3. Living with God – in this case we obtain the image of the world as a reflection of Heaven, not reaching consciously, neither our instrumentality nor other instrumentalities [8].

Each of the above-mentioned relationships takes place in a different time. The fulfilment of the < I-Thou > relationship happens only in the present time, while the present time is neither a point nor a seeming clock-stopping. Buber calls this phenomenon a 'complete presence in the moment'. If the subject faces many contents, and not only an individual < Thou >, the relationship takes place in the past, and is not of an instrumental character [9].

The relationships between subjects are explained by Buber in terms expressing emotions. Very different emotions may accompany man when a person encounters another person [10].

According to Buber, each subject possesses predispositions for love, however, the emotion itself develops only during the dialogue. Love plays a very important role in the < I – Thou > relationship. If we take responsibility for another human being (which results from the definition of love) we make the subjects equal, irrespective of their position in the surrounding world, and one level allows an equal communication [11, 12] .

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5 Buber M. Życie między osobą a osobą. Więź, 5, 1980.
6 Buber M. Ja i Ty. op.cit. 43–59.
7 Buber M. Życie … op.cit.
8 Bukowski J. Poznanie przez spotkanie. Znak, Kraków 1984, 360/361.
9 Doktór J. Filozofia dialogu Martina Bubera. Życie i myśl, 1980 no. 6.
10 Buber M. Życie…op.cit., no. 6.
11 Buber M. Spojrzeć na człowieka. Życie i myśl, 1980, 6.
12 Buber M. Ja i Ty….op.cit., 47.

According to Buber, 'Love' is not detached from reality, but it is acting in the world. Due to love, one subject is capable of eliciting another subject from the generality, and it is able to give a unique character to another human being. It is due to love that we can and want to act, help others, cure and bring-up. There is no better or worse love, there is only one. Also, it is not possible to separate the essence of love from its manifestations. We reach for this emotion to help others with overcoming their fears and anxiety, as well as to allow another human being to help us. Buber argues that sensual love is closer to hatred, as one may hate only some quality of another being. The one who perceives the whole being, enters the state of love. Love may be discussed only in case of the relationship < I – It > (subject – object). Nevertheless, the experience of hatred is closer to the relationship < I – Thou > than the situation of the lack of any emotions (love or hatred). Buber says that the human being is immersed in lofty melancholy caused by a constant transition from the relationship < I – Thou> into the relationship < I – It > [13, 14].

The greatest merit of man resides not in the fact of overcoming the world of things, but in constant attempts to commit this act.

In this theory, the 'Word' is of a twofold nature. It is simultaneously a matter and a masterpiece. It is an instrument in the cognition of an object, and at the same time, a masterpiece resulting from meeting, and a masterpiece around which the meeting takes place[15].

Buber distinguishes a 'dialogue' and 'the life of dialogue'. Dialogue means for him a certain form of bi-lateral or multilateral verbal communication between people. The life of dialogue means the attitude towards another person, to whose questions one should reply by words, acts, or silence. 'Dialogue' is one of the possibilities of performance of the 'life of dialogue life'. Conversation is a distorted form of a 'dialogue', it possesses the form of a 'dialogue', but it does not have its essence, according to Buber, it lacks the real participation of the partners[16].

To the basic terms of Martin Buber's philosophy belong also: *'individuum'* and *'person'*. The concept of *'individuum'* comprises what differentiates us from others – character, race, way of acting, capabilities, occupations performs, etc. Within a *'person'* is that due to which we enter into the relation with others. This is my < I > , but it does not mean that I am anyone, but that I simply exist. If at the meeting < I > is not personal, but individual, the relationship is < I – It >. This, however, does not mean that in the relationship < I – Thou > we reject individuality. It is a part of each subject, therefore, in the meeting with another person each subject is at the same time an *'individuum'* and a *'person'* [17].

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[13] Bukowski J. Poznanie przez spotkanie. Znak, Kraków 1984, 360/361.
[14] Doktór J. Filozofia dialogu Martina Bubera. Życie i myśl, 1980, 6.
[15] Buber M. Słowa – zasady. Znak, Kraków 1974, 26.
[16] Czaplejewicz A. Dialogika i pragmatyczna teoria dialogu. Przegląd humanistyczny, 1977, 6.
[17] Buber M. – Osoba i prawda. Znak, Kraków 1981, 324.

Buber also took a position concerning the *'interpersonal sphere'*, understood not only individually, but also socially. With respect to the social phenomena, one may talk about common responses to the common experiences, however, it only means that all individual existences are closed in a group existence. Fellowship relieves man from loneliness, confusion, and fear of the world, but at the same time attenuates all personal inclinations. To the objection that society is based on the *'interpersonal sphere'*, Buber replies that it is necessary to analyze the term *'relationship'*. One may talk about social relationships only when there is no reciprocity and timeliness of the event. What does it mean that an event is reciprocal and timely? In a dialogue, each party is aware of the other subject, and the meeting takes place in the present time. Social relation, understood as a social phenomenon, is defined in this way by an observer from outside, and although it happens in the present time, it is described only as the past [18].

From the point of view of philosophy of dialogue, Buber defines *'interpersonal'* as: actual events between people, be they fully mutual or capable of mutual intensification or completion, for the participation of both partners is in principle imperative'. The sphere of the *'interpersonal'* is that of each other – *vis-a-vis*, we call its evolution – the dialogical sphere[19].

The interpersonal sphere is filled by personified cooperation. These are neither actions by individual partners nor the sum of their actions, this is an entirely new category, created in the space in-between them. Within this scope of problems, there is also the differentiation between being and seeming. Buber distinguishes between two different types of human existence. The first type is living in accordance with the essence of a given object. This activity is not conditioned by the outer world. This is a constant accentuation of the real reactions and feelings with respect to the surrounding world. The second type is acting deprived of spontaneity, directed towards the creation of self-image according to the situation. This division concerns only the ideal types, in daily life these types are generally mixed with one another, with the prevalence of one or the other. In this classification there is also 'a realm of genuine appearance'. The person is so much concerned with the imitation of a heroic model (idol) that becomes something of what he imitates, and appearance becomes reality [20].

The more the appearance arises from a lie and is permeated by it, the more threatened is the interpersonal sphere. According to Buber, a lie is not only changing the facts, it is also a falsified existence, especially dangerous for the < I – Thou > dialogue. Seeming living leads to the loss of an opportunity which is provided by the meeting of man and man. In the interpersonal sphere, truth means that one imparts to the other what one is. This obviously does not mean the question

[18] Bukowski J. Zarys filozofii spotkania. Znak, Kraków 1987.
[19] Buber M. Życie… op. cit.
[20] Ibidem.

of *'flooding'* the other with most intimate confessions, but of allowing the person, with whom one communicates, to take part in our confessions. Buber perceives leaving the vicious circle of appearances only by evoking in oneself an aversion for any falsification of oneself. In order to become a 'person' one needs confirmation by the other *'person'*, therefore, the chance for evoking abomination is relatively high. An *'image person'* verifies another person only seemingly, and a verified seeming being gives only an *'image person'*.

In addition, Buber undertakes another plot, the problem of pride. This is the attitude that brings a man to the level of a thing.

Resignation from pride is not easy, even when, or mainly when it seems to us that we are not proud, then exactly we are at the peak of this phenomenon. Pride cannot be suppressed by orders. One has to pass through the phenomenon of purification [21].

In the process of purification we shake off everything that is worldly and what defines us. Before becoming transformed into a person, we enter the relationship < I – Thou >, the sphere of the *'between'*, i.e. *'we pass through nothingness'* [22].

Fellowship with the other man is an ideal for which we strive. Sharing ourselves with another man does not impoverish us, because in a correct relationship this man also shares with us. In addition, there occurs the value which is created only in such a fellowship. Dialogue is an idea of providing assistance to others, as well as to oneself. However, the sacrifice of oneself must reach very deeply. In order to understand the partner, his fears and despair, we must experience this ourselves. This eliminates the presence of two separate languages in one dialogue [23].

Conversation plays an important role in the life of the dialogue. Buber claims that most of what we commonly call a conversation may be defined as *'chatting'*. On an everyday basis, people speak only and exclusively to themselves, even if it takes the forms of a dialogue. 'To themselves' – means that while talking with others we are not able to overcome our own problems and experiences. We are incapable of trying to experience the feelings and experiences of another man (today we speak about the lack of empathy) [24].

The precondition of a good conversation is that we consider every man we meet as a partner. This means, that we accept his being different and confirm his personality, even when we do not agree with him. Buber simply contends to 'look inside' another man, i.e. to perceive him as a unique wholeness, which leaves an imprint on his manifestations, behaviours, and attitudes. This is impossible when we assume only a cognitive position with respect to the partner. In contemporary times, the majority of meetings are characterized by an analytical and reductive

[21] Buber M. Wina i poczucie winy. Znak, Kraków 1967, 156.
[22] Buber M. Słowa – zasady. Znak, Kraków 1974, 26.
[23] Buber M. Życie …op.cit.
[24] Doktór J. Filozofia dialogu Martina Bubera. Życie i myśl, 1980, 6

approach to another man. The tendency towards the unification of specific traits, and bringing these traits down to the level of genetics is observed. From the point of view of Buber's philosophy of dialogue, such interpersonal relationships are mutual objectification [25].

Another discouragement limiting the dialogue between people is an attitude imposing certain ideas to another man. For a *'propagandist'* a person does not count, but solely exerting an effect on this person. The objective is depersonalization and taking possession of the other man. A counterbalance is an 'opening' attitude. As an example, Buber presents the attitude of a good teacher. He is the carrier of certain ideas, which he considers as positive, therefore, he wishes to find and develop these ideas in his students. He cannot separate himself from the students by the difference in his position. In the education process he gives himself to the disposal of another man. He helps them to find themselves, and in the moments of doubt, may count on their support. In this relationship, the roles of a teacher and a student are equally important. Also, this meeting should be permeated with love which strengthens both parties, and simultaneously brings about responsibility [26].

According to Buber, education is not a type of *'permeating'* another man, but rather 'embracing' him – simultaneously experiencing what the other person experiences. Buber distinguishes three forms of dialogue embracing:

1. abstractive – when in the argument there occurs a dazzling feeling of the partner being right, which enriches the conversationalist,
2. pedagogic attitude – the teacher is constantly present in the student's experiences, however, there is no complete mutuality. The teacher is at two ends of dialogic reality – as a participant and observer, while a student is only at one end.
3. friendship – starts at the moment when a clever student is capable of experiencing the situation from the other side. Then the pedagogic attitude ends [27].

While presenting the above-mentioned attitudes, Buber indicates that they should not be combined with the concepts of modesty and conceitedness, because these are states of mind, individually psychological facts with an ethical touch.

Summing up, it should be remembered that the principles of a correctly kept conversation, according to Buber, comprise treating the other person as a unique partner, irrespective of the fact whether we agree with him or not concerning the issue discussed. An open expression of what we have to say about this problem (nothing else but assertiveness, which today makes a career), but without unnecessary *'babbling'*. Avoiding any appearances and directing the dialogue, but instead, maintaining its indirect character and spontaneousness. Apart from clear and explicit principles, Buber's dialogue has its consequence. This is education in dialogue and for dialogue.

[25] Buber M. Spojrzeć na człowieka. Życie i myśl, 1980, 6.
[26] Buber M. Wychowanie. Znak, Kraków 1968, 167/170.
[27] Buber M. Wychowanie. op.cit.

Humanistic psychology, by Carl Rogers, is the elaboration and new interpretation of Martin Buber's dialogue. Both thinkers in their theories start from human personality crisis and deformation of contacts with others. Their considerations are antidote to anxiety and stresses of man resulting from the functioning in the surrounding world. Rogers constructs his theory primarily for the physiotherapist, whose task is to teach another man to be himself, experience himself and others more directly, and make real contact with others. Here, an 'authentic' attitude of a therapist, which he shows to the person who has come to see him, is necessary. The goal of therapy is to show how to be oneself, which will also allow acceptance of the other man. What does it mean to be oneself? This is to constantly select objectives, fight for own autonomy, and enjoy the fact that we change [28].

This fundamental satisfaction of this 'movement' should gradually embrace the entire life and give it a new form. To be oneself is to be a complexity. We are internally complicated, therefore, this must be manifested in our behaviour. Finally, to be oneself is to 'make friends' with own experience. Only after these preconditions are satisfied, we become a person ready for dialogue with another man. The whole of psychotherapy is biased towards the correction of mistakes and deficiency with respect to communication [29]. Contemporary man suffers from distortion of communication, both internal, and with others. A therapist helps him to listen to himself which, in turn, exerts a beneficial effect on wider contacts. In Rogers' theory, the terms dialogue and communication are applied interchangeably.

Attempts of reporting the attitude of the partner play a special role in dialogue. The one who is capable of the most precise expression of somebody else's thoughts will be able to present his views to the other party (today, this is spoken of as feedback information). This obviously requires courage, because to strive to understand another man is to agree for a change which will happen in us under the influence of his attitudes. In addition, Rogers introduces the term group discussion, where the third person plays a very important role (today, the leader of the therapeutic group, and superior to him as supervisor). This person is a revisor of mistakes committed during interpretation, as well as a mediator between opposite views. Rogers claims that humanity has become mature enough to solve even the greatest conflicts in a dialogue. Interpersonal contacts, leading to the creation of new values, are a cure for any anxiety. Due to meetings and conversations we start to appreciate other people, appreciate creativity, and appreciate its role in the growth of common knowledge [30].

People who adequately meet with others become more responsible for themselves, show a greater flexibility, are more capable for creative adaptation, and simultaneously, become a unique person. Similar to Buber, Rogers applied his

[28] Buber M. Rogers C. Dyskusja. Znak, Kraków 1968, 11–12.
[29] Rogers C. On Becoming a Person. Houghton Mifflin Company, Boston 1961.
[30] Rogers C. Terapia nastawiona na klienta. Thesaurus – Press, Wrocław 1991.

theory to develop a new method of education. The attitude of a teacher should be analogous to that of a therapist, characterized by genuineness, authenticity and unconditioned acceptance of the person of a schoolchild or a student. The differences concern, for example activity, which the teacher should show, however, should not impose anything. The teacher's task is to react to the learner's initiative, maintaining this initiative, and assist with designing goals which a learner poses in front of him. Most of the teacher's work should consist in preparatory activities and the creation of conditions in which learners would safely encounter reality [31].

Experience should be a basis for education. With respect to evaluation, posing requirements, or using sanctions, Rogers totally distances himself from this, and considers that the greatest examination for a pupil is life itself. The application of grading or sanctions sometimes evokes rebellion against school in a pupil, but more often induces an attitude of passive surrender to the deforming effects. In the process of education, the most important element is motivation. A positive motivation is obtained only in the case of an adequate attitude of a teacher, ending with friendship with a learner. According to Rogers, a teacher is a person who does not impose his knowledge on students, it is the task of the students to extract from him the information they need. Initially, this method causes chaos in a group, but ultimately triggers intellectual activity. The students start to seek their own way and reply to the questions posed, based on their past experiences.

In daily life, Rogers proposes to start discussion groups, which would help to solve problems, and make an attempt to commonly relieve conflict situations. Today, a part of therapeutic groups function on the basis of these views. Rogers was the first to transfer the theories of dialogue between people from considerations to the practical ground [32].

Among the precursors of interpersonal communication, a philosopher of dialogue, rev. Józef Tischner, occupies an outstanding position. According to Tischner, human everyday reality, in spite of appearances, is not filled with meetings with others. Although we are surrounded by people, we do not perceive them with our senses, we perceive outer appearance, which is not a man as such. It comes to a proper man-to-man relationship when the 'need' arises. This need has an obligatory character and it is this necessity which is an instrument, and at the same time, a core of the meeting with another person. Tischner distinguishes two ways of perceiving the other person in interpersonal relationships. 'Dialogical openness', i.e. a relationship based on satisfying mutual 'demands', and 'intentional openness' objectifying the interlocutor [33].

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31 Rogers C. Terapia nastawiona na klienta. op.cit.

32 Margasiński A. Probucka D. [ed.] Etyka – Psychologia – Psychoterapia. Wydawnictwo Aureus, Kraków 2004.

33 Tischner J. Filozofia dramatu. Wydawnictwo Znak, Kraków 2006.

According to Tischner, 'dialogical openness' requires a tremendous contribution of both parties. It is necessary to find motivation for it (eliminate fears), specify the place and way of meeting, and negotiate a common language [34].

Tischner introduces to philosophy the concept of a 'genuine dialogue' based on the assumption that in order to get to know the truth about ourselves and the world, we must leave 'the shelter of seclusion' and combine our cognitive capabilities with the cognitive capabilities of the other man. Only together we have the way of looking at the truth about ourselves and society [35].

An important element of Tischner's philosophy of dialogue is the concept of 'empathising' (in interpersonal communication the concept of empathy), empathising does not mean sympathy, but understanding someone else's emotions. In the practice of interpersonal communication, empathy is often confused with sympathy, which hinders its proper application in relation with another person [36].

Before it comes to dialogue, a plane of meeting is needed, according to Tishner, not only an external space (physical place) is indispensable to meet with another man. The most important is so-called 'backup', similar interests, tastes, past, and hopes for the future. A 'backup of meeting' is widely understood sphere of ideas and values professed by the dialoguing people [37].

While describing a person, one cannot omit such concepts as: 'freedom', 'good', or 'generosity'. Each of them is reflected in relation with another person. According to Tischner, the one who tries to enslave others with any instruments known to mankind (by sex, authority, money, acc. to the author) will not be free. While allowing other man to be himself we experience own freedom and the good resulting from it. Good is born from relationships, and not loneliness. This is how Tischner comprehends the phenomenon of generosity, and such generosity may evoke gratitude [38].

Each of the very briefly presented theories defines the role of the participants of dialogue, specifies the space and language of dialogue, presents benefits and duties resulting from entering into relations with another person, laying the grounds for the theory of interpersonal communication in the area of motivation, knowledge and capabilities.

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34 Tischner J. Etyka Solidarności. Wydawnictwo Znak, Kraków 1981.

35 Tischner J. Boski rodowód wolności czyli Bądź wolność Twoja. Znak, Kraków 1998, 517.

36 Tischner J. Etyka… op.cit.

37 Tischner J. Filozofia… op.cit.

38 Tischner J. Etyka Solidarności. Wydawnictwo Znak, Kraków 1981.

1.2. Paradigms of medicine and way of perceiving a patient

Encyclopaedic sources define 'paradigm' as a word of Latin origin, translated as a typical example or pattern of something [39]. As a philosophical term, paradigm is a commonly adopted theoretical belief and experimental methods which are the research tradition. The term was introduced into general philosophy in the 18th century by G. Ch. Lichtenberg, and into philosophy of science in 1962 by Th. S. Khun [40].

The creator of the theory of science, Kuhn admits that it is relatively difficult to provide a concise definition of this term. It is usually used as a collective concept, which covers all which the representatives of a particular scientific discipline consider as obvious.

The term paradigm, in one case, has a global sense and covers all internalized beliefs of a scientific group, and in the other case, distinguishes a certain especially important type of these beliefs, i.e. subsets of the first ones [41].

To be more precise, it is worth adding that the paradigm of science contains such elements as meaning of the most fundamental concepts (in medicine, e.g. health, illness, patient), boundaries of the area of the conducted studies (where medicine begins and where it ends), basic theories (e.g. mechanical model of disease), as well as research methods and values recognized by people of a given branch of science (in this case, all the sciences dealing with medical problems) [42, 43]. The presented elements concern so-called 'scientific community' that consists of people practising a particular specialty. Linked by common elements of their education and apprenticeship they approach themselves and are approached by others as individuals responsible for striving for the performance of specific goals, including the education of their successors" [44].

However, before proceeding to a more detailed discussion concerning Khun's theory of science, one cannot omit its forerunner, Ludwik Fleck.

The basic concept of the theory of knowledge of Fleck's reflection is 'thought collective', according to which each cognition concerning the development

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39 Kopaliński W. Słownik wyrazów obcych i zwrotów obcojęzycznych. PW „Wiedza Powszechna". Warszawa 1989, 378.

40 Kalisiewicz D. Burek R. Gadacz T. Wojnowski J. [ed.] Encyklopedia PWN w trzech tomach. PWN, Warszawa 1999, 2, 777.

41 Khun T. S. Dwa bieguny. PIW, Warszawa 1985, 321, 406, 409.

42 Wolff H. R. Pedersen S. A. Rosenberg R. – Filozofia medycyny. Wydawnictwo PWN, Warszawa 1993, 20, 54–55, 56–57, 60–61, 167–170, 250–251.

43 Khun T. S. The structure of scientific revolution, The University of Chicago Press, Chicago 1970, 57, 89.

44 Khun T. S. Dwa bieguny. PIW, Warszawa 1985, 321, 406.

of mankind, social cognition, is crossing the borders available for an individual – it takes place collectively [45].

The researchers move about within limits of cognition, delineated by to-date scientific experiments, culture, and social norms. During the analysis of own activity of a researcher one should consider at least three fundamental issues – who performs the recognition?, what is subject to cognitive analysis?, and by what methods it is cognized? – this is not about the researcher's technical instruments, but primarily his socio-psycho-cultural burden.

"...statement, 'Someone recognizes something' –, demands ... some such supplement as, ' on ... fund of a certain knowledge', or, better, 'as a member of a certain cultural environment', and, best, ' in a particular thought style, in a particular thought collective'" [46].

Although the '*thought collective*' consists of *individuals,* it is *not simply* the aggregate *sum* of them. According to Fleck, the result of a cognitive process always has a cognitive context.

"The individual within the collective is never, or hardly ever, conscious of the prevailing thought style, which almost always exerts an absolutely compulsive force upon his thinking and with which it is not possible to be at variance"[47].

As an example Fleck provides, among other things, an example of the development of medical knowledge about syphilis, where the gross of the perceptions concerning this disease come from collective social and religious impressions.

"...all motives of a specified sequence of ideas come from collective image: disease as a punishment for sinful lust – is a collective idea of religious community. Disease as a result of the effect of a constellation of stars belongs to the astrologists' collective. Speculative metaltherapy of practicing physicians created the idea of mercury. The thought about blood was transferred by physicians-theoreticians from the old vox populi ('blood is a special fluid'). The thought concerning an infectious agent leads retrospectively through the modern etiologic stage, as far as to the collective image about the demon of the disease" [48].

It would seem that Fleck ignores the role of an individual in the research process. There could be nothing more wrong, he perceives the importance of an individual, but only as an element of a larger whole. Without an individual it would be difficult to have a whole, but only from the perspective of a whole/collective, one may talk about proper scientific achievements of man.

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45 Fleck L. Psychosocjologia poznania naukowego: Powstanie i rozwój faktu naukowego oraz inne pisma z filozofii poznania. Wydawnictwo UMCS, Lublin 2006, 46–114.

46 Ibidem, 68.

47 Ibidem, 70.

48 Ibidem, 70.

"... study of thought complex creates thorough essentials of the theory of cognition. If it is possible or should one analyse the course of the game only from the aspect of single kicks? The entire sense of the game would be lost!"[49].

The subsequent important concept in Fleck's reflection is 'thought style'. This concept is related with the popularization of a scientific discovery. The sole scientific discovery may never reach social memory and may not serve as reference to further scientific discoveries. The discovery must remain within the thought style of a given epoch, i.e. in collective thought. Thought style of a particular epoch gives the direction to individual studies and verifies these studies from the aspect of adopting or rejecting from collective thought.

"In social memory there are fixed and may develop only relations which are in accordance with the style of a given epoch. In this way astrology contributed to the fixation of the veneric character of syphilis as its first differentia specifica" [50].

The consequence of 'thought style' is 'thought compulsion' which, one the one hand, is a type of readiness for specified perception and action, determined by a particular epoch, and on the other hand, a type of blockage against creative and exploratory thinking of the researcher [51].

"If an expanded, closed system of beliefs is formed, which consists of many details and relations, it resists anything that contradicts this system (objection to it is – the author) 'unthinkable', (what contradicts the system) – the author 'remains unnoticed'"[52].

From the point of view of Fleck, the 'fact' is not the state of things or an authentic event. It is a special approach to things and events, by way of the cognitive means available on a particular level of culture development.

"A scientific fact may be provisionally defined as a conceptual structure equivalent to the thought style (Begriffsrelation), which may be studied from historical, individual and collective psychological aspects, but which could never be constructed in its entire contents, based on such an approach. Here, it manifests itself the phenomenon of an active and passive part of knowledge, as well as the fact that quantitatively both components increase with acts" [53].

Thus, according to this approach, what is the concept of 'truth'? The truth, as understood by Fleck, is not a dyadic relationship between judgement (thought) and the state of things. Each judgement/thought is enclosed in the current state

[49] Fleck L. Psychosocjologia poznania naukowego: Powstanie i rozwój faktu naukowego oraz inne pisma z filozofii poznania. Wydawnictwo UMCS, Lublin 2006, 74.

[50] Ibidem, 27.

[51] Fleck L. Problemy naukoznawstwa, „Życie nauki. Miesięcznik Naukoznawczy" V. I (1946), 5, 322–336.

[52] Fleck L. Psychosocjologia…op.cit., 55–56.

[53] Ibidem, 114.

of knowledge and culture. In the process of arriving at truth, one deals with three components, thought (judgement), cultural means and conditions, and the state of things. From such a perspective it is difficult to consider whether certain ideas are true or false, it is rather that they may lose importance due to cultural changes.

> *"In general, it is not sensible to recognize by thought collective the adopted and effectively applied beliefs as 'truth or mistake'. They developed science and brought about satisfaction. They have been outrun, not due to their being false, but due to the development of thinking. Our concepts also will not survive."* [54].

Thus, what is scientific cognition according to Fleck? We can talk about a scientific discovery only when we can display its historical character, mark a moment of transition of a given idea from its past to its future.

> *"Therefore, to cognize is primarily to establish, according to the given assumptions, imposing themselves perforce results. Assumptions are equivalent to active relationships and are a collective part of cognition. Forced results are equivalent to passive relationships and create what is called an objective reality. The share of an individual is the act of contending"* [55].

According to Fleck, an element which is difficult to overcome in cognition is cognitive resistance against the research activities which do not fall within a particular thought collective. As an *antidote,* Kuhn introduces into his theory of science, apart from paradigm, the concept of scientific revolution.

Khun's theory shows that the representatives of a given scientific domain (in this case medicine), move within the limits of a paradigm with which they are familiar, in theory, practice, and education [56].

Paradigms of a specific domain of science do not change for long periods of time. The researchers solve all problems within the conceptual apparatus delineated by paradigm. Khun calls this time the period of 'normal science'. Within this period there constantly appear new problems, which are interesting for researchers, the solving of which takes place in accordance with the rules accepted in a particular paradigm.

From time to time, in science there occur discoveries which collide with the to-date theories. However, they do not instantly lead to the change of paradigm. The scientific community often does not want to change the existing paradigm. It is only due to many anomalies that cause a crisis in science, which allows the rejection of old schemes and beginning the construction of new ones [57].

Khun implements in science the division into pure science, where the primary duty of a scientist is seeking truth, and technology, where the activity of a scien-

[54] Fleck L. Psychosocjologia…op.cit., 93.

[55] Ibidem, 69.

[56] Khun T. S. Dwa bieguny. PIW, Warszawa 1985, 321, 406, 409.

[57] Khun T. S. The structure of scientific revolutions. The University of Chicago Press, Chicago 1970.

tist focuses on the knowledge of how something functions, and the technique by which a representative of a particular domain of science is capable of performing, based on a particular science, some practical actions. Usually, each of these domains concerns separate sciences (e.g. physics is a pure science, technology – engineering, and technique – skills of piloting a plane).

Medicine is a special type of domain. It covers all these types of activity. Physicians dealing with basic studies in a laboratory deal with pure science. The testing of new drugs, from the scientific perspective presented by Khun, is a technology, while examining and treating a patient – is a technique. This complexity of medicine causes non-uniformity of individual medical paradigms. In each of the above-mentioned domains, paradigm had somewhat different assumptions. The presented study is devoted to medical practitioner-patient relationship, therefore, the discussions about paradigms, presented below will concern mainly medical technique, however, there will also be references to pure science and technology.

The theory of paradigm presented above, served as an introduction to the philosophy of medicine, and an analysis of medical patterns (paradigms), which in various ways handle the attitude towards disease and patient, and consequently towards communication with the latter (applied or not in various paradigms).

The first paradigm, the paradigm by Hippocrates, covered so-called humoural pathology differentiating among four 'humours': blood (hot and wet), phlegm (cold and wet), yellow bile secreted by the liver (hot and dry) and black bile secreted by the liver (cold and dry), and considered that in healthy individuals these elements are in balance. However, in order to discover whether this balance is maintained, an interview with a patient is necessary. Communication with a patient in combination with observation of this patient (i.e. reading non-verbal language, body language) enables the making of a diagnosis. Until as late as the 17th century humoural pathology had its followers. Nevertheless, among the variety of schools at that time, the model based on speculative realism dominated in medicine of the 17th and 18th centuries. The medical professionals at that time enjoyed a high social prestige. They did not examine their patients, as is practiced today, but first listened to all the complaints, to which they owed a part of their prestige and respect (similar to clergyman in a confessional), and subsequently they prescribed agents which, in their opinion, were the most effective. At this point, the role of a patient ended, he could only undergo any treatments with trust (bloodletting, enema, laxative or herbal brews) [58, 59]. Contemporary traditional medicine, or in other words, unconventional medicine, uses these patterns while approaching

[58] Wolff H. R. Pedersen S. A. Rosenberg R. Filozofia medycyny. Wydawnictwo PWN, Warszawa 1993, 20, 54–55, 56–57, 60–61, 167–170, 250–251.

[59] Khun T. S. – The structure of scientific revolutions. The University of Chicago Press, Chicago 1970, 50.

a patient, therefore, it is no wonder that despite common sense, it enjoys such a great popularity.

At the beginning of the 19th century, a scientific revolution took place in medicine. Speculative realism was replaced by empirically controlled realism.

French pathologists identified disease with anatomical damage. They compared the results of post mortem examinations with the observation of patients when they were still alive. At the end of the century, a group of other researchers presented a physiological theory of a disease, confirmed by laboratory tests. However, irrespective of the adopted point of view: anatomic, physiological, biochemical or microbiological, laboratory results were the most important criterion. Ultimately, during this period, the biological concept of disease consolidated itself, combining all the previous theories, with the exception of those which were not confirmed empirically [60]. This was exactly the time when medicine started to lose the perspective in which a man was the most important. The patient started to be slowly reduced to the role of a carrier of disease. This was the disease that played a major role in the medical professional-patient relationship. This was not a man who was ill, but a biological organism. The mechanistic model, constituted the entire description of the concept of a disease.

In the 30s and 40s of the last century, there began to germinate radical changes in the way of thinking in medical sciences. There occurred two extreme trends in thinking – medical empiricism and realism which, in their general form, have survived to this today. Nevertheless, at that time, empiricism was of greater importance. Physicians began to have doubts concerning to the applied methods of treatment. A strong need for observation no longer concerned a laboratory, but was expanded by observation at the patient's bedside. However, the observation still remained focused on the disease itself. Jules Galaret, the representative of empirical approach in medicine, recommended that: physicians should not base their therapeutic decisions on speculative theories and deduction, but should explore the largest number of patients possible, and count how many of them died and how many survived [61]. There is no place for theory, there is no place for man, only dry (statistical) facts count.

Such trends in the philosophy of medicine as existentialism, phenomenology or hermeneutics (briefly the art of interpretation), approached differently to the role of a patient. According to such an approach, a man is more than merely a biological organism, and medicine is more than a branch of natural sciences. The focus of considerations of these trends is the problem of the human being from its emotional aspect. Kierkegaard, Heidegger, Gadamer, Sartre or Habermas proclaimed a non-naturalistic concept of man, and their ideas are the foundations of the

[60] Wolff H. R. Pedersen S. A. Rosenberg R. Filozofia medycyny. Wydawnictwo PWN, Warszawa 1993, 20, 54–55, 56–57, 60–61.

[61] Ibidem, 167–170, 250–251.

medical paradigm based on such a way of perceiving human being-patient. The non-naturalistic approach is illustrated by the flowing sentence: Just as a physician might say that there very likely is not one single living human being who is completely healthy, so anyone who really knows mankind might say that there is not one single living human being who does not despair a little, who does not secretly harbour an unrest, an inner strife, a disharmony, an anxiety about an unknown something or a something he does not even dare try to know, an anxiety about some possibility in existence or an anxiety about himself, so that, just as the physician speaks of going around with an illness in the body, he walks around with a sickness, carries around a sickness of the spirit that signals its presence at rare intervals in and through an anxiety he cannot explain [62].

This disharmony mentioned by Kierkegaard cannot be measured by statistical methods, this anxiety and lack of coherence deprive laboratory tests devoted to the disease with a hundred percent certainty. The phenomena of human fear and depression are best illustrated by the limitations of the naturalistic approach, with this anxiety not being a pathological state, but, as Heidegger claims, is a special 'privileged condition for self-discovery' [63].

Both Kierkegaard and Heidegger do not question the necessity for examining man in an empirical way, this serves primarily the description of the current situation, while the proper interpretation is possible only by referring to the hermeneutic reflection. Human being-patient, according to this philosophical trend, is a free being and aware of own freedom. This is much more than the biological or social being. A human being is a synthesis of the infinite and the finite, of the temporal and the eternal, of freedom and necessity, in short, a synthesis [64].

To the synthesis of the body and soul we will come back in further considerations. Synthesis is not a one-dimensional being, which is relatively easy to measure, investigate, weigh, examine, based on analyses, statistics, and laboratory tests, cure.

In Kierkegaard's theory, there is also a third important element, the self, personality – an element which constitutes man and determines his specificity [65].

A full image of man contains a biological and psychosocial element, while these elements are combined by the feeling of own identity, capability for auto-reflection, willingness, free choice. The above-mentioned attributes of identity are important for the reflection over human being-patient. A characteristic trait of a human being is the capability for comprehension and interpretation of own actions and living conditions, the skill of making choices according to own preferences, insight into own < I >. Due to such an insight into the < I > a medical

[62] Gotfredsen E. Medicines Historie. Arnold Busck, Copenhagen 1950, 237.
[63] Heidegger M. Sein und Zeit. Max Niemeyer. Tubingen 1976, 228–325.
[64] Ibidem, 228–325.
[65] Kierkegaard S. Bojaźń i drżenie. Choroba na śmierć. PWN, Warszawa 1982, 146–147, 157, 167.

practitioner may acquire a part of knowledge concerning a patient's health, and may activate the patient's will to fight in the process of treatment. He may have a constant discrimination in the emotional sphere of human being-patient (if he only wishes to use it). This < I > in a human being-patient allows abstraction from own feelings and understanding the feelings of a human being-patient (empathic skills). This subjectivity of both parties of a dialogue is manifested in constant attempts to understand and interpret the sense of the surrounding world. In this case, the interpretation must be of a subjective character. Each patient has a different attitude towards own disease, and what really matters in the process of treatment are not anatomical or physiological abnormalities, but the subjective perception of the state of things by a patient. In the presented theories no one ignores the fact that man is a biological organism. Philosophers of this orientation just claim that a human being defined as a person cannot be fully understood from the naturalistic perspective [66].

The 19th century was a period of development of the philosophy of medicine in Poland. As a separate scientific discipline, it was very creatively developed between 1870–1940. Philosophical considerations concerning the problem of health, illness, attitude towards a patient, were successfully carried out by the subsequent three generations of physicians, the majority of whom were practitioners. Philosophy of medicine was approached not only as considerations over medical practice, but also as an art, considering all psychological, social, and ethical aspects. The reflection was of a holistic character.

Outstanding figures of this period were primarily: Tytus Chałubiński (1820–1889), Henryk Łuczkiewicz (1826–1891), Alfred Sokołowski (1849–1924), Edmund Biernacki (1866–1910), Zygmunt Kramsztyk (1848–1920), Władysław Biegański (1857–1917), Stanisław Trzebiński (1861–1930), Władysław Szumowski (1875–1954), Ludwik Zembrzuski (1871–1962), Adam Wrzosek (1875–1965), Ludwik Fleck (1896–1961) and Julian Aleksandrowicz (1908–1988). The majority of them remained under the influence of the Polish philosophical school in Lvov (later in Warsaw), founded by Kazimierz Twardowski (1866–1938), where they dealt with, among other things, explanation of the importance of language as a carrier of ideas, indicating the usefulness of linguistic and conceptual analysis (grounds for sciences concerning communication – author's note) [67].

Chałubiński interpreted the concept of disease in a way revolutionary at that time. He stated that a disease is not the opposite of health. A disease is the process

[66] Wolff H. R. Pedersen S. A. Rosenberg R. Filozofia medycyny. Wydawnictwo PWN, Warszawa 1993, 20, 54–55, 56–57, 60–61, 167–170, 250–251.

[67] Gawrychowski J. Skalski J. Gawrychowski S. Tradycje filozoficzne w polskiej medycynie. Kardiochirurgia i Torakochirurgia Polska 2006, 3 (2), 236–241.

which takes place in the body 'despite its physiological goals – due to special internal or external conditions' [68].

Łuczkiewicz, apart from the studies of problems concerning the cardiovascular system, in 'medical propedeutics' presented the analysis of basic concepts within the scope of philosophy of medicine.

> *"Medicine, in an ordinary, commonly adopted meaning, is a science about treatment of diseases, i.e. restoration of health disturbed by a disease 1...1) (author's note). The origin of the term 'medicine' is explained in various ways. Some seek its origin in the word 'medicina', which for Romans originally meant a shed or shack where Greek slaves performed their barber's craft, and idle spectators came for the latest gutter talks. Others derive this term from the word medeor = cure, or finally from the country Medya, where this science was supposed to come from Greece"*[69].

The subsequent eminent thinker was Biegański. From among many views which are important from the aspect of medicine, he claimed that a pathological process is inseparably related with the environment. In his opinion, health and illness are various symptoms of the adaptation of the organism to the external conditions, adaptation to various stimuli. A ground for transition from health to illness is the level of external excitements – moderate maintenance of the organism in health, whereas excessive in illness [70].

Biegański was the first in Europe to elaborate the fundamentals of deontology. He contained them in his 'Thoughts and aphorisms about medical ethics', where he stated, among other things, that:

> *"Science deprived of humanistic ideas ruins the psyche of man. The one who is not a good man, will not be a good physician, who is not moved by human misery, who has not softness and sweetness in manner, whose will is not strong enough to be always and everywhere self-possessed – let him better choose another profession, because he will never be a good physician"* [71].

Julian Aleksandrowicz referred to Biegański's considerations. He decisively emphasized the combination of man with the environment, which was inseparably associated with the use in medical reflection of holistic methodology (so-called ecologism). He claimed that deficiency of elements exerts the most unfavourable effect on life processes. Man living in a polluted environment, without supplementation of microelements, is exposed to many civilisation diseases, in consequence, to damage of the cerebral structures. The ultimate effect may be

[68] Chałubiński T. Metoda wynajdywania wskazań lekarskich. Plan leczenia i jego wykonanie. Warszawa 1874, 14–64.

[69] Łuczkiewicz H. Kurs propedeutyki lekarskiej czyli wstęp do nauki medycyny. Drukarnia Gazety Lekarskiej, Warszawa 1876.

[70] Biegański W. Logika medycyny, czyli krytyka poznania lekarskiego. Warszawa 1908, 132, 261–7

[71] Biegański W. Myśli i aforyzmy o etyce lekarskiej. PZWL, Warszawa 1957, 57–77.

a change of man's psychology (not only an individual but also mankind) in the direction of rejection of any ethical values. The technicisation of daily living, according to Aleksandrowicz, originated an era of 'a cruel man' in the place of 'a thinking man'[72].

Aleksandrowicz perceived a disease, a patient and medical practitioner, not as isolated beings, but directly mediated in the outer world phenomena and objects. He connected human health directly with man's psychological status. According to him, a healthy man is the one who accepts own 'self', who has a sense of physical, mental, ethical, and aesthetic efficacy', the one who accepts the world as it is. In order to maintain health it is necessary to aim at Plato's Big Tree: truth, goodness, and beauty. According to Aleksandrowicz, irrespective of the condition of the internal organs, and even in the case of terminally ill patients, health may be restored by the mobilization for action or passion [73].

Kazimierz Wize (1873–1953), who has not been mentioned before, perceived medicine also through the prism of relations with patients. The basis of good treatment were five virtues cardinal for a physician: wisdom, enthusiasm, bravery, devotion, and mission [74].

From the point of view of this dissertation, Romuald Wiesław Gutt is also worth mentioning. He brought into the Polish school of medical philosophizing, elements concerning communication with a patient and in medical teams by emphasizing that 'One should remember about the value of the word of the one who expresses this word, and its interpretation' [75].

The nature of contemporary medicine, in fact, is mediated in the 19th century, when physicians started to systematically examine the structure and function of the human body in the state of health and illness, and when the concept of medicine was defined as a domain of natural sciences, where any pathological processes are explained in terms of anatomy and physiology.

Modern medicine still has not reached the end of the mechanical model of disease, which is a primary element of the current paradigm. The first attempts at breaking this paradigm started as late as in the 60s and 70s of the last century, and revolved around the scope of problems of medical ethics undertaken by clinicians (this scope of problems will be discusses in the subsequent section), emphasizing the role and importance of patient's psychological element. It revolves around the scope of problems arising from the philosophical dualism (division into body and mind), and totally rejected the belief that a patient is merely a biological mecha-

[72] Aleksandrowicz J. Duda H. U progu medycyny jutra. PZWL, Warszawa 1988, 88–132.

[73] Aleksandrowicz J. Nie ma nieuleczalnie chorych. Wydawnictwo Łódzkie RSW Prasa Książka Ruch, Łódź 1987, 16–26

[74] Musielak M. Filip K. Wize as a physician and a medical ethicist. Arch Hist Filoz Med. 2000, 63, (3–4), 71–7.

[75] Domosławski Z. Wprowadzenie do medycyny. Kolegium Karkonoskie w Jeleniej Gorze PWSZ, Jelenia Góra 2007, 110.

nism which underwent 'mechanical damage'. A patient is also a human being who thinks and acts, has hope and suffers. This division evoked a subsequent problem, the way of affecting mind and body. Descartes was the first to deal with analysis of the interrelation between body and mind [76].

He did not succeed in explaining the interrelation between mind and body, nor also unequivocally explained this problem to other theories (logical behaviourism, causal theory of mind, theory of identity, functionalism, internationalism). In return, in medicine, especially in psychiatry, the theoretical problem posed in this way allowed the solving of many practical issues (e.g. in neurophysiology).

These considerations have also found their reflection in the classification of diseases: somatic, mental, psychosomatic. They also expanded the perspective of medicine, where the activity of a medical professional covers both the sphere of bodily and mental processes. In addition, medical practitioners are becoming aware of the duty to respect a patient's dignity and autonomy. Therefore, why, in our opinion, is contemporary medicine still stuck in a mechanistic paradigm? Firstly, it is because there is a gap between the awareness of patient respect and its multidimensional character, and everyday practice. Secondly, and most importantly, one of the basic elements of the paradigm is education, which has not changed since the 19th century with respect to communication with a patient, i.e. the consideration in the process of treatment and nursing of patient's spiritual and emotional sphere. Even if it is considered as a practical value, it is not promoted in vocational education.

1.3. Theories in medical ethics and place of the patient in relation to medical professional

Medical ethics may be placed on the border of medicine and philosophy. Its medical character is determined by the scope of problems undertaken, while the ways of thinking about this scope of problems and attempts to solve them come from philosophical areas, precisely, from the scope of philosophy of morality. The basic concepts around which will revolve the presented theoretical considerations in the area of medicine are: patient's good (approached in various ways), and obligations of a medical professional (also possessing many definitions). Let us start, however, from the general characteristics.

While adopting the above-mentioned assumptions, we enter the areas of normative ethics (from Greek: ethos = custom, character, and Latin: norma = regularity), leaving aside the descriptive ethics (Latin: mos = custom, practice), which deals mainly with describing and reconstructing the morality of single subjects

[76] Descartes R. Zasady filozofii. PWN, Warszawa 1960, 33.

and social groups [77]. Normative ethics tries to show according to what rules, norms or principles we should act, in order that our actions bring about moral good. It says 'How to live and what is important for man' [78].

It may be seen that the first and basic task of normative ethics is the practical function. Normative ethics covers: the science of the good (agathology), the science of values (axiology), the science of virtues (aretology), and the theory of moral obligation (deontology). In order to better understand the principles of classification of normative systems, it is necessary to discuss several concepts which are basic for normative ethics. Firstly, moral values, i.e. goals of worthy actions requiring performance. A moral value has an imperative character (in effect, categorical) for a good man. Thus, who is a good man? This is primarily someone who knows what is good, someone who also devoted his time to reflection and analysis of the concept of good (Socrates). A good person is someone who loves good (Plato) [79].

A good man is also someone who desires good, which is personified in striving towards the good of someone else, which is not the performance of any ethical codes, but listening to own impulse (Levinas) [80]. Also someone who by habit feels pleasure while dealing with good and goodness, in other words bravery, shown in a practical way (Aristotle) [81].

To be good is to be brave, virtuous and wise, and moral virtue is the expression of man, through theory and practice of moral . The prize for such an attitude is the feeling of happiness [82].

What combines a good man with moral values are moral norms. The validity of norms decides about their mediation in good, whereas a moral subject provides them with strength. The most original solution to the problem of imperativeness of norms was provided by Kant. According to him, the duty to maintain humanity as the highest value obliges us to moral actions. In acting according to the categorical imperative we protect our humanity, and at the same time, we do moral good [83].

Moral concepts may be classified based on the concepts 'values', 'norms, and 'virtues'. The most frequent criteria encountered, are moral goods as the highest goal (autotelic). On this Plato's and Mill's ideas are built, also, on this basis the ethical system of Catholicism is founded. Felicitologic/eudaimonistic ethis (ethics of happiness) as the highest, sometimes the only value considered as variously

77 Szewczyk K. Dobro, zło i medycyna. Filozoficzne podstawy bioetyki kulturowej. PWN, Warszawa-Łódź 2001, 144–145.

78 Laertios D. Żywoty i poglądy słynnych filozofów. PWN, Warszawa 1982, 17.

79 Platon – Uczta. PWN, Warszawa 1988 104, 107.

80 Levinas E. Całość i nieskończoność. Eseje o zewnętrzności. PWN, Warszawa 1998, [in:] Dzieła wszystkie no. 5, 365–367.

81 Arystoteles Etyka nikomachejska. PWN, Warszawa 1996, 85–89.

82 Platon Uczta. PWN, Warszawa 1988, 104, 107.

83 Kant I. Krytyka praktycznego rozumu. PWN, Warszawa 1984, 144.

defined happiness. There are ethical theories, which as their highest goal consider obligation (deontological ethics), also called code of ethics, because their originators very often code moral duties. Occupational ethics (including physicians, nurses, paramedics, physiotherapists) belong to this group.

The deontological plot also occurs in Catholic ethics (Commandments). Moral systems are also divided from the aspect of human attributes – we speak about the ethics of reason, which orders to act morally (Kant), or ethics of feelings. At present, the division of the moral thought is mainly between utilitarian ethics, referring to usefulness, and absolutist ethics [84].

In the contemporary world, 'good' is increasingly more often identified with health. Physicians slowly overtake the role of philosophers, clergymen, the latter within moral imperatives, threatened with eternal damnation and hell, while physicians threaten with disease, pain, and suffering as a penalty for the sin of neglecting health. This universality of application of medical ethics resulted in studies of occupational detailed ethics (bioethics). As this ethic also has an application, which is wider than the majority of occupational ethics (in own profession only), and covers with its norms not only medical practitioners but also ordinary people, it requires detailed divisions into culture ethics and regulative bioethics.

The task of culture bioethics is primarily the construction of an ideal of morally good medicine, and to this pattern, a morally good society. In order that these ideals can be implemented in practice, culture bioethics constructs theoretical essentials of the ethics of medicine, and in a dialogue with society, establishes goals for clinical actions of the medical staff [85].

Regulative bioethics deals mainly with the elaboration of principles, codes, guiding the functioning of medicine and its individual staff members. It is the oldest and the most developed part of bioethics, which directly refers to the Hippocratic Oath.

In the clinical (theoretical) part it searches for truth (for the future patient's good), while in the medical (practical) part deals with the concept of 'patient's good' [86].

A proper communication with a patient is exactly a part of patient's good and constitutes the essence of the presented dissertation, therefore, let us consider bioethical theories from this point of view.

According to all medical codes, patient's good is subject to gradation, in the foreground is human life, followed by health, health prophylaxis, alleviation of suffering

[84] Szewczyk K. Dobro, zło i medycyna. Filozoficzne podstawy bioetyki kulturowej. PWN, Warszawa-Łódź 2001, 144–145.

[85] Katz J. Ethics and Clinical Research Revisited Hastings Center Report. 1993, 5, 37.

[86] Szewczyk K. Etyka i deontologia lekarska. PAN, Kraków 1994, 91.

and preventing suffering [87, 88, 89, 90]. Throughout the epochs, these values were accompanied by various attitudes of medical professionals and patients themselves.

The ideal of every epoch is a world without diseases, suffering, and death, whereas the method which would lead to this is struggle with the causes of these phenomena. Technology, which is constantly developing and specializing in this area, creates the semblance of victory. From the field of vision of medicine understood in this way, man has disappeared, and the concepts of disease, health, pain and suffering have become alienated. They became the only goal and subject of medical actions. Pasteur, due to the systematization of etiology of infectious diseases, contributed to the change in the functioning of medicine. From the contemplative science it changed into technological science, and thanks to this, it could declare ruthless combat with any diseases. The terminology became a military terminology (in medicine there still functions the expression about struggling with a disease, medical staff is a medical service), and ethics – the ethics of combat. The diseases became independent beings, and the patient relationship was reduced to the level of a carrier of disease. The medical professional-patient relationship changed into the medical professional-disease relationship [91]. Patient's good was identified with the elimination of the disease, and indirectly – death. On this ground the ethical paternalism (in medical sciences) originated.

There are three types of paternalism related with biopsychosocial sciences: authentic, authorized and unauthorized. The authentic paternalism refers to pedagogy. For the relationship patient-medical professional only authorized and unauthorized paternalism is adequate.

According to John Rawls, a contemporary **American** philosopher, who deals with good, rightness and social justice, authorized paternalism is the topic in the argument for equal liberty and concerns a lesser freedom. In the original position, the parties assume that in society they are rational and able to manage their own affairs. Therefore, they do not acknowledge any duties to self, since this is necessary for their further good. But once the ideal conception is chosen, they will want to insure themselves against the possibility that their powers are undeveloped and they cannot rationally advance their interests, as in the case of children, or that through some misfortune or accident they are unable to make decisions for their good, as in the case of those seriously injured or mentally disturbed. For these cases the parties adopt the principles stipulating when others are authorized to act in their behalf and to override their present wishes if necessary, and they do this recognizing that sometimes their capacity to act rationally for their good may fail,

87 Szawarski Z. W kręgu życia i śmierci. Moralne problemy medycyny współczesnej. KIW, Warszawa 1987, 9.

88 Przysięga Hipokratesa, < http://www.oil.org.pl >.

89 Bogusz J. Chorzy w stanach terminalnych a etyka zawodowa w medycynie, Bydgoszcz 1985, 5.

90 Kodeks etyki lekarskiej, < http://www.nil.org.pl >.

91 Biernacki E. Zasady poznania lekarskiego. E. Wende i s-ka, Warszawa 1911, 60.

or be lacking altogether'. In addition, after recovery of rational powers, the person who had been subjected to paternalistic actions should confirm the consent for our decisions made on his behalf, and agree that we did the best for him [92].

Such a conceptualization of paternalism (restriction of patient's freedom) may be considered as just, considering the fact that a seriously ill patient most frequently knows nothing about medicine, has no strength, and also often does not want to listen to a lecture concerning the advantages and disadvantages of a given method of treatment, not to mention the making of a decision in this matter. What he wants is only to totally trust a medical practitioner and follow his orders. Unfortunately, the border between authorized and unauthorized paternalism is not precisely delineated, therefore, it is difficult to assess from which moment a medical professional begins to betray a patient's trust. On the one hand, it could be assumed that the majority of patients are adults, thus satisfying the basic criterion of autonomy (adult – self-determined, self-maintained, self-responsible, etc.).

On the other hand, it may be assumed that each disease is the cause of the limitation of autonomy through uncertainty, lack of medical knowledge, and need for assistance. Thus, the only thing that we can state concerning the border between authorized and unauthorized paternalism is its changeability, which is affected by the change in the dynamics of relationships between the patient and medical professional. This is the patient's state which should legitimize the attitude of a medical professional. A patient who is unconscious should be approached in a different way (justified paternalism), differently in the first stage of the disease, differently during convalescence, and still differently in a chronic disease. This equivocality of paternalism evoked a fierce discussion concerning not only the way of its functioning, but also its validity.

The paternalistic model in medicine is associated with authoritarianism, domination, arbitration, manipulation of a patient or deceiving him. An especially acute criticism of paternalism was performed in Anglo-American ethics in the 70s and 80s of the 20th century. It was presumed that the whole of medicine, since as late as antiquity, has been paternalistic. Beauchamp and Childress in their 'Principles of Biomedical Ethics' formulated four principles of bioethics (so-called prinicipism): autonomy, beneficence, nonmaleficence, and justice. Unfortunately, their equivocality, which led to a conflict between the principles formulated, especially between patient autonomy and the autonomy and beneficence of a physician, did not end the dispute in this matter. In this dispute, the autonomy of a patient is brought to the forefront [93].

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92 Rawls J. A theory of justice. Oxford University Press, Oxford 1971, 248–249.

93 Komrad M.S. A defence of medical paternalism, maximizing patients autonomy. Journal of medical Ethics 1983, 9, 38–44.

The followers of autonomy emphasized that even in antiquity paternalism with relation to a patient was not quite clear [94]. In antiquity, paternalism was justified, purposeful, and morally legitimized in the case of persons who have no autonomy, or whose autonomy is to a sufficient degree restricted permanently or transitionally. In any other case the autonomy should be respected, even when it was restricted by a disease, because it concerned a human being ("free" – author's note) [95].

A patient's autonomy emphasizes his role in the process of treatment, enhances his dignity, and returns his freedom. Such a perspective of the medical professional-patient relationship resulted in the reformation of the medical law and ethical principles. Regulations protecting against the abuse with respect to patients incapable of expressing their consent in the process of treatment were developed, and various models of the medical professional-patient relationship were precisely specified (which have their reference to other medical professions). In bioethics, a legalistic model is mentioned – where, on the one hand, it is a physician, and on the other hand, a client, an economic or business, consumer model – where a physician deals with a consumer, and contract model – where the relationship between physician and patient is limited to negotiations or signing a contract. This contract is understood as a promise, moral or religious obligation [96, 97, 98].

The consumptive model assumes that the physician is a salesman of a certain medical product. He is subject to provisions similar to those concerning commercial services. He should inform a patient about benefits and risks borne, as well as concerning the costs. The physician's advice should be formulated in a way not to affect the patient's decisions, and the patient's decision, even if not in accordance with the medical art, is absolutely obligatory for a physician: 'The customer comes first' [99].

The subsequent model is the negative model. A physician and patient carry out a discussion about what is the most important for a patient psychologically and physically in the process of treatment. Both parties must accept all the established conditions. If a patient wishes so, the physician will accept this, all within this framework is good, e.g. resigning from treatment, assistance with suicide or an active euthanasia [100].

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94 Witwicki W. Platona państwo z dodaniem siedmiu ksiąg „Praw", PWN, Warszawa 1958, 458.

95 Biesaga T. Autonomia lekarza i pacjenta a cel medycyny. Medycyna Praktyczna, Kraków 2005, 3408.

96 Gajewski W.T. Paternalizm czy autonomia. Eskulap Świętokrzyski, 2005, 11

97 Pellegrino E. D. Thomasma D. C. The virtues in medical practice. Oxford University Press, New York – Oxford 1993, 56, 57–164.

98 Pellegrino E. D. Thomasma D. C. For the patient's good: the restoration of beneficence in health care. Oxford University Press, New York, 1988, 49.

99 Veatch R. M. Justice in health care: the contribution of Edmund Pellegrino. The Journal of Medicine and Philosophy, 1990, 15/3, 278–280.

100 Biesaga T. Autonomia lekarza i pacjenta a cel medycyny. Medycyna Praktyczna, Kraków 2005, 34 08.

The contract model assumes that both parties, the physician and patient, have a right to distrust and suspect protecting own autonomy. Therefore, while signing a contract a patient has a right to appoint prepaid experts, lawyers, who in his name will take care that the service is provided adequately and to the patient's benefit. A physician must take care of own affairs in a similar way. A patient wants a maximum medical service for a minimum price, whereas a physician wants to do the least for the highest price possible. While avoiding difficult demands he wants to exclude risky commitments, the dissatisfaction of which could end up in the courtroom [101, 102, 103].

This distrust and suspicion serves primarily the development of bureaucracy and enrichment of lawyers, while it limits the treatment to a minimum established in the contract, even if there emerge new therapeutic possibilities.

It is difficult to find evidence that the patient-medical professional relationship based on a contract (before contract there was no confidence) will better protect patient autonomy than the relationship patient-professional, where the basis is an obligation built on the patient's confidence in the medical professional.

The contract model, by its definition, does not impose engagement on the medical professional, and simultaneously evidences the lack of confidence on the part of the patient.

Such an approach may have a devastating effect on the ethos of the medical professional. Both parties (initially) as the only evil regard the lack of observance of the provisions of the contract. Considering the fact that a patient, due to the disease, is emotionally distorted, affected by pain, anxiety, sometimes despair, it is difficult to talk about a comparable predisposal of both parties of the signed contract. Also, very often, the level of medical knowledge (unless the patient is a medical professional) is considerably higher on the part of the medical professional. Such a contract, in order to satisfy the goal of bringing about good to a patient, should be signed between a medical professional and the patient's medical adviser, whom a patient has trusted [104].

Additionally, such a model of patient-medical professional relationship deprives the former (in the case of incompetence) of any chance for properly carried out therapy. From such a perspective, for example, people who are unconscious, disabled or afflicted by severe defects, mentally or terminally ill, have no chance of being properly treated, because they are not autonomous and responsible for

[101] Pellegrino E. D.- Toward a virtue-based normative ethics for the health professions. Kennedy Institute of Ethics Journal, 1995, 3, 267.

[102] Pupek-Musialik D. Bryt W. Pacjent – lekarz: relacja pozytywna a może konflikt postaw czy interesów?. [in:] Problematy i dylematy współczesnej medycyny, Ogólnopolska konferencja naukowa, Lublin 2005.

[103] Biesaga T. Pacjent jako osoba. [in:] Problematy i dylematy współczesnej medycyny, Ogólnopolska konferencja naukowa, Lublin 2005.

[104] Ibidem, 37–38

own future and own affairs. The autonomy of a patient has turned against him. Only those who are aware and strong may count on proper assistance, while weakness, by the fact itself, is inherent in the definition of a patient. In such a model of relationship, a physician loses his freedom (is frequently restricted to every word in the contract), and at the same time, not obliged in his occupational duties to use own conscience (he is only contractually obliged).

As it can be seen, the absolutization of autonomy in the relationship patient--medical professional may do much harm. Unfortunately, in the models discussed, the concept of the goal of medicine was lost. The patient's good was considered only from certain aspects. In this context, the paternalism-autonomism dispute occurred as a dispute between two forms of the same individualism, a dispute of an egoist freedom of a patient and an egoist freedom of the physician [105]. According to Vetach, autonomy gives each act the trait of rightness, irrespective if the act is good. Respecting such an autonomy is a moral obligation, even when it does not lead to any good [106]. In this way, autonomy was placed above patient's good.

Only an appropriate understanding of the goal of medicine may overcome weaknesses, not only of an autonomous approach to a patient, but also paternalism. Medicine is a specific domain of theory and practice, and similar to the relationship medical professional-patient, very complicated. To this relationship contribute elements of psychology, sociology, philosophy (ethics), law, and pedagogy. Without consideration of the contribution of each of these domains, a proper functioning of such a relationship is not possible. The goal of medicine is the care of a patient's health. The patient's good is a medical good, individual good of a patient, his personal good and ultimate good.

Therefore, the starting point and the point of reference, and the primary principle of medical ethics, is not the autonomy of the physician or patient, but beneficence with respect to patient, performed with mutual confidence. This includes patient care. Every health problem is the object of common concern for the physician and patient. A disease has not only a subjective dimension, it becomes, in such a relationship, an existential state of someone else. This state delineates the method of treatment, and how much autonomy or how much paternalism will be in the therapy. In such a relationship, neither freedom nor autonomy are the highest values, but another person [107, 108].

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[105] Gajewski W.T. Paternalizm czy autonomia. Eskulap Świętokrzyski, 2005, 11.

[106] Veatch R. M. Justice in health care: the contribution of Edmund Pellegrino. The Journal of Medicine and Philosophy, 1990, 15/3, 278–280.

[107] Pellegrino E. D.- Toward a virtue-based normative ethics for the health professions. Kennedy Institute of Ethics Journal, 1995, 3, 267.

[108] Pupek-Musialik D. Bryl W. – Pacjent – lekarz: relacja pozytywna a może konflikt postaw czy interesów? [in:] Problematy i dylematy współczesnej medycyny, Ogólnopolska konferencja naukowa, Lublin 2005, 50–51.

The value of a person should not be reduced only to one dimension – freedom. In this case, the criterion of good is dignity, and not freedom. Through respect for another man (a patient) we respect his autonomy.

Apart from autonomy, other elements also contribute to the patient's good. Apart from personal good (experienced by a patient bodily), the patient's good as a person, there is also a medical good. The latter is defined by knowledge and medical art. Only globally comprehended good may delineate the way of acting of a medical professional. In addition, confidence between the medical professional and patient, which cannot be guaranteed by any contract, also plays a very important role in therapy. Mutual trust will allow the building of an interpersonal relation, which will enable a medical professional to act in the best interest of the patient, and provides the patient with a feeling of safety. Confidence allows the patient to focus his efforts during therapy merely on the struggle with the disease. However, in order to gain this confidence it is not enough to be a physician, nurse, therapist or a paramedic [109, 110] .

For the building of confidence it is necessary to possess a specified moral level and a proper personality. In order to properly provide assistance to others one must be a good man. Any external goals with respect to medicine cannot play a primary role in therapy (money, power, prestige). Neither the State, nor politicians, pharmaceutical or industrial companies, or any other ideology cannot decide about treatment. The patient must always remain in the focus of actions by medical professionals. To the vices which certainly destroy confidence belong: greediness, corruptibility, incompetence, dishonesty, and lack of sensitivity. Confidence is enhanced by: sympathy, intellectual honesty, prudence, justice, and courage. A medical professional equipped in such traits creates conditions for trust and triggers in himself and in the patient all psychological and spiritual powers conducive to health [111].

1.4. Ethics of care as a foundation of relationships between medical professional and patient

The greatest error, which enables any distortions in the medical professional––patient relationship, in paternalistic and autonomic ethics, is the lack of balance between the subjects. In paternalism this is an excessive power of the medical

[109] Hartman J. Metodologiczna i społeczna koncepcja bioetyki. [in:] Problematy i dylematy współczesnej medycyny, Ogólnopolska konferencja naukowa, Lublin 2005, 39–40.

[110] Witek E. Mitologia choroby. [in:] Problematy i dylematy współczesnej medycyny, Ogólnopolska konferencja naukowa, Lublin 2005, 63–64.

[111] Biesaga T. Pacjent jako osoba. [in:] Problematy i dylematy współczesnej medycyny, Ogólnopolska konferencja naukowa, Lublin 2005, 37–38.

professional, while in the relationship based on autonomy, the patient's freedom placed above all [112].

Szewczyk proposes a new, balanced relationship, which he presents under the notion of the ethics of concern. He starts his considerations from the verification of autotelic good, presented in the ethical codes of physicians, nurses, paramedics, and physiotherapists. The medical code considers as its highest good: life, health, struggle with suffering, and patient care. The order of good is important. Life and health are most important, seemingly this is the right hierarchy, however, when fighting for life, often, in spite of everything, medicine begins to prolong a patient's death in an unjustified way. Patient and his significant others pay for it, financial costs increase, which is not without importance from the point of view of other patients. In other care, the part of medicine which has the task of controlling pain may be exposed to the temptation to ultimately eliminate this pain and perform euthanasia. While fighting for life and health and struggling with suffering, a medical professional may relatively quickly perform reification (objectification) of a patient. The patient's good is no longer the goal, the patient becomes a carrier of abstract concepts, such as health, life and suffering – becomes, for a medical professional, a means to obtain goal. Therefore, in the first place among autolitic goods in medicine patient care should be placed. In this context rescuing life, restoration of health or alleviation of suffering should be considered [113].

In order to define patient care and justify its primacy among autolitic goods, Szewczyk refers to Levinas's rationalism and philosophy of dialogue. He patterns the medical professional-patient relationship in the I/Other relation. As is known, this relationship is asymmetric, knowledge and experience are on the part of the medical professional, therefore, Szewczyk proposes role reversal. The patient will become the master and teacher [114].

The patient knows his pain and suffering the best, has own understanding of the world, including the perception of disease and death. The obligation of a medical professional is, by listening to a patient, recognize his world, and approach the patient's speech very widely (let us remember about body language) [115].

Nevertheless, medical obligation does not end at the sole listening. An attentive listening should be followed by a response [116].

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[112] Bauman Z. Etyka ponowoczesna. PWN, Warszawa 1996, 124.

[113] Szewczyk K. Dobro, zło i medycyna. Filozoficzne podstawy bioetyki kulturowej. PWN, Warszawa-Łódź 2001, 184–187.

[114] Szewczyk K. Troska, zaufanie i sprawiedliwość jako wartość ustanawiająca w etyce medycznej. Astrum, Wrocław 2000, 174.

[115] Szewczyk K. Dobro, zło i medycyna. Filozoficzne podstawy bioetyki kulturowej. PWN, Warszawa-Łódź 2001, 358.

[116] Szewczyk K. Troska, zaufanie i sprawiedliwość jako wartość ustanawiająca w etyce medycznej. Astrum, Wrocław 2000, 180.

In order to understand the patient's speech and properly respond to his requests, the medical professional must not only listen, but also know the patient's entire sociocultural context. The lack of proper understanding of a patient excludes an adequate care. Wide socio-psycho-philosophical knowledge about the patient and his environment is, according to Szewczyk, equally important for the process of care as medical knowledge *sensu stricte* [117].

In this concept, autonomy reveals itself in a relatively specific way. Following Levinas, Szewczyk speaks for freedom of choice of ways of doing good by medical staff, which in any case must be a response to the patient's request. The medical professional has a right, which is a positive freedom, to do good for a patient and to care of him. The patient's autonomy is restricted by compassion. Although a widely understood good is what the patient himself considers a value, he is not allowed in a moral sense to demand services, which would be a manifestation of unconcern with respect to him, or would be of an unjust character with relation to others [118].

In the case of inadequate patient's expectations, the medical professional has an obligation to convince the patient about the moral inadmissibility of such a request.

The dialogue between a medical professional and patient, apart from care, is established by one more value – justice. It brings care of patient, and reminding about the presence of society. According to Szewczyk, as an injustice may be considered the conduct of the physician or nurse who cares of the patient in an 'unrestricted' way (strength and means inadequate to the needs).

The basic values in the ethics of care are: occupational perfectionism, the above-mentioned autonomy, patient's confidence, patient's life, health, and elimination of pain and suffering. Here, pain and suffering are general concepts, their substantiation will also be the comfort and dignity of dying, as well as so-called 'calm death'. Care should limit actions which serve the sustaining of life. Dying and death are not relative, but are the final stage of earthly life, and in some circumstances, discontinuation of the fight for survival is the most appropriate. It is replaced by concern and care of a dying person. In the ethics of care, only the prohibition of euthanasia is of an unconditional character.

A patient, within his freedom, has at his disposal the possibility to break the relationship with the medical professional. In case if this relationship is not violated, in the ethics of care, there occurs a further value – patient's confidence. The obligation of the medical professional is to care about the patient's confidence and

[117] Szewczyk K. Etyka medyczna. Powstanie, rozwój, zadania. [in:] Medycyna i Humanistyka, Part I, Wrocław 1998, 29.

[118] Szewczyk K. Etyka i deontologia lekarska. PAU, Kraków 1994, 91.

never abuse it. The breaking of the relationship caused by the loss of confidence is considered as a moral fault of the medical professional [119].

In the process of building confidence, the space between subjects is filled with various emotions, from sympathy, through friendship, to love. The most appropriate state of emotion between the patient and medical professional is sympathy, understood as empathy (understanding of someone else's emotions, and not feeling the same). Love brings about fear for the beloved person, which hinders proper care. Compassion should not be confused with love [120].

Szewczyk, after Ramsay, names the medical professional-patient relationship which is in accordance with values an alliance. The alliance is of a dialogue character, based on trust on the part of the patient. In order not to lead to the breaking of the alliance, the medical professional must resign from the role of an expert and his claims of being infallible. He does not have to have a final word in this dialogue, but should be accompanied by the awareness that in the contact with the patient he is obliged to take into account patient's pain, suffering, helplessness, feeling of guilt, shame, as well as insincerity resulting from the shame of feeling guilty, and often also rebellion and aggression resulting from the feeling of being disadvantaged. Simultaneously, a medical professional should, in his relationship with the patient, consider occupational moral standards. The maintenance of patient's confidence consists in a constant balancing between one and the other. This is how, in the ethics of care, medical occupational professionalism is understood. A good medical professional is not only fluent in the technical part of his occupation, but most of all is a wise man. Moral norms obtain their validity only due to ethical virtues. A wise man triggers the entire system of care. The most important virtues of a medical professional are moral sensitivity, need for recognizing and assimilate values, which must be accompanied by intellectual sensitivity. A wise medical professional constantly expands his medical and ethical knowledge, respects someone else's autonomy, is tolerant, kind, patient, loyal and evokes trust. These virtues are a basis which allows patient care.

Concern should always be accompanied by the skills of listening and empathy. Such knowledge and skills should be acquired as early as at the basic educational stage.

The acquisition of such knowledge should take place at every stage of occupational development.

> *"The acquisition of knowledge should be a process which has no end, which is strongly connected with obtaining knowledge of facts and ethics. Both types*

[119] Szewczyk K. Chwytanie się metafory. Przyczynek do opisu świadomości tanatologicznej naszych czasów. Kultura i Społeczeństwo, 1998, 2, 175.

[120] Szewczyk K. Etyka medyczna jako etyka troski. Wydawnictwo AM, Łódź 1998, 55.

of knowledge and skills are extremely important for the physician and nurse, and are a part of occupational perfectionism"[121].

In the patient-medical professional relationship the latter must always be aware of the ethical goals of his current actions, health, life, dignity or comfort of dying.

Ethics of care, apart from the relationship < I – Other> (patient-medical professional), considers the place of the < Third >, society, speaking about restriction of care by the previously-mentioned justice. Szewczyk postulates the development of institutional rules of just distribution of care. In the situation of deficit, the distribution of allowances for treatment should be approached as a 'statistical compassion', and should concern the organizers of public health and medical professionals who have contact with the patients themselves.

"The concerned, and at the same time, just physician must learn to place an individual patient on the background of a community wider than the patient – family, people afflicted by the same disease, finally an individual age group. An administrator of medical services who shows these virtues must absolutely strive towards the foundation of institutions which would enable physicians and nurses to practice just medicine, responsibly sharing care on the level of patient-medical professional relationship, however, with consideration of the Third" [122].

Undoubtedly, an extensive interpretation of the ethics of care concerning behaviours with respect to the patient, caring, listening, responding, knowledge of patient's philosophical-social context, is a very humanitarian reference to another man which, in this case, is the patient. It establishes high requirements for the medical staff, similar to the requirement of being a wise man, i.e. sensitive, patient, tolerant, evoking confidence, open to knowledge, and medical and behavioural skills. This is indeed an unattainable ideal of the medical professional, however, worthy of attempts to attain it. The postulate concerning the new methods of education of future medical professional at Medical University is also noteworthy. In the entire concept by Szewczyk, only social justice in treatment may evoke doubt. Human life and health are such precious values that without clear and unequivocal guidelines concerning the distribution of medical funds, there open wide grounds for abuse, however, this is a problem for another dissertation.

[121] Szewczyk K. Psucie złota (polemika z poglądami Petera Singera). Edukacja filozoficzna, 1997, 2, 121.

[122] Ibidem, 121.

2. Motivation, knowledge and skills – communication competences

Communication is a common and basic form of human interaction. Throughout their lives, people develop their communication competences in an intuitive way. Each social interaction, formal or informal, provides a testing-ground for developing communication skills. However, because this knowledge is often acquired outside the structure of formal education, it is often disordered and its practical value not always appreciated. Systematically gaining knowledge of communication skills is not easy, especially as less and less time tends to be spent on writing. It is this systematic knowledge of communication skills, which is generally learnt at school. In family homes, people develop the principles of social coexistence; but not for example how to make eye contact (i.e. showing willingness to communicate) and how to use gestures. These skills are not usually taught, but acquired through practice [123].

Scientists engaged in research concerning communication (philosophers, psychologists, sociologists, educators and psychotherapists) show not only knowledge may be acquired, but we can effectively develop skills as well. They demonstrate that difficulties of people in adapting, for instance, to the role of physician, may result from improper communication with other people. Furthermore, they point out that the communication between the physician and the patient is an important therapeutic factor [124,125]. There are various theories of communication. Some of them deal with considerations about communicating as a method of applying pressure (manipulation). Man is treated there as an object of influence. The next theories concern information. In these approaches, the communicators constitute a system that can be described by mathematical-technical language, and man is one of many equivalent elements of the system and does not have individual characteristics. There are opposing trends based on humanistic psychology. In this approach, man in communication is mainly committed to the goal of self-realization, i.e. the full development [126, 127].

[123] Morreale S.P. Spitzberg B.H. Barge J.K. Komunikacja między ludźmi, motywacja, wiedza i umiejętności. PWN, Warszawa 2007, 66–68, 75–79, 87.

[124] Grzesiuk L. Trzebińska E. Jak ludzie porozumiewają się? Instytut Wydawniczy „Nasza Księgarnia", Warszawa 1978, 8–9,

[125] Mayerscough P.R. Ford M. Jak rozmawiać z pacjentem. Wydawnictwo psychologiczne; Gdańsk 2001, 13.

[126] Mika S. Wstęp do psychologii społecznej; PWN, Warszawa 1972 [in:] Grzesiuk L. Trzebińska E.- Jak ludzie porozumiewają się? Instytut Wydawniczy „Nasza Księgarnia", Warszawa 1978, 8.

[127] Newcomb T. M. Turner R.H. Converse P.E. Psychologia społeczna, PWN, Warszawa 1970 [in:] Grzesiuk L. Trzebińska E. – Jak ludzie porozumiewają się? Instytut Wydawniczy „Nasza Księgarnia", Warszawa 1978, 9.

We based this work on theories considering the balance between pursuing one's own aspirations (i.e. job satisfaction of physician) and satisfying the desires of other people (i.e. the health and satisfaction of patient). We will start by defining the term "communication competence", that is the way in which appropriate communication is measured. There are several definitions of the term.

1. **Communication competence** defines the extent to which the desired outcomes are accomplished through communication in a way appropriate to the context. It determines whether a person communicates effectively and adequately to the context [128] .
2. **Communication competence** is the use of verbal and / or non-verbal behavior to accomplish the preferred outcomes in a way that is fitting the context [129].
3. **Communication competence** is the ability to communicate using verbal and non-verbal language (the term introduced to psycholinguistics by Campbell and Wales in 1970). Knowing all the rules of language use depending on the situation and the social role is a feature of communicative competence [130].

These definitions, that were developed in the rules and principles of communication, describe what should be the content and form of communication depending on who, with whom, under what circumstances and for what purpose undertakes the exchange of information. On the one hand, they indicate how to behave in a given situation, and on the other hand, they affect the expectations of the other party. Non-compliance with these rules, resulting from their ignorance or disregard, can cause confusion, anxiety or dissatisfaction, for example, of the patient. It may also cause the appearance of unrealistic expectations in a patient (expectation of "a miracle") [131].

The number of impressions caused by communication behaviors is uncountable, and therefore in order to better define the communication competence, we will focus on the basic standards of **clarity, appropriateness and effectiveness in communication.**

Clarity is the basis of utterance; it combines the precision of the message (clarity) and an understanding, i.e. the extent to which the communicator understands the intended meaning of information. In social relations, both the precision of utterance and understanding, are not the goals as such. Interpersonal relationships are the ultimate goal, therefore defining of good communication by clarity raises some implications difficult to define unambiguously. Some communication theorists assume that the precision and understanding lead to **consent,** i.e. professing

[128] Spitzberg B.H. Cupach W.R. Interpersonal Communications and competence, Beverly Hills 1984, [in:] Morreale S.P. Spitzberg B.H. Barge J.K. Komunikacja między ludźmi, motywacja, wiedza i umiejętności. PWN, Warszawa 2007, 65

[129] Morreale S.P. Spitzberg B.H. Barge J.K. Komunikacja między ludźmi, motywacja, wiedza i umiejętności. PWN, Warszawa 2007, 66–68, 75–79, 87.

[130] Podgórecki J. Komunikacja społeczna, Instytut Nauk Pedagogicznych, Opole 2000, 2–5.

[131] Salmon P. Psychologia w medycynie. GWP, Gdańsk 2002, 148.

similar values and beliefs on a given subject. Unfortunately, practice shows that even with good precision and understanding, without the goodwill of the parties, consent is not possible. Similarly, precision as an independent measure of the communication competence is questionable; sometimes too precise message violates the norms of politeness, and consequently causes a lack of understanding. **Ambiguous communication** used instead produces a better effect [132, 133].

Appropriateness of communication is a standard that is applicable in a given context, i.e. avoiding violation of the rules of behavior that are codified in every culture, community groups and associations. Appropriate communication is usually unnoticeable to the participants. Only violation of the rules of appropriateness by eliciting sanctions shows communication inappropriateness. **Sanction** is the kind of feedback that makes the communicators aware of breaking the rules. Appropriateness is always assessed by other people [134].

We evaluate the **effectiveness** by ourselves; it describes the extent to which communication achieves the desired outcome. Each party of communication usually expects different results. A physician expects the effects of his help, respect, satisfaction, etc. and the patient frequently expects improvement of health, though competitive goals may happen (other profits resulting from the patient's role). The effectiveness of communication is closely related to the concept of **goals**. How do we know that we are effective in communication? It can be estimated by the obtained outcomes of communication. We have the valued outcome, we achieve the goal that we have set (the easiest way to evaluate the outcomes is by comparison to the realized goals). We achieve something that required a lot of effort from us [135]. Standards are interrelated.

Good communication must be correct in all three aspects, errors may occur particularly with regard to the effectiveness and appropriateness. The theorists provide four types of goal-oriented communication behavior: inappropriate and ineffective, inappropriate and effective, appropriate and ineffective, and appropriate and effective. Based on the above behavior, communicative competence grid has been developed.

Minimizing communication is the type of communication in which we are inappropriate and ineffective. We fail to achieve the desired goal of communication; in addition we discourage our interlocutors. A good example of this behavior is shouting at the interlocutor, the frustration, aggression, resentment, etc., demonstrated by the pitch/tone of voice and the body.

[132] Cupach W.R. Spitzberg B.H. The dark side of interpersonal Communications. Erlbaum, Hillsdale NJ 1994, 105–124.

[133] Eisenberg E.M. Ambiguity as strategy in organizational communication. Communication Monographs, 51, 1984, 224–242.

[134] Morreale S.P. Spitzberg B.H. Barge J.K. Komunikacja między ludźmi, motywacja, wiedza i umiejętności. PWN, Warszawa 2007, 66–68, 75–79.

[135] Dervin B. Voight M.J. Progress in communication sciences v. 3, Norwood, NJ 1982, 85–126.

Sufficing communication – in this case, the communicator behaves properly, but this will not affect his/her effectiveness. The communicator lacks openness and willingness to communicate. The attitude of communicator allows for surviving in relationships with other people. This may be due to his/her timidity, problems with eloquence, low self-esteem, etc.

Maximizing communication – in this case, the person behaves inappropriately but is effective. He/she will achieve the goals primarily by drawing attention and aggression. The goal is a single win and not a lasting and proper communication; therefore, the communicator uses lying, manipulation, coercion, exploitation and hurting others.

Optimizing communication – this is the proper kind of communication. Interlocutors achieve their goals in an appropriate way accepted by both parties. The effectiveness is supported by satisfaction and the prospect of further appropriate communication [136].

The complexity of reality makes the stability of proper communicative competences difficult. The balance between being appropriate and a desire for effectiveness is very delicate. The grid of communication competence is a kind of most important guidelines in this complex relationship. It shows, however, only what in this regard should be achieved but does not show how to do it. In a broader perspective, the factors influencing the appropriateness and effectiveness are the motivation, knowledge, skills and contexts.

Motivation is the extent to which a person seeks competent communication in a given context. Motivation can be negative or positive, affective and cognitive, and focused on I, or the Others.

Negative motivation is caused by factors that make communication difficult, such as fear, anxiety, and consequently avoiding contacts with other people. In this case, the most important is self-knowledge concerning motivation for communication. It allows for choosing the solution appropriate for a given (negatively-motivated) person; for example the choice of studies and professional career requiring little communication skills (not medical studies) or effective intra- and interpersonal training.

Positive motivation results from the effort we put in communication with other people, as well as our expectations. With the increase in effort and benefits, positive motivation increases. For example, a medical worker on an internship is much more positively motivated for communication (as he/she is subject to assessment and trying to get a job) than the long-term worker employed for an indefinite period. Positive / negative motivation dichotomy is also used to influence others. In this aspect,

[136] Cahn D.D. Conflict in personal relationships. Hillsdale, NJ 1994, 183–202.

we decide whether the message is helpful or detrimental, and that brings agreement or divisions, and whether it is/ is not beneficial for others [137].

In **affective / cognitive** terms, motivation is defined by the extent of influence of emotions or intentions on interpersonal communication. Each message can express mainly emotions or be the product of thinking and planning and insight into own emotions. Focusing on **I / The Other** explains whose needs are to be met by the communication. In the optimizing version the needs of both communicators should be satisfied.

Knowledge is also essential for the competent communication. It includes the content about what to say, i.e. **declarative knowledge**, and the procedures by which the content will be presented, i.e. **procedural knowledge**. **Declarative knowledge** includes knowledge of topics, words, meanings required in a given situation.

Procedural knowledge is the knowledge about how to collect, plan, and restore declarative knowledge in a given situation. Since all cultures appreciate the communicative competences, common cross-cultural rules have been developed, assuming that a fully competent person is aware of cultural differences and has knowledge about them.

The (intercultural) rules of conversation comprise:

Courtesy: speaking correct language, courteous statements, the right style of nonverbal behavior, asking for feedback, active listening,

Roles: recognition of ethnic identity, avoiding stereotyping, gender- related behavior, playing the role of a professional or a student,

Content: using the correct argumentation in the statements, complying with the theme of the conversation, constructive criticism,

Expressiveness: assertive manner of speaking, without prejudice to the rights of another person, openness,

Interpersonal relations: showing the appropriate level of dominance or submission, expressing appropriate friendliness or hostility, the feeling of freedom, perception of predictability in the behavior of the other person, showing confidence,

Goal: gathering information, achieving personal goals,

Understanding: being empathic in the right way (not excessively), being understood,

Self-affirmation: mutual acknowledgment of own statements, self-esteem,

Acknowledging cultural affiliation: the pride of own cultural identity, avoiding shame or embarrassment [138].

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[137] Morreale S.P. Spitzberg B.H. Barge J.K. Komunikacja między ludźmi, motywacja, wiedza i umiejętności. PWN, Warszawa 2007, 66–68.

[138] Collier M.J. A comparison of conversations among and between domestic culture groups: How intra- and intercultural competencies vary. Communication Quarterly, 36, 122–144.

Skills are the final essential element of the communication competence, i.e. goal-oriented repetitive behaviors. The repeatability of behaviors proves their mastery and conscious use in certain situations. Communication skills are at a general and individual level. The **general level** of skills includes, among others: asking questions, presenting facial expression of emotions (anger, sadness, joy, etc.) associated with the greeting (bows, hugs, waving). At the **individual level**, each communication event presents a unique interaction. Therefore, some of the skills are used in all the meetings, and the others – only occasionally. Different roles and situations require different connections of mastered skills. However, one can always use the baggage of experience resulting from performing various social roles. This knowledge is called a **working model**.

Each relationship between people takes place in a specific context. **The context** sets boundaries that allow for better defining what is the process of communication and how it should look like. The context is characterized mainly by the **type and level**. Types of contexts relate to culture, the time in which there is an interaction, interpersonal relationships, situations, and functions. The context level is defined by the number of people involved in the communication (interpersonal context, small group, and public communication) [139].

Cultural context includes sustainable patterns of judgments and behaviors characteristic of a certain group. In communication, **time** is the collective and the individual reception of the sequence and progress of events.

Interpersonal relationships are another kind of context. The behavior of one of the communicators affects the behavior of the other. Achieving the communication goals is closely related with the objectives of the interlocutors. The degree of mutual influence is determined by **affiliation**, i.e. emotional aspect of the relationship involving intimacy (love, friendship, sexual desire, affection, etc.), kinship (being a child, parent, relative or kinsman), and hostility. Closeness in the relationship affects the communication competence. Moreover, the people who are able to achieve intimacy in communication, represent a high level of communication competence [140, 141].

Place is the fourth type of the context. It contains all the physical characteristics: temperature, light, space, the location of objects and the means by which we communicate and has a direct impact on the quality of communication. The last

[139] Spitzberg B.H. Brunner C.C. Toward a theoretical integration of context and competence inference research. Western Journal of Speech Communication, 56, 1991, 28–46; [in:] Morreale S.P. Spitzberg B.H, Barge J.K. – Komunikacja między ludźmi, motywacja, wiedza i umiejętności. PWN, Warszawa 2007.

[140] Gudykunst W.B. Nishida T. The influence of cultural variability on perceptions of communication behavior associated with relationship terms. Human Communication Research, 13, 1986, 147–166.

[141] Knapp M.L. Ellis D.G. Williams B.A. Perceptions of communication behavior associated with relationship terms. Communication Monographs, 47, 1980, 267–278.

type of context is **function**, i.e. everything the interlocutors wish to attain at the meeting. Finally, let us consider the overall communication process.
Conscious intentions of the communicator serve different purposes:

1. They meet the needs and benefits of the communicator,
2. They meet the needs of the interlocutor,
3. They serve getting familiar with the views, feelings, beliefs of both of the interlocutors (without the intention to influence),
4. In technical terms, they are used to achieve common goals.

Frequently, intentions are of mixed character. For their implementation, there is a **content**, which is appropriately **codified**. Apart from words, we encode the content by facial expressions, gestures, tone, looking (or not) at the interlocutor's eyes, physical distance, appearance (dress, make-up), and the gestures of the entire body. They are called **signals.** Silence is also one of them. The signals can be intentional or unintentional. Regardless of the intentions of the communicator, all of the signals are decoded.

The interlocutor uses **decoding** in order to understand the communicator's signals. **Interpretation** is always just the interlocutor's idea as to the intention of the communicator (without clarification it may be far from the intentions of the communicator). The interlocutor is not a machine, his/her interpretation is affected by current emotions; the same message might, depending on the mood of the interlocutor, have a good or bad interpretation. From the communicator's information, the interlocutor will chose first what he/she needs, what is interesting, unknown or new. In addition, he/she will always refer to his/her experiences and the message will be interpreted with regard to his/her experiences. The interpretation is also affected by the mutual communicator-interlocutor relationship. Therefore, for the best interpretation of the communicator's content, **feedback** is necessary, that is comparison of the communicator's intention with the interlocutor's interpretation. Without feedback, each message will be hardly explicit [142].

The above knowledge shows, that in order to be perceived as a communication-competent person, it is not enough just to be polite, courteous and kind, or have professional knowledge (e.g. needed in medical professions for care, medical rescue and rehabilitation). One needs to have the right motivation, as well as context- appropriate knowledge and skills. In the medical professions, involving working with people, communication competence is an essential tool in work, and education motivation, knowledge and communication skills increases the likelihood of giving appropriate assistance.

[142] Grzesiuk L. Trzebińska E. Jak ludzie porozumiewają się? Instytut Wydawniczy „Nasza Księgarnia", Warszawa 1978, 13–27.

3. Interpersonal communication and quality care

Appropriate information and informing the patient about his/her health condition, securing the dignity and sense of safety, showing respect and support by the physician, allow for good communication, and thus getting to the core of the disease, and provide the physician with respect and cooperation of patients. Therefore, let us discuss in sequence each of the conditions of good physician-patient relationship.

Studies confirm that patients usually expect precise information about their health. They want to understand what is happening to them, it allows them to "give sense" to the disease affecting them and its symptoms [143, 144].

Psychical symptoms of patients undergoing treatment have been divided into two types. **Fear of consequence** concerns the results of treatment and **procedural anxiety** – the intervention itself. The first kind of fear is most often unavoidable, although its level decreases with better communication level between the medical staff and the patient. High level of procedural anxiety clearly confirms the negligence of physicians in providing information to the patients. Explaining during surgery or therapy, what will happen and what the patient will be feeling, prevents the accumulation of procedural anxiety. To make that information effective, one should refer to the patient's experiences, and not provide information from the perspective of physician (often incomprehensible to the patient).

Ensuring the patients that their feelings are **normal** (!) in such circumstances, as opposed to such messages as "do not be afraid" or "please do not be upset", which deprive the patients of the right to possess feelings – reduces the sense of threat.

Many patients, despite a strong sense of anxiety and fear, avoid talking about their feelings, reasonably considering them unfounded, which of course does not eliminate the feelings, only suppresses them. So the first task of the physician is to identify the patient's sensations (the easiest way is to ask), and then ensure him/her that strong fears, from the rational point of view, without the reasons are treated as **normal** (!).The anxiety level is also reduced by the information about what the patient can do to make the medical staff activities easier. The patient focuses then on the problem or activity, but not on fear [145]. His/her participation in decision-making (locus of control) leads to consent to the activities of physician and, more importantly, the patient fulfills physician's recommendations. It may seem para-

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143 Ley P. Communicating with patients. Improving communication, satisfaction and compliance. Chapman and Hall, London 1988, 20–50.

144 Salmon P. Psychologia w medycynie. GWP, Gdańsk 2002; 156–157.

145 Ibidem.

doxical that on the one hand, patients expect choice opportunities and the offer of taking control in the treatment process (to what medical interventions they agree, what type of treatment they chose etc.), on the other hand, they cannot and usually do not want to take responsibility in this process. The solution becomes easy when we realize what the choice and control really mean for the patient.

Patients expect the physician to listen to their concerns and preferences, and will ensure them to be taken into account when making decisions. Patients' involvement during treatment will also be possible (a list of actions that the patients might take to assist physician in treatment). It should be remembered that the involvement is a condition that might be judged only by the patient. It must make sense from the patient's point of view. Many of patients' needs are met by involving patients in treatment and making information accessible to them.

Patients also expect from the physician (which is rarely explicitly verbalized) respect for the dignity and sense of security. Autonomy and dignity are particularly important when dealing with someone's body. And although patients expect from the physician help, and theoretically should give themselves into physician's hands without any claims, the duty of physician is to obtain a consent for any activity, starting from examination of the throat through measuring the blood pressure up to and including major surgery. Failure to follow these rules only apparently makes the physicians' work easier and shortens their working time. In the end, it leads to non-adherence to recommendations, passive resistance, lack of progress in therapy and at the end a bad opinion about the physician's work [146].

Unfortunately, in medical practice, the medical personnel usually consider normal conducting medical procedures on the body of the patient without the patients' consent and without giving them a choice. And even a revolutionary change in medicine would be simply to ask the patients, in relation to the provision of information, what they would like to know. Then the patients would define their needs accurately, and in addition would give the physicians additional information about how much they want to control their condition.

Extensive European research on patient satisfaction was conducted using a questionnaire EUROPEP, consisting of 7 modules:

1. Patient's feelings during taking history by the doctor,
2. Patient's feelings during a physical examination,
3. Information received by patients from the doctor about the disease and treatment,
4. Patient's feelings about the disease history (previous visits) and the future (specialist consultations, hospitalizations),
5. Assessment of patient's contacts with other medical personnel,
6. Overall assessment of the GP,

[146] Peerbhoy D. Hall G.M. Parker C. Shenkin A. Salmon P. Social Science and Medicine. 47, 5, 1 September 1998, 595–601(7).

7. Patient's personal data [147].

The study was conducted in 16 countries: Austria, Belgium, Denmark, Finland, France, Spain, Holland, Iceland, Israel, Germany, Norway, Portugal, Slovenia, Sweden, Switzerland, and the United Kingdom. In each country, patients emphasized that they got satisfaction from everything that was based on good communication with physicians.

- adequate (in patient's opinion) duration of the consultation – care of the patient's needs
- confidentiality of information – a sense of security and dignity,
- complete information about the disease – the dignity of the patients and the control of their own health,
- making the patients feel comfortable talking about their illness – the feeling of being listened to and understood,
- the ability to be treated constantly by the same doctor – relationship based on ties,
- information obtained from the physician about prevention of diseases – knowledge emphasizing patient decision-making in the treatment.

The above activities considered satisfying for the patient, accounted for 80% of all those in the study [148].

Therefore a postulate addressed to physicians, is taking up training on communication skills, as well as the introduction of such training to the curriculum minimum for all medical majors. This is not only to facilitate the exercise of the profession or improvement of professional qualifications, but is the basic element of professional skills.

Here are the basic **rules,** under which correct **communication trainings** are built:

1. **Knowing self** – every day we should spend fifteen – twenty minutes to analyze the objectives taken by us, as well as our traits of character and ways of conduct in everyday life.
2. **Interoperability** – the grounds of good communication is our concern for the fair meeting of our commitments and reliability in fulfilling promises.
3. **Selectivity of reception** – we should remember that there are no physical abilities to receive all the messages flowing from us and to us, and during the selection, an unintended change of meaning may occur.
4. **Too early assessment** – the biggest obstacle to communication is the tendency to deny, judge or evaluate, before listening and understanding the message coming to us.

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147 Kurpas D. Sapilak B.J. Steciwko A.F. Ocena satysfakcji pacjenta dializowanego jako wykładnik jakości opieki długoterminowej świadczonej w praktyce lekarza rodzinnego. Problemy Lekarskie 2006, 45, 3, 99–100.

148 Ibidem, 99–100.

5. **Comprehensive defense** – no agreement can be reached, if we assume our right and infallibility in each case in advance.
6. **The meaning** is more important than the form – focusing only on the form of communication or on specific words or parts of sentences may be a barrier to good communication.
7. **Sensitivity to the condition of the recipient** of message- during communication careful attention should be paid to non-verbal information (body language, facial expression, voice intonation), which most completely reflects the emotional state of our interlocutor.
8. **Design of feedback** – asking many questions is conducive to deeper understanding and minimizes misinterpretation of coming to us message.
9. **Decrease of embarrassment** – full acceptance of asked questions, without malicious comments or gestures of disapproval provides good communication atmosphere.
10. **Clear presentation of the problem** – while communicating we stick to a clearly defined problem without digressing.
11. **Relativity of views** – mental readiness and openness is needed in good communication for considering a different opinion.
12. **Change of roles** – for good communication sometimes it is worth looking at the problem from the interlocutor's point of view.
13. **Advantages of disagreement** – it is worth remembering that disagreement is an integral part of social life, and this allows for enriching our own point of view. Someone who has different opinion than ours is not our enemy.
14. **Mild denial** – the objection or discord are parts of appropriate communication; only the way we do it is important. It should be expressed in the mildest possible form.
15. **Respect for the partner** – indicating the weaknesses or the shortcomings of interlocutor's personality is highly conflict -triggering. Assessment should concern the content and not the person. If the criticism concerns the behavior, then we evaluate only a particular attitude or specific behavior.
16. **Encouraging** – a smile, praise, approval, are important elements of good communication. We should take every opportunity to express them to our interlocutor; it encourages and triggers goodwill.
17. **Building security** – nobody changes their beliefs under the influence of advice, persuasion or requests. It needs a broader look at the problem. However, it is impossible without a sense of security.
18. **Non-verbal behavior** – the tone of voice, facial expressions and gestures can cause reluctance or irritation. Therefore, during conversation we try to avoid those elements of non-verbal communication, which we do not approve in others.

19. **Maintaining concision** – during conversation, we should be argumentative, it does not matter whether we talk about something cheerfully or seriously, and at what level of abstraction; concision is important.
20. **Importance of the interlocutor** – while talking to us, each interlocutor must have a sense of being an important person, it does not matter, what role he/she plays; whether he/she is our superior, or our patient [149].

Finally, the benefits that can be achieved during good communication between health professional and patient are worth reviewing and highlighting. Undoubtedly, they are highly significant and allow for practicing the medical professions in the right way.

Good communication results in:

1. decrease of emotional tension in a patient (which allows further communication and exchange of information),
2. obtaining accurate data, allowing for effective diagnosis of the illness,
3. decrease of the patient's resistance to therapy and to medical professional,
4. enhancing the confidence of patient in physician (the patient may be persuaded to different ways of therapy),
5. increase of the patient's involvement in the treatment process (no need to control patients, they care for their own good),
6. increase in the patient satisfaction level and thus decrease in the number of complaints against individual physicians and generally health care [150, 151].

[149] Więckowska E. Zasady komunikowania międzyludzkiego. [in:] Komunikowanie się lekarza z pacjentem. Astrum, Wrocław 2000, 28–32.

[150] Manyande A. Salmon P. Effects of preoperative relaxation training on postoperative analgesia: immediate increase and delayed reduction. British Journal of Health Psychology 3, 1996, 215–224.

[151] Barański J. Waszyński E. Steciwko A. Komunikowanie się lekarza z pacjentem. Astrum, Wrocław 2000, 155–163.

4. Current issues and discussions about communication between professionals and patients

4.1. Overview

Dissonance between the high 'technical' professionalism of health professionals and a relatively low level of patient satisfaction with care received is a phenomenon observed in many countries. Some studies show, that the above-mentioned situation occurs in the case of an inadequate interpersonal communication between health care professionals and patients.

The literature concerning the scope of problems discussed is comprehensive and has been the subject of many reports of a review or meta-analysis character. At the beginning of this century, the impact of training programmes on nursing communication was called into question by Kruijveret et al. [152]. The recent meta-analysis showed a moderate effect of communication skills training (CST) on communication behaviour. Patients might benefit from specifically trained health professionals, but strong studies are lacking. Despite this, applying CST for professionals is a promising approach to change their communication behaviour and attitudes [153,154]. Another article reports on a systematic review of qualitative studies on patients' experiences of preoperative communication with healthcare professionals. The authors conclude, that communication is critical for providing efficient care to patients. However, healthcare professionals showed different needs and feelings for communication [155].

The communication skills and art associated with nursing services are neither innate nor automatic. Communication skills are acquired and refined only through practice. Some results suggest that a communication skills training programme could be valuable for reinforcing basic/intuitive communication strate-

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[152] Kruijver IP. Kerkstra A. Francke AL. et al. Evaluation of communication training programs in nursing care: a review of the literature. Patient Educ Couns. 2000, 39 (1), 29–45.

[153] Barth J. Lannen P. Efficacy of communication skills training courses in oncology: a systematic review and meta-analysis. Ann Oncol. 2011, 22(5), 1030–1040.

[154] Sargeant J. MacLeod T. Murray A. An interprofessional approach to teaching communication skills. J Contin Educ Health Prof. 2011, 31(4), 265–267.

[155] Chan Z. Kan C. Lee P. Chan I. Lam J. A systematic review of qualitative studies: patients' experiences of preoperative communication. J Clin Nurs. 2012, 21(5–6), 812–824.

gies, assisting in the acquisition of new skills, and ensuring communication supply availability [156, 157, 158].

Effective communication is a vital component of nursing care, however, nurses often lack the skills to communicate with patients and other health care professionals. Communication skills training programmes are frequently used to develop these skills. However, there is a paucity of data on how to evaluate such courses in the best way. A number of recent developments in medical and nursing education have highlighted the importance of communication and consultation skills (CCS). Although such skills are taught in all medical and nursing undergraduate curricula, there is no comprehensive screening or assessment programme of CCS [159].

Empathic communication skills are critical for providing high-quality nursing care to holistically understand the patient's perspective. Implications for practice explore the utility of empathy instruments in nurse education, such as empathy progression through the curricula. For nursing educators, the development of instruments to measure the effectiveness of teaching strategies and pedagogy for empathy enhancement in practice is important [160].

Some authors use the Empathic Communication Skills Scale (ECSS) and the Empathic Tendency Scale (ETS) to evaluate the empathic skills and empathetic tendency of nursing students. Their findings have shown that empathic skills are developed during undergraduate nursing education. However, at the same time, the empathetic tendency has been in decline [161].

The aim of another study was to evaluate the relationship between students' self rating of their own communication ability and their satisfaction with a nurse training course, compared with an objective measure of communication skills [162]. A similar survey was conducted to gain insight into the role of European haematology nurses and identify their learning needs. The respondents believed that they were

156 Włoszczak-Szubzda A. Kompetencje komunikacyjne personelu medycznego. Badanie stanu oraz ocena potrzeb komunikacyjnych (Communication competencies of medical personnel. Testing and assessment of communication skills). Poland: Medical University of Lublin, Lublin 2009 (in Polish).

157 Włoszczak-Szubzda A. Jarosz M.J. Professional communication competences of nurses. Ann Agric Environ Med. 2012, 19(3), 601–607.

158 Radtke JV. Tate JA. Happ MB. Nurses' perceptions of communication training in the ICU. Intensive Crit Care Nurs. 2012, 28(1), 16–25.

159 Ryan CA. Walshe N. Gaffney R. Shanks A. Burgoyne L. Wiskin CM. Using standardized patients to assess communication skills in medical and nursing students. BMC Med Educ. 2010, 17(10), 24.

160 McMillan LR. Shannon DM. Psychometric Analysis of the JSPE Nursing Student Version R: Comparison of Senior BSN Students and Medical Students Attitudes toward Empathy in Patient Care. ISRN Nurs. 2011, 726063. Published online 2011 May 11.

161 Ozcan CT. Oflaz F. Sutcu Cicek H. Empathy: the effects of undergraduate nursing education in Turkey. Int Nurs Rev. 2010, 57(4), 493–499.

162 Mullan BA. Kothe EJ. Evaluating a nursing communication skills training course: The relationships between self-rated ability, satisfaction, and actual performance. Nurse Educ Pract. 2010, 10(6), 374–378.

well trained, possessed good communication skills and played a key role within the multidisciplinary team. However, a small but significant number of nurses indicated that they had a limited role to play in patient education (42%), and only 38% agreed that they played an important role in facilitating patient choice [163].

Measuring patient-centred communication is notoriously difficult. There is a need for several measures as proxies for patient centeredness: empathetic behaviours, 'reciprocity', decreased biomedical talk, 'appropriate responses' and length of uninterrupted patient talk. Using real patients and assessing their satisfaction with communication may be the ideal method [164].

Other authors have underlined that a short course for nurses on handling difficult communication situations resulted in significant improvements in self--efficacy, but not in performance. Teaching communication skills in community--based settings are important for the safety and effectiveness of patient care. One possible approach is to focus on specific communication skills rather than a full suite of skills [165].

Many researchers and educators focus on psychiatric, oncologic, and terminal care nursing. Some of them underline that psychiatric nursing is a specialty that emphasizes utilization of communication skills to develop therapeutic relationships. Patient simulation, including High Fidelity Human Simulation (HFHS), is one method that may be used for students to practice and become proficient with communication skills in a simulated environment [166, 167, 168]. However, other findings indicate that training communicative skills using the group psycho-education method can decrease the occupational stress of psychiatry ward nurses [169].

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163 Aerts E. Fliedner M. Redmond K. Walton A. Defining the scope of haematology nursing practice in Europe. Eur J Oncol Nurs. 2010, 14(1), 55–60.

164 Sheldon LK. An evidence-based communication skills training programme for oncology nurses improves patient-centred communication. enhancing empathy. Reassurance and discussion of psychosocial needs. Evid Based Nurs. 2011, 14, 87–88.

165 Doyle D. Copeland HL. Bush D. Stein L. Thompson S.A course for nurses to handle difficult communication situations. A randomized controlled trial of impact on self-efficacy and performance. Patient Educ Couns. 2011, 82(1), 100–109.

166 Kameg K. Howard VM. Clochesy J. Mitchell AM. Suresky JM. The impact of high fidelity human simulation on self-efficacy of communication skills. Issues Ment Health Nurs. 2010, 31(5), 315–523.

167 Kameg K. Mitchell AM. Clochesy J. Howard VM. Suresky J. Communication and human patient simulation in psychiatric nursing. Issues Ment Health Nurs. 2009, 30(8), 503–508.

168 Sleeper JA. Thompson C. The use of hi fidelity simulation to enhance nursing students therapeutic communication skills. Int J Nurs Educ Scholarsh. 2008, 5, 42.

169 Ghazavi Z. Lohrasbi F. Mehrabi T. Effect of communication skill training using group psychoeducation method on the stress level of psychiatry ward nurses. Iran J Nurs Midwifery Res. 2010, 15(Suppl 1), 395–400.

In oncology practice, communication skill (CS) training is useful for improving a nurse's ability to recognize the distress of patients diagnosed with cancer [170, 171]. Oncologic nurses have found educational intervention highly acceptable, and reported increased confidence in their ability to provide information and support for patient's parents, and to initiate discussion about emotional issues, as well as reduced use of blocking [172]. Communication skills are the key to quality end-of-life care. While learning general, transferable communication skills, such as therapeutic listening, has been common in nursing education, learning specific communication tools, such as breaking bad news, should also be the norm for nursing education [173]. An interactive educational workshop can improve end-of--life communication skills [174].

Depression is a common response among cancer and long-term care patients to their diagnosis and treatment, however, in about 50% of cases it remains undetected. The short training programme demonstrated success in improving nurse communication skills and confidence in dealing with patient depression [175].

Regardless of the nursing specialty, published studies have shown that a communication skills training course can improve the self-efficacy of health care professionals, and has shown a significant increase in patient-centeredness and patient satisfaction concerning information and continuity of care, as well as high satisfaction of family members [176, 177]. At the same time, increase in self-control, communication skills and problem solving skills at the time of dealing with the

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170 Fukui S. Ogawa K. Ohtsuka M. Fukui N. Effects of communication skills training on nurses' detection of patients' distress and related factors after cancer diagnosis: a randomized study. Psychooncology. 2009, 18(11), 1156–1164.

171 Langewitz W. Heydrich L. Nübling M. Szirt L. Weber H. Grossman P. Swiss Cancer League communication skills training programme for oncology nurses: an evaluation. J Adv Nurs. 2010, 66(10), 2266–2277.

172 Turner J. Clavarino A. Butow P. Yates P. Hargraves M. Connors V. Hausmann S. Enhancing the capacity of oncology nurses to provide supportive care for parents with advanced cancer: evaluation of an educational intervention. Eur J Cancer. 2009, 45(10), 1798–1806.

173 Shannon SE. Long-Sutehall T. Coombs M. Conversations in end-oflife care: communication tools for critical care practitioners. Nurs Crit Care. 2011, 16(3), 124–130.

174 Hales BM. Hawryluck L. An interactive educational workshop to improve end of life communication skills. Contin Educ Health Prof. 2008, 28(4), 241–248.

175 Brown RF. Bylund CL. Kline N. De La Cruz A. Solan J. Kelvin J. et al. Identifying and responding to depression in adult cancer patients: evaluating the efficacy of a pilot communication skills training program for oncology nurses. Cancer Nurs. 2009, (3), E1–7.

176 Norgaard B. Communication with patients and colleagues. Dan Med Bull. 2011, 58(12), B4359.

177 Liu LM. Guarino AJ. Lopez RP. Family Satisfaction With Care Provided by Nurse Practitioners to Nursing Home Residents With Dementia at the End of Life. Clin Nurs Res. 2012, 21(3), 350–67.

patients and their relatives is a step in reducing one of the factors of violence at the workplace [178].

The taught and required scope of communication knowledge and skills, as well as the methods of discovering and developing communication motivations among pre-graduate and post-graduate students, is an important issue. Some findings suggest that 'role-play' may have a place in teaching communication skills in pre- and post-graduate education, as well as continuing education. Interdisciplinary communication training may provide even more effective learning [179]. Controversially, assessments by clinical supervisors indicate that communication training modules, including standardized patients and an Objective Structured Clinical Examination (OSCE), are superior to communication training modules with peer role-playing [180].

A learning experience which incorporates standardized patients and feedback from faculty facilitators can promote authentic inter-professional learning, and develop students' confidence to communicate in a team environment [181]. Similarly, another paper describes the implementation of a practice-change project for simultaneously developing collaboration and communication skills by pairing pre-licensure student nurses in clinical assignments [182].

There are also more innovative and challenging proposals. One study describes an innovative assessment approach for first year nursing students which addressed the development of a beginning knowledge base in therapeutic communication. Use of a creative assessment approach, incorporating art creation, shows much promise in bridging the gap between a superficial understanding of concepts and an understanding characterised by deeper learning [183].

Another study assessed the effectiveness of a learner-centred simulation intervention, designed to improve the communication skills of pre-professional sophomore nursing students. An innovative teaching strategy has been evaluated, in which com-

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178 Eslamian J. Fard SH. Tavakol K. Yazdani M. The effects of anger management by nursing staff on violence rate against them in the emergency unit. Iran J Nurs Midwifery Res. 2010, 15 (Suppl 1), 337–342.

179 Kesten KS. Role-play using SBAR technique to improve observed communication skills in senior nursing students. J Nurs Educ. 2011, 50(2), 79–87.

180 Schlegel C. Woermann U. Shaha M. Rethans J. van der Vleuten C. Effects of Communication Training on Real Practice Performance: A Role-Play Module Versus a Standardized Patient Module. J Nurs Educ. 2012, 51(1), 16–22.

181 Solomon P. Salfi J. Evaluation of an interprofessional education communication skills initiative. Educ Health. (Abingdon) 2011, 24(2), 616.

182 Bartges M. Pairing students in clinical assignments to develop collaboration and communication skills. Nurse Educ. 2012, 37(1), 17–22.

183 Emmanuel E. Collins D. Carey M. My face. A window to communication: using creative design in learning. Nurse Educ Today. 2010, 30(8), 720–725.

munication skills are taught to nursing students by using trained actors who serve as standardized family members in a clinical learning laboratory setting [184].

The central focus of another study was investigation of the effects of the introduction of a new system of formative assessment on students' perceptions of their communication skills, by recruiting patients to assess the student who provided their treatment on that day. The students who were interviewed, all stated that they were comfortable with the patients assessing them, and for some it made them feel more confident. Some students were surprised by the marks, which the patients gave on some aspects of their communication, particularly pertaining to maintaining eye contact [185].

4.2. Physicians

Why does a doctor need communication skills? Perhaps this is a process taking (anyway, too short) valuable time for consultation? Perhaps it is an unprofessional inclusion of emotional aspects to occupational activities? What and for whom do such skills serve? Treatment? Patient? Physician? Studies carried out in this area indicate that not only patient satisfaction, but also primarily the recognition of doctor's therapeutic methods (obedience of orders), as well as quicker regaining of health by a patient, depend on the doctor's communication skills, the

[184] Zavertnik JE. Huff TA. Munro CL. Innovative approach to teaching communication skills to nursing students. J Nurs Educ. 2010, 49(2), 65–71.

[185] Davies CS. Lunn K. The patient's role in the assessment of students communication skills. Nurse Educ Today. 2009, 29(4), 405–412.

way of passing on information, ability to show support and respect, and capability for evoking liking in a patient [186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196].

Respect, and in consequence, the trust of patients are evoked primarily by physicians who are capable for expressing empathy, and in a proper way (not too laconic and not too excessive) informing patients about their state of health [197, 198, 199, 200]. However, medical relations, similar to all other forms of social interaction, requires from its participants cooperation and coordination (which is the main part

[186] Cals JW. de Bock L. Beckers PJ. Francis NA. Hopstaken RM. Hood K. de Bont EG. Butler CC. Dinant GJ. Enhanced Communication Skills and C-reactive Protein Point-of-Care Testing for Respiratory Tract Infection: 3.5-year Follow-up of a Cluster Randomized Trial. Ann Fam Med. 2013, 11(2), 157–64.

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[190] Meystre C. Bourquin C. Despland JN. Stiefel F. de Roten Y. Working alliance in communication skills training for oncology clinicians: a controlled trial. Patient Educ Couns. 2013, 90(2), 233–8.

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[192] Jahng KH. Martin LR. Golin CE. DiMatteo MR. Preferences for medical collaboration: patient-physician congruence and patient outcomes. Patient Education and Counseling. 2005, 57(3), 308–314.

[193] Kaplan SH. Greenfield S. Ware JE. Jr Assessing the effects of physicianpatient interactions on the outcomes of chronic disease. Medical Care. 1989, 27(3 Suppl), S110–S127.

[194] Ong LM. de Haes JC. Hoos AM. Lammes FB. Doctor-patient communication: a review of the literature. Soc Sci Med. 1995, 40(7), 903–918.

[195] Stewart M. Brown JB. Donner A. McWhinney IR. Oates J. Weston WW. Jordan J. The impact of patient-centered care on outcomes. J Family Pract. 2000, 49(9), 796–804.

[196] Trummer UF. Mueller UO. Nowak P. Stidl T. Pelikan JM. Does physician-patient communication that aims at empowering patients improve clinical outcome? A case study. Patient Educ Counsell. 2006, 61(2), 299–306.

[197] Hall JA. Epstein AM. DeCiantis ML. McNeil BJ. Physicians' liking for their patients: more evidence for the role of affect in medical care. Health Psychol. 1993, 12(2), 140–146.

[198] Beach MC. Roter DL. Wang NY. Duggan PS. Cooper LA. Are physicians' attitudes of respect accurately perceived by patients and associated with more positive communication behaviors? Patient Educ Counsell. 2006, 62(3), 347–354.

[199] Levinson W. Roter D. Physicians' psychosocial beliefs correlate with their patient communication skills. J General Internal Med. 1995, 10(7), 375–379.

[200] Street RL Jr. Gordon H. Haidet P. Physicians' communication and perceptions of patients: is it how they look, how they talk, or is it just the doctor? Soc Sci Med. 2007, 65(3), 586–98.

of doctor's role in professional communication). It is worth considering its basic aspects, on behalf of improvement of communication itself and effective education in this area [201]. The main element of the perception of a doctor by a patient is the style of managing therapy: democratic, partnership, negotiating, paternalistic, etc. [202]. This style may evolve according to the increase in occupational and life experience, change in the world-view, philosophy of life, and primarily under the effect of medical and communication training [203, 204].

The subsequent important element of doctor-patient relationship is the way of informing the patient (with respect to both: the form and contents), in combination with patience and support, expressed within the information provided. This is also accompanied with the inclination (by doctors) towards succumbing to stereotypes. The higher the stereotyping of the world-view, the lower the communication level [205, 206]. And finally, the *sine qua non* condition – unconditional acceptance of the patient, without which the correct professional doctor-patient communication is not possible.

Posing any condition (e.g. of the type: the patient must be clean or the patient cannot be abrasive), hinders communication primarily for the doctor, who, instead of treating, checks if the patient fulfils his/her conditions, and if this is not the case, changes the medical treatment into didacticism. For better understanding, the authors are of the opinion that the patient's education for the role of a patient is indispensable, but it has to be carried out at a proper place and time [207].

4.3. Nurses

In our day and age, nursing is understood as the care of an individual from conception to dignified death. An important competence of a nurse, apart from performing medical procedures, is the provision of patient care through showing concern, support with a 'good word', i.e. offering another person the things which bring relief in suffering.

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201 Street RL. Jr. Millay B. Analyzing patient participation in medical encounters. Health Commun. 2001, 13(1), 61–73.

202 Jarosz MJ. Kawczyńska-Butrym Z. Włoszczak-Szubzda A. Modele komunikacyjne relacji lekarz – pacjent – rodzina. Med Og Nauk Zdr. 2012, 18(3), 212–218.

203 Bertakis KD. Helms LJ. Azari R. Callahan EJ. Robbins JA. Miller J. Differences between family physicians' and general internists' medical charges. Med Care. 1999, 37(1), 78–82.

204 Paasche-Orlow M. Roter D. The communication patterns of internal medicine and family practice physicians. J Am Board Fam Pract. 2003, 16(6), 485–93.

205 Burgess DJ. Fu SS. Van Ryn M. Why do providers contribute to disparities and what can be done about it? J General Internal Med. 2004, 19(11), 1154–1159.

206 Van Ryn M. Burgess D. Malat J. Griffin J. Physicians' perceptions of patients' social and behavioral characteristics and race disparities in treatment recommendations for men with coronary artery disease. Am J Public Health. 2006, 96(2), 351–357.

207 Elso ChJ. Hayes JA. Relacja terapeutyczna. GWP, Gdańsk 2004, 228, 2005. ISBN 83-89574-41-1.

Nurses often face the problem of how to serve patients, respect their dignity and rights, while using modern medical technologies which often dehumanize the object of a nurse's actions – making the patient an object of technical medical interventions. Also, approaching the medical sector primarily or exclusively in the market categories, may intensify the phenomenon of patient depowerment and dehumanization, making him/her an object of transaction, i.e. a client. In that context, D. Sturgeon has discussed how the adoption of targets to evaluate care and compassion seems to reflect a market-driven or bureaucratic approach to health care [208].

Despite differences, measurability and outcome are considered the most important indicators of quality [209]. Such a situation negatively affects not only the performance of the profession and fulfilment of the role of a nurse, but also exerts an unfavourable effect on those who are ill in their fulfilment of the role of patients.

Therefore, the construction of procedural (technical) qualifications of nurses must be accompanied by them also developing communication competences indispensable for the construction of adequate, empathic relationships with others [210]. There is a need for empathy, communication skills and non-judgmental patient-centred care: major themes in the new NMC (Nursing & Midwifery Council) standards [211].

The extent to which this emphatic 'sensitization' exists, and the level of nurses' professionalism is evaluated today by the patients, and the care cannot be considered as being of high quality unless the patient is satisfied [212]. Obviously, it is relatively difficult to define what patient satisfaction is. It is certain that it comes from the realm of subjectivity which, however, does not in any way decrease its importance in the shaping of the professional attitudes of nurses. Considering the communication skills in the work of a nurse, as well as in the education in this profession, facilitates work, and at the same time, elevates the level of both nurse and patient satisfaction which, in turn, affects the level of a patient's activity in the process of treatment and the intensity of cooperation with a nurse. As a result, this all translates into the ultimate effectiveness of a medical intervention [213].

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[208] Sturgeon D. 'Have a nice day': consumerism. compassion and health care. Br J Nurs. 2010, 19(16), 1047–1051.

[209] Robinson KL. Watters S. Bridging the communication gap through implementation of a Patient Navigator program. Pa Nurse. 2010, 65(2), 19–22.

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[211] Griffiths J. Speed S. Horne M. Keeley P. 'A caring professional attitude': What service users and carers seek in graduate nurses and the challenge for educators. Nurse Educ Today. 2012, 32(2), 121–127.

[212] Vuori H. Patient satisfaction an attribute or indicator of the quality of care? QRB Qual Rev Bull. 1987, 13, 106–108.

[213] Prot K. Pałyska M. Anczewska M. Indulska A. Raduj J. Badanie satysfakcji pacjenta w warunkach opieki środowiskowej. Postępy Psychiatr Neurol. 2005, 14(4), 299–304.

4.4. Paramedics

The occupation of a paramedic or emergency medical technician is an occupation especially exposed to emotions which are strong and difficult to unequivocally interpret. Paramedics, on a daily basis, deal with pain, suffering, and fear of patients and their significant others, and experience their own fear, helplessness, or sometimes anger. Knowledge of the level of these emotions allows adequate education in the provision of assistance and protection against occupational burnout. Similar to other medical professionals, the management of own emotions and those of others is an important element in the work of a paramedic [214].

An assessment of this situation is based on individual statements expressed by professional paramedics, however, there is a lack of studies related with this aspect of the occupation of a paramedic, which would enable improvement of educational strategies and be useful in everyday practice.

Paramedics frequently 'touch' the phenomenon of the death of patients, and sometimes of own paramedic colleagues. Sometimes, there falls on their shoulders the necessity to inform relatives of a patient's death, or disclose to the families the death of colleagues who tragically passed away. There is no painless way to pass on such information, nevertheless, there are methods which help to relieve own stress in such circumstances in the most humanitarian way possible. Studies concerning education in this aspect of communication indicate that even a basic course helps the trainees and their care receivers [215, 216].

Prophylactic psychological care allows the understanding of the state of own feelings and the feelings of those to whom the paramedic provides help. In this way, the paramedic learns what to expect at work from the psychical aspect, and how to cope with the burden of feelings, perceptions and emotions which are inseparable in the life of each individual [217].

Paramedics should know how to cope themselves, and assist a patient in life-threatening situations and poor prognoses, how to behave while facing a dying patient and his/her family, and also how to behave with respect towards aggressive patients, how to cope with a disabled patient, communicate with children, adolescents and old age patients. They should also know how to work as a team during a rescue operation, how to manage the rescue team during difficult situations, mass accidents and disasters, not only from the purely medical but also the psy-

[214] Smith-Cumberland TL. Feldman RH. EMTs' attitudes' toward death before and after a death education program. Prehosp Emerg Care. 2006, 10(1), 89–95.

[215] Ward J. McMurray R. The unspoken work of general practitioner receptionists: a re-examination of emotion management in primary care. Soc Sci Med. 2011, 72(10), 1583–7.

[216] Smith-Cumberland TL. Feldman RH. Survey of EMTs' attitudes towards death. Prehosp Disaster Med. 2005, 20(3), 184–8.

[217] Goniewicz M. Włoszczak-Szubzda A. Psychoprofilaktyka akcji ratunkowej w kształceniu ratowników medycznych. [in:] Konieczny J. [ed.], Edukacja w ratownictwie medycznym. Oficyna Wydawnicza Garmond, Poznań 2005.

chical aspect. The paramedic should be familiar with the symptoms, effects, and ways of coping in the situation of burnout syndrome. In order to develop emotional intelligence, it is beneficial first to know the essentials, and have the possibility of practical training [218, 219].

An elementary duty of each paramedic is the provision of assistance and care. What does this mean in the sphere of communication competences? It is best defined by the English word 'CARE' – approached as an acronym for the list of four skills: Comfort, Acceptance, Responsiveness, Empathy [220].

The feeling of psychological comfort of a patient results from the paramedic's skills of undertaking the scope of problems which are commonly considered as sensitive or painful (deformations, disfigurements, urinary incontinence, sexuality, death, etc.), which are relatively often encountered by a paramedic while performing occupational activities. The more uncomfortable the paramedic feels, the greater the discomfort is experienced by the patient [221].

Acceptance – is respecting a patient's feelings and attitudes. This is a trait which, on the one hand, makes the paramedics aware that they are dealing with a human being, not an object, and on the other hand, a paramedic is also just a human being subjected to cultural, moral and social prejudices. Obviously, these prejudices have to be eliminated, but to do so, paramedics have to know that they possess such prejudices [222].

Responsiveness – is the correct perception of cues and signs coming from the patient by verbal and non-verbal routes, and their use to provide assistance to this patient. The capability to respond depends on the skills of an active, concentrated listening and observation of the patient, paying attention to voice modulation, hesitation, gesture or other body sign language [223].

Empathy – is often defined as the capability to experience the psychological states of others, skills of understanding their way of thinking, and looking at reality from their perspective. This definition may frequently evoke doubts among medical professionals who provide help to others. Each individual has some resistance against entering into such a situation. Therefore, it is necessary to explain and emphasize that empathic reactions do not mean that the person who provides assistance experiences the same feelings as the patient. Paramedics share these feelings to a degree to which they are understood and recognized, and in the same

[218] Myerscough PR. Ford MJ. Talking with Patients: Keys to Good communication. Oxford Medical Publications, Oxford 1996.

[219] Salomon P. Psychologia w medycynie. GWP, Gdańsk 2002. 7. Fengler J. Pomaganie męczy. Wypalenie w pracy zawodowej. GWP, Gdańsk 2002.

[220] Myerscough, op.cit.

[221] Fengler J. Pomaganie męczy. Wypalenie w pracy zawodowej. GWP, Gdańsk 2002.

[222] Jurkowski R. Komunikowanie się. Zarys wykładu. Oficyna Wydawnicza WSM SIG, Warszawa 2004.

[223] Myerscough PR. op.cit.

circumstances would probably experience similar feelings. Trained empathic skills allow the delineation of the limits of emotional engagement in a patient's problems. These limits do not have to be established by means of inadequate attitudes, being patronizing, condescending, preponderant, turning everything into a joke or being ignorant [224, 225].

The four above-described skills allow handling of the emotional aspect of a patient in a way safe for the care provider, and with a proficiency equal to that in the 'technical' sphere. The creation of a comfortable atmosphere and acceptance enable control of negative, sometimes destructive emotional responses of a paramedic. Responsiveness and empathy allow the recognition of the psychical state of a patient, and to deal with it without escaping into indifference or excessive sympathy.

Assertiveness – awareness and respecting own right and skills of their execution without violating the rights of others, is useful in the work of a paramedic, both when dealing with patients and in a rescue team. Assertiveness is based on honesty and openness, allows the relief of negative feelings and, in consequence, to avoid or defuse conflicts [226, 227].

The languages of communication, verbal and non-verbal, are equally important elements of providing assistance. Verbal language is divided into the component concerning communication with a patient, and the component which is used when talking about the patient. Both components are of tremendous importance in shaping an adequate occupational attitude of paramedics, and both are an educational component of the psycho-prophylaxis of a rescue action. It is obvious that the way of talking to another person conditions good or bad communication. One may not be familiar with the principles of good verbal communication, however, its usefulness is unquestionable. The role of the language used by the professionals (paramedics) is less obvious. Medical staff often use their own terms, not understood by patients. If these alternate terms objectify a patient e.g. banana – patient with yellow jaundice (AmE), goldbrick – patient who demands more attention than their (minor) condition warrants (AmE), player – complaining, irritating patient (AmE), rock – very stable patient (AmE), medical professionals may subconsciously approach a patient as an object. In everyday practice, such talking and thinking about a patient allows distancing oneself from the patient's suffering, and thus reduce own stress. This seemingly helps, but relatively quickly leads to dehumanization of the activities undertaken, and only apparent provision of assistance to another person.

[224] Wilczek-Różyczka E. Empatia i jej rozwój u osób pomagających. WUJ, Kraków 2002.

[225] Matthews G. Zeinder M. Roberts RD. Emotional Intelligence: Science and Myth, MIT Press, Cambridge 2004.

[226] Grzesiuk L. Style komunikacji interpersonalnej. Wydawnictwo Uniwersytetu Warszawskiego, Warszawa 1979.

[227] Grzesiuk L. Trzebińska E. Jak ludzie porozumiewają się. Nasza Księgarnia, Warszawa 1978.

Knowledge concerning body language of patients is a very valuable instrument in the work of a paramedic. The entire non-verbal context provides information about the emotional state of the person who needs assistance – and unequivocal information because, according to the experts in non-verbal communication, the human body does not lie. Considering the time limitations of rescue action, knowledge of this type is even more important. Touch is a component of non-verbal communication. Intimacy (closeness) has connotations with sex or aggression, and in various cultures there are specified social norms which regulate the accepted area and way of touching, according to the type of relationship. This is often a problem in the work of paramedics, because while examining or dressing they work in a sphere to which, in normal conditions, only the closest people are admitted [228, 229, 230].

Duress of circumstances, saving health and life, is not a reason for being unaware of a patient's feelings. Flexing muscles by a patient is nothing but an attempt to behave bravely during examination. Each touch has the features of a message. The essence of the problem consists in, among other things, that the delicate and gentle touch anticipated by the sufferer may have unexpected sexual connotations. Similarly, a determined touch, a so called 'heavy hand' of the examiner, is an attempt to get rid of sexual connotation resulting, '*nota bene*' from the lack of professional self-confidence [231, 232].

4.5. Physiotherapists

The ethos of a physiotherapist defines what good occupational practices should characterize a physiotherapist. General principles cover an evaluation of an adequate attitude, i.e. respectable coexistence and behaviour with respect to others, as well as normal social relationships and a positive attitude towards oneself and the surrounding world [233]. If physiotherapists lacks a deeper ethical awareness, they may reason and/or act ethically to a varying extent: only ethically conscious physiotherapists will know when they reflect and act ethically [234]. They are required to make autonomous clinical and ethical decisions based on communication

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228 Thiel E. Komunikacja niewerbalna – mowa ciała. Astrum, Wrocław 1997.

229 Tkaczyk L. Komunikacja niewerbalna – postawa mimika, gest. Astrum, Wrocław 1997.

230 Bierach AJ. Komunikacja niewerbalna. Astrum, Wrocław 1998.

231 Myerscough op.cit.

232 Salomon P. Psychologia w medycynie. GWP, Gdańsk 2002. 7. Fengler J. Pomaganie męczy. Wypalenie w pracy zawodowej. GWP, Gdańsk 2002.

233 WCPT. Declarations of Principle – Ethical Principles World Confederation for Physiotherapists, < http://www.wcpt.org >.

234 Praestegaard J. Gard G. The perceptions of Danish physiotherapists on the ethical issues related to the physiotherapist-patient relationship during the first session: a phenomenological approach. BMC Med Ethics. 2011, 12, 21.

and relationships with their patients, other health care team members, and health care institutions [235].

The subjective opinion of a patient is the ultimate measure of physiotherapists' professional attitude. Even the most able team of therapists will not be able to create a collaborative framework unless their patients are willing to grasp the opportunity offered to them [236]. In this occupation, there is also a need for sensitivity to others, tolerance, acceptance, understanding of the psychological essence of suffering and illness, and above all, motivation to provide assistance for patients. According to the self-determination theory, support from health care practitioners can promote patients' autonomous motivation and greater long-term behavioural persistence [237].

A physiotherapist should possess the skills of empathic understanding of patient, also how to respect patient's feelings and sensations. Kindness, engagement in the recognition of a patient's individual life situation, as well as his/her personality traits, allow the physiotherapist the 'maximisation' of the techniques of providing assistance to a patient [238].

An ethical duty of a physiotherapist is also care about maintaining psychical hygiene in the circle of own activity, and not creating stress. A proper atmosphere at the workplace enables a physiotherapist to enjoy the performed occupation, and postpone the effects of occupational burnout which, at the same time, protects patients. Educational standards are necessary to satisfy the requirements posed by the World Confederation for Physical Therapy (WCPT) which expects physiotherapists to:

1. respect the rights and dignity of all individuals,
2. comply with the laws and regulations governing the practice of physical therapy in the country in which they practice,
3. accept responsibility for the exercise of sound judgement,
4. provide honest, competent and accountable professional services,
5. provide quality services,
6. receive a just and fair level of remuneration for their services,

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[235] Delany CM. Edwards I. Jensen GM. Skinner E. Closing the gap between ethics knowledge and practice through active engagement: an applied model of physical therapy ethics. Phys Ther. 2010, 90(7), 1068–78.

[236] Thomson D. An ethnographic study of physiotherapists' perceptions of their interactions with patients on a chronic pain unit. Physiother Theory Pract. 2008, 24(6), 408–22.

[237] Lonsdale C. Hall AM. Williams GC. McDonough SM. Ntoumanis N. Murray A. Hurley DA. Communication style and exercise compliance in physiotherapy (CONNECT). A cluster randomized controlled trial to test a theory-based intervention to increase chronic low back pain patients' adherence to physiotherapists' recommendations: study rationale, design, and methods. BMC Musculoskelet Disord. 2012, 13(1), 104.

[238] Osińska K. Refleksje nad etyką lekarską. Wydawnictwo Archidiecezji Warszawskiej, Warszawa 1992.

7. provide accurate information to patients/clients, to other agencies and the community about physical therapy and the services physiotherapists provide,
8. contribute to the planning and development of services which address the health needs of the community [239].

The presented above, review of undertakings concerning health professional communication competences indicate that the efficiency of shaping communication competences among students, based on standard education within the scope of psychology and psychotherapy, is relatively low. Knowledge obtained in the area of psychology and psychotherapy is not spontaneously translated into the anticipated communication competences while practicing the occupation.

There are many methods of shaping and evaluating health professional communication. Most of the reviewed results indicate the necessity to systematically supplement knowledge and skills, both among students and occupationally active professionals. However, one should be aware of the systemic, organizational and cultural differences which may considerably limit the scope of information exchange in such a sphere so sensitive to cultural factors as interpersonal communication.

[239] WCPT. Declarations of Principle – Ethical Principles World Confederation for Physiotherapists, < http://www.wcpt.org >.

5. Theoretical background of research

In health care, similar to other domains, three scopes of competences contribute to the professionalism in the area of communication: 1) motivation, 2) knowledge and 3) skills.

Motivation biases the behaviour of an individual towards the achievement of specified states of affairs which are important for this individual. The motivation process consists of a set of individual motives. A motive may be termed as an experience, stimulating an individual to action, or refraining from it, or hindering its performance. Communication motivation is an inspiration, engagement and encouragement to contact with others (patients or co-workers). By its definition, communication encompasses respect, tolerance for dissimilarity, respect for rights, and non-violation of another person's limits.

Knowledge of interpersonal communication covers contents concerning what should be said or done in specified situations, as well as procedures, based on which these contents will be introduced into practice. It is necessary to recognize the complexity of interpersonal contacts, however, only its adequate application in practice makes a person communicatively competent [240, 241]. Communication knowledge, although indispensable for a basic recognition of the scope of communication problems, is poorly occupationally useful for nurses if not accompanied by skills.

Communication **skills** include, among other things, emotional intelligence, i.e. personal competences of an individual, understood as skills of recognizing own emotional states and the emotional states of others, as well as skills of using own emotions and coping with emotional states of others which, in spite of the common opinion, may be trained and developed. Three main models of emotional intelligence delineate the scope of communication skills. Emotional intelligence covers the capability of understanding oneself and one's own emotions, managing and controlling these emotions, capability for self-motivation, empathy and skills of a social character. Peter Salovey et al. mention four spheres contributing to emotional intelligence: perception of emotions, supporting thinking by means of emotions, understanding emotions, and regulating emotions [242].

According to Rauven Baron, emotional intelligence consists of five components: intrapersonal intelligence, interpersonal intelligence, coping with stress,

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[240] Morreale SP. Spitzberg BH. Barge JK. Human communication: Motivation, knowledge and skills. Wadsworth Thomson Learning, Belmont, California 2002.

[241] Matthews G. Zeinder M. Roberts RD. Emotional Intelligence: Science and Myth. MIT Press, Cambridge 2004.

[242] Salovey P. Brackett MA. Mayer JD. Emotional Intelligence: Key Readings on the Mayer and Salovey Model. NY: Dude Publishing, Port Chester 2007.

and capability for adaptation and general mood [243]. Within emotional intelligence, it is recommended that nurses should be educated, among other things, in three main groups of competences:

1. Psychological competences (relations with oneself, i.e. skills from the scope of intrapersonal intelligence):
   a. self-awareness: skills of recognizing own emotional states, knowledge of own feelings, values, preferences, possibilities and intuitive assessments, i.e. emotional awareness,
   b. self-evaluation: self-esteem, self-confidence, awareness of own capabilities, skills and one's own limitations, skills of experiencing oneself irrespective of the judgements of others,
   c. self-control and self-regulation: skills of consciously reacting to external stimuli and regulation of own emotional states, skill of coping with stress, shaping own emotions according to oneself, with own standards, principles and adopted values.
2. Social competences (relations with others, i.e. skills from the scope of interpersonal communication):
   a. empathy: skills of understanding the emotional states of others, becoming aware of their feelings, needs and adopted values, i.e. the understanding of others, sensitivity to their sensations, attitude biased towards providing assistance and supporting others, capability for perceiving and understanding social relations,
   b. assertiveness: possessing and expressing one's own opinion, and direct, open expression of emotions, attitudes and adopted values within limits which do not violate the rights and psychical territory of others, capability for defending own rights without violation of the rights of others to defend them,
   c. persuasion: skills of rousing in others the desired behaviours and reactions, i.e. exerting an effect on others, skills of winning others over on behalf of agreement, skills of alleviating conflicts (necessary in health promoting education),
   d. leadership: capability to create visions and stimulate human motivation for their performance, capability to win over followers,
   e. cooperation: capability for relationship building and cooperation with others, team working skills on behalf of the achievement of common goals, skills of collective performance of tasks and mutual problem solving.
3. Praxeological competences (in other terms acting competences – our relation to tasks, challenges and actions):

[243] Matthews G. Zeinder M. Roberts RD. Emotional Intelligence: Science and Myth. MIT Press, Cambridge 2004.

a. motivation: own involvement, emotional predispositions which lead to new goals or facilitate their achievement, i.e. striving towards achievements, initiative and optimism,
b. adaptation skills: skills of managing one's own internal states, skills of coping in a changing environment, flexibility in adjustment to changes in the surroundings, capability for acting and undertaking decisions under stress,
c. conscientiousness: capability of assuming responsibility for tasks and their performance, skills of drawing satisfaction from the duties performed, consistency in acting, in concordance with self-adopted standards.

Other concepts associated with health professional interpersonal competences which are worth mentioning are: moral imagination, trust, and 'therapeutic emplotment'.

Skilled communication in medical practice requires students to move beyond simply learning superficial communication techniques and behaviours. A conceptualization of **moral imagination** is usually drawn from the works of Hume, Aristotle and Gadamer. Students must exercise moral imagination on two levels: towards the direct communication exchange before them, and to the representative nature of simulation encounters. The limits of moral imagination in simulation-based education must be carefully considered [244].

Trust has been identified in the literature as being a crucial element in establishing an effective nurse- patient relationship. Before a nurse can achieve a trusting relationship with a patient, he/she first has to develop a rapport with them. Rapport is a term used to describe, in common terms, the relationship of two or more people who are '*in sync*' or '*on the same wave length*' because they feel similar and/or relate well to each other [245].

'Therapeutic emplotment' develops from two philosophical strains: one emphasizing the connection of speech to actions, the other the linguistically-mediated nature of human experience. 'Therapeutic emplotment' is the creation of story-like structures through therapist-patient interactions, which encourage the patient to see therapy as integral to healing. 'Therapeutic emplotment' may provide health professionals with a way of improving communication and relationship skills [246].

[244] Chen RP. Moral imagination in simulation-based communication skills training. Nurs Ethics. 2011, 18(1), 102–111.

[245] Belcher M. Jones LK. Graduate nurses experience of developing trust in the nurse-patient relationship. Contemp Nurse. 2009, 31(2), 142–152.

[246] Tropea S. 'Therapeutic emplotment': a new paradigm to explore the interaction between nurses and patients with a long-term illness. J Adv Nurs. 2012, 68(4), 939–947.

6. Research

6.1. Study design

It seems that general psychological and communication knowledge, although indispensable for a basic recognition of the scope of communication problems, is poorly occupationally useful for health professionals if not accompanied by specially trained professional communication skills. It seems that despite international and cultural differences, if there is a lack of practical classes in intra-psychological and intra-communication training, the general psychological and communication knowledge imparted alone, may be used improperly.

The primary goal of the presented study was evaluation of the level (study of the state) of professional communication competences of medical/health professionals (physicians, nurses, paramedics, physiotherapists), and determination of the factors on which this level depends. A final goal was analysis of the needs and educational possibilities within the existing models of education in the area of interpersonal communication provided by higher medical education institutions.

In order to achieve the presented goals, the following research questions were formulated:

1. What is the level of individual communication competences of medical/health professionals (knowledge, motivation and skills)?
2. Are there any differences in the level of professional communication competences according to the model of education? i.e.:
    1. education within the scope of general psychological knowledge,
    2. education within the scope of general interpersonal communication,
    3. education within the scope of professional interpersonal communication skills.

Based on our earlier studies, the following research hypotheses were posed:

1. The level of individual communication competences of paramedics based on general psychological and communication knowledge is relatively low.
2. There are significant differences in the level of communication competences according to the education model applied in the education of health professionals.

6.2. Methods

In the research process, three basic scopes of communication competences were considered: 1) motivation, 2) knowledge, and 3) skills. Motivations bias the behaviour of an individual towards the achievement of specified states of affairs

which are important for this individual. The motivation process consists of a set of individual motives. A motive may be termed an experience stimulating an individual to action, or refraining from it, or hindering its performance. Knowledge of interpersonal communication covers contents concerning what should be said or done in specified situations, and procedures based on which these contents will be introduced into practice. It is necessary to recognize the complexity of interpersonal contacts, however, only its adequate application in practice makes a person communicatively competent [247, 248].

To communication skills contribute, among other things, emotional intelligence, i.e. personal competences of an individual, understood as skills of recognizing own emotional states and the emotional states of others, as well as skills of using own emotions and coping with emotional states of others which, in spite of the common opinion, may be trained and developed [249, 250, 251].

The investigation of these scopes is important from the aspect of understanding the research problems posed, and a potential design for their repair programme. In the research process, three methods were used:

1. analysis of documentation (education standards, programmes, curricula and syllabuses),
2. diagnostic survey concerning professional communication competences of health professionals (new designed instrument – questionnaire),
3. testing of professional self-evaluation from the medical/health professionals aspect – the 20 items adjective check list [252].

Analysis of documentation covered an evaluation of official education standards currently in effect in Poland. Based on these standards, individual schools engaged in the education of health professionals develop their own education programmes, curricula and syllabuses. Curricula and syllabuses in 20 higher medical/health education institution in Poland were compared. Analysed documents were available on the websites of these educational facilities.

The 54 items in the questionnaire and test examine the following:

1. within the scope of motivation:

[247] Matthews G. Zeinder M. Roberts RD. Emotional Intelligence: Science and Myth, MIT Press, Cambridge 2004.

[248] Morreale SP. Spitzberg BH. Barge JK. Human communication: Motivation. knowledge and skills. Wadsworth Thomson Learning, Belmont, California 2002.

[249] Chen RP. Moral imagination in simulation-based communication skills training. Nurs Ethics. 2011, 18(1), 102–11.

[250] Belcher M. Jones L. Graduate nurses experience of developing trust in the nurse-patient relationship. Contemp Nurse 2009, 31(2), 142–52.

[251] Tropea S. Therapeutic emplotment: a new paradigm to explore the interaction between nurses and patients with a long-term illness. J Adv Nurs. 2012, 68(4), 939–47.

[252] Włoszczak-Szubzda A. Kompetencje komunikacyjne personelu medycznego. Badanie stanu oraz ocena potrzeb komunikacyjnych. Praca doktorska, Wydawnictwo Uniwersytetu Medycznego w Lublinie, Lublin 2009.

a. affective dimension vs. cognitive (shows to what extent communication is motivated by emotions, and to what extent by intentions, if the message is the result of the 'stream' of emotions or the effect of consideration and planning),
b. positive vs. negative dimension (if the message is useful or harmful, advantageous or disadvantageous for a patient),
c. directed towards 'Own self' vs. biased towards 'Others' (if the message was generated exclusively for own needs, or considered others).

2. within the scope of knowledge:
   a. declared dimension (what to communicate?)
   b. procedural dimension (how to communicate?)
3. within the scope of skills:
   a. dimension of carefulness (skills of showing during an interaction – interest, concern and attention to a patient or patients),
   b. dimension of expressiveness (skills of managing verbal and non-verbal communication),
   c. dimension of coordination (skills of managing the course of interaction),
   d. dimension of self-possession (in interpersonal communication this is a basic requirement of being competent).

The new designed questionnaire and adjective test, were subjected to standardization from the aspect of reliability and validity by means of:

1. pilot studies,
2. competent judges test,
3. Kendall's coefficient of concordance (Kendall's W) examining the degree of conformity assessments of competent judges,
4. test-retest method examining the reliability (stability) of the instrument,
5. t-Student test for paired samples, investigating the significance of the differences between each pair of questions in test and retest.

As a result of pilot studies investigating face validity, the contents of one of the questions was changed (the respondents reported lack of understanding of the concept used), and one item was added as a result of suggestions by the respondents. Competent judges assessed content validity (intrinsic) of the instrument, from the aspect of adequacy of its content with respect to the objective of the study and position in theory, level of difficulty of the contents, correlation between problems, clarity of instructions, as well as the level of acceptance while completing. The group of judges covered 6 specialists representing the following areas of knowledge: 1) medicine/health, 2) philosophy/ethics, 3) pedagogy, 4) law, 5) psychology. Table 1 presents the results of examinations of the level of concordance between the judges' opinions

Table 1. Kendall's test of level of concordance of competent judges.

Characteristics of the instrument	W	p	*Ri*	$(ri)^2$
Adequacy to the problem	0.86	<0.01	0.83	69%
Easiness of completing	0.87	<0.01	0.84	71%
Clarity of instructions	0.86	<0.01	0.83	69%
Level of contents acceptance	0.88	<0.01	0.86	73%
Level of contents difficulty	0.88	<0.01	0.86	73%
Correlation of problems	0.91	<0.01	0.90	81%

W – Kendall's W,
p – significance,
ri – mean correlation of evaluations,
$(ri)^2$ – percentage of variance of general concordance of evaluations.

Reliability was investigated by means of the 'test-retest' method, by examining the same group twice, every 2 weeks. The results were calculated in a logic test (1 – concordance, 2 – lack of concordance). The mean concordance was 85%. The last method, applied for the standardization of the instrument, was t-Student test investigating, with a significantly positive correlation between every pair of the questionnaire items (from test and retest), the presence of statistically significant differences. Out of 54 pairs of questions, statistical differences were observed only in two pairs.

6.3. Data analysis

The qualitative data (education standards, curricula and syllabuses) were subjected to detailed content investigation from the aspect of understanding of the posed research problems. The obtained quantitative data were subjected to statistical analysis by means of SPSS statistical software with the use of data transformations (counting, recoding, etc.), descriptive statistics and hypothesis testing. The presence of dependency between qualitative variables were investigated by means of Pearson's chi-square test, whereas the significance of differences between quantitative variables was examined with the use of t-Student tests or a single factor analysis of variance (ANOVA) and post-hoc tests. The p values < 0.05 were considered statistically significant.

6.4. Participants

During the studies, the following conditions of objectivity were preserved**:**

a. independence of the respondents (without unconscious pressure, e.g. resulting from subordination, when the surveyor is a lecturer or supervisor, and the respondents are his/her students or subordinates),
b. all respondents expressed informed consent to participate in the studies,
c. conditions of conducting the studies were standardized for all examined groups,
d. the questionnaire form included precise and clear instructions.

Survey questionnaires were handed out to participants by the pollsters, who explained the purpose of the study and the method of filling them. The respondents had 60 minutes to complete the questionnaire.

The presented research was carried out as part of a many-year programme of monitoring and evaluation of the education of health professionals (including physicians, nurses, paramedics, physiotherapist and dieticians) in interpersonal communication, conducted at the institutions educating medical professionals in Lublin (Poland). In the pilot study, in order to standardize the research instrument, a total number of 30 respondents were examined. The respondents participating in the pilot study were not enrolled into the main study.

Pollsters distributed 854 questionnaires, of which 788 (92%) were completely or partially filled, but 29 (4%) of them contained too much missing data and were excluded from the study.

Finally the study groups covered a total number of 759 respondents in the following sub-groups:

1. occupationally active medical professionals (293 respondents – physicians, nurses paramedics, physiotherapist), who were covered by a pre-graduate standard educational programme, and not trained in interpersonal communication skills as part of their continuing education,
2. students covered by a standard educational programme (406 respondents),
3. students who, in addition to a standard educational programme, attended extra courses in professional interpersonal communications, as part of the pilot educational programme (60 respondents).

In three medical professions (nursing, physiotherapy, emergency medicine) the group of occupationally active medical professionals constituted 30%–39%, the group of students covered by a standard educational programme 43%–52%, and the group of students who, in addition to a standard educational programme, attended extra courses, 17%–19%. In case of physicians, only occupationally active physicians (43%) and students of medicine covered by standard programme (57%) were compared, because students of medicine were not covered by extra courses (Chart 1, Table 2).

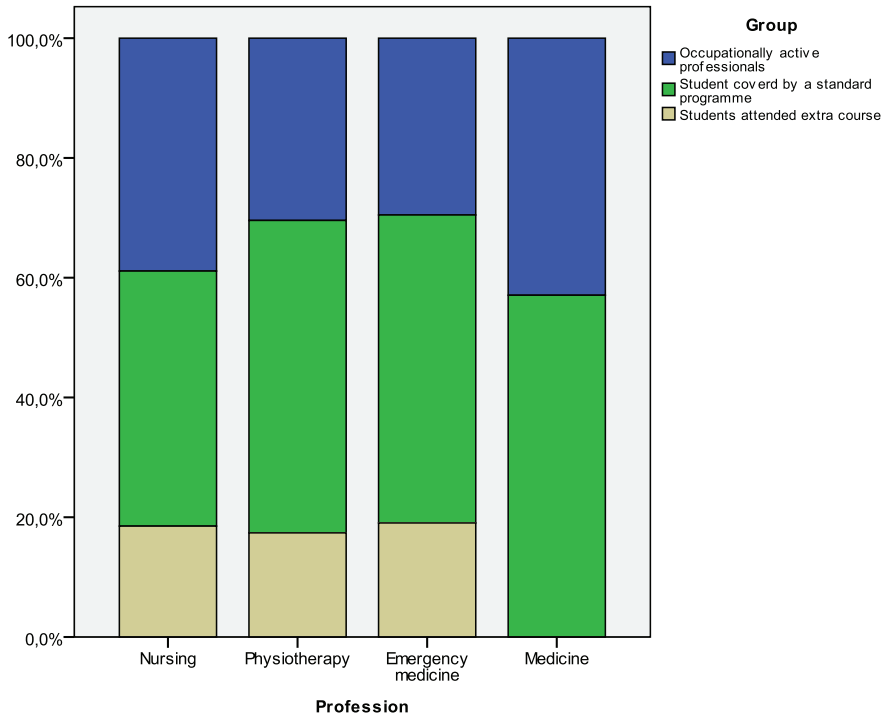

Chart 1. Structure of study groups.
Source: The present study

Table 2. Groups of participants

			Group			Total
			Occupationally active professionals	Students covered by a standard programme	Students attended extra course	
Profession	Nursing	N	42	46	20	108
		%	38,9%	42,6%	18,5%	100,0%
	Physiotherapy	N	35	60	20	115
		%	30,4%	52,2%	17,4%	100,0%
	Emergency medicine	N	31	54	20	105
		%	29,5%	51,4%	19,0%	100,0%
	Medicine	N	185	246	0	431
		%	42,9%	57,1%	,0%	100,0%
Total		N	293	406	60	759
		%	38,6%	53,5%	7,9%	100,0%

The structure of gender in the study groups was similar (Fig. 2). In all of the groups, women dominated. In the group of occupationally active medical professionals, they accounted for over 66%, and in the group of students covered

by a standard educational programme, they constituted 65.5% and in the group of students who attended extra courses, they accounted for over 73%. The differences are not statistically significant (Table 3).

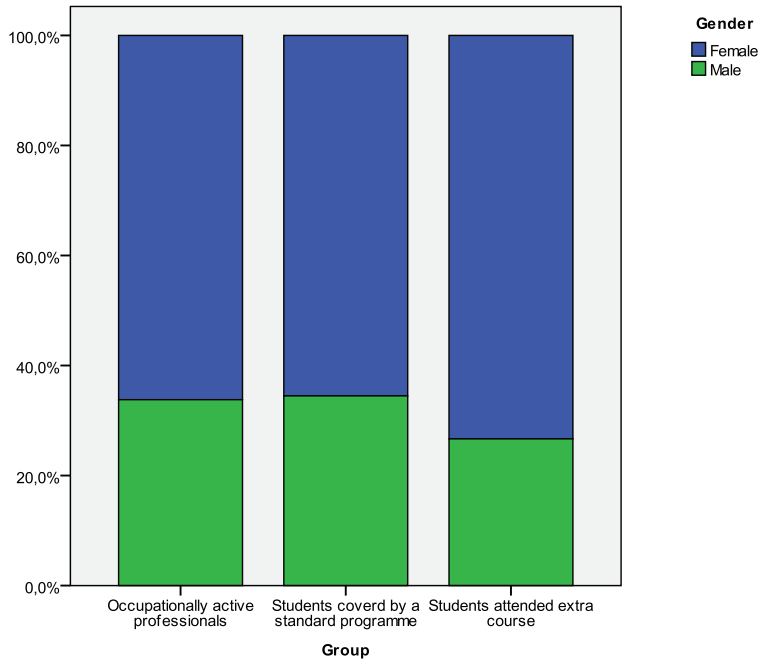

Chart 2. Gender structure of study groups.

Source: The present study

Table 3. Gender structure of study groups.

			Gender		Total
			Female	Male	
Group	Occupationally active professionals	N	194	99	293
		%	66,2%	33,8%	100,0%
	Students covered by a standard programme	N	266	140	406
		%	65,5%	34,5%	100,0%
	Students attended extra courses	N	44	16	60
		%	73,3%	26,7%	100,0%
Total		N	504	255	759
		%	66,4%	33,6%	100,0%

	Test	df	p
Pearson's Chi-square	1,439	2	,487
N of valid observations	759		

The degree of feminization of the medical professions is varied, as can be seen in Figure 3. In the studied professions the highest percentage of women, more than 92%, relates to nursing. In the case of physiotherapy, the proportion

of women exceeds 76%, and among physicians and medical students – close to 63%. Men dominate only in emergency medicine (more than 57%). The differences, observed in the structure of gender in different medical professions (Table 4) were statistically significant (p <0.000).

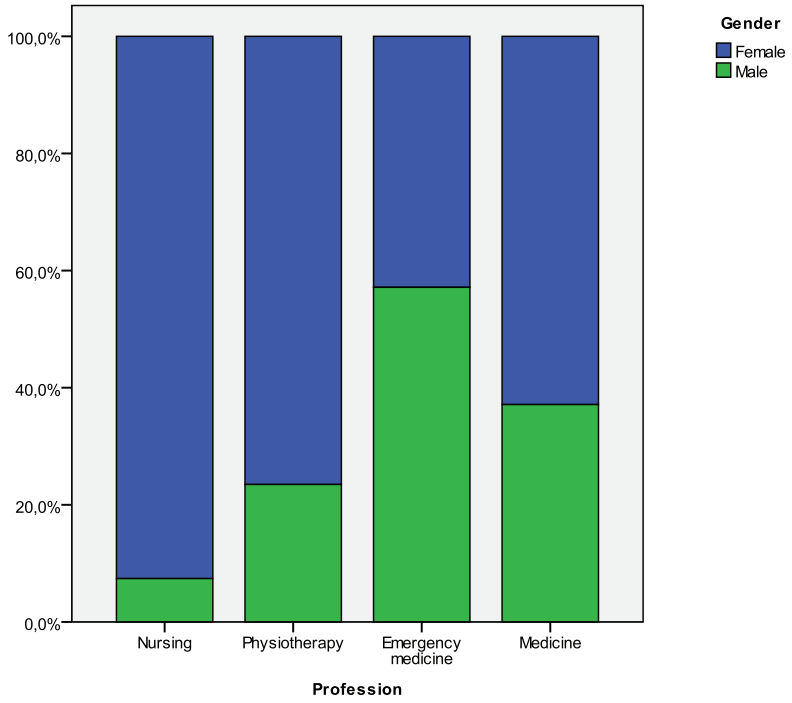

Chart 3. Structure of gender in different medical professions.

Source: The present study

Table 4. Structure of gender among different medical professions.

			Gender		Total
			Female	Male	
Profession	Nursing	N	100	8	108
		%	92,6%	7,4%	100,0%
	Physiotherapy	N	88	27	115
		%	76,5%	23,5%	100,0%
	Emergency medicine	N	45	60	105
		%	42,9%	57,1%	100,0%
	Medicine	N	271	160	431
		%	62,9%	37,1%	100,0%
Total		N	504	255	759
		%	66,4%	33,6%	100,0%

	Test	df	p
Pearson's Chi-square	66,977	3	,000
N of valid observations	759		

The age structure of a group of men and women participating in the study was similar (Figure 4) and slight differences proved statistically insignificant (Table 5).

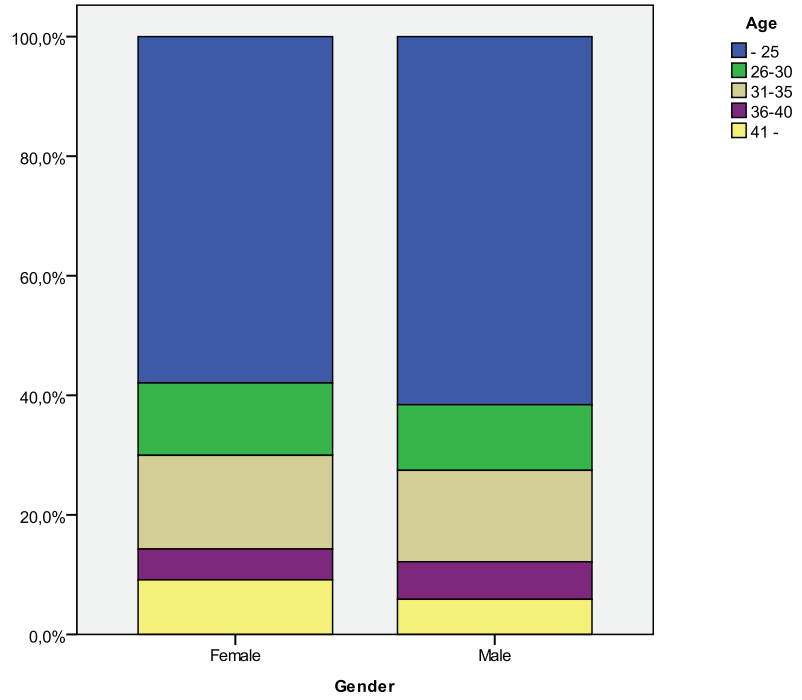

Chart 4. Age and gender of participants.
Source: The present study

Table 5. Age and gender of participants.

			Age					Total
			- 25	26-30	31-35	36-40	41 -	
Gender	Female	N	292	61	79	26	46	504
		%	57,9%	12,1%	15,7%	5,2%	9,1%	100,0%
	Male	N	157	28	39	16	15	255
		%	61,6%	11,0%	15,3%	6,3%	5,9%	100,0%
Total		N	449	89	118	42	61	759
		%	59,2%	11,7%	15,5%	5,5%	8,0%	100,0%

	Test	df	p
Pearson's Chi-square	3,174	4	,529
N of valid observations	759		

The age structure of different medical professions proved to be highly variable (Figure 5). The overwhelming predominance of young people among physiotherapists and paramedics results from the fact that education in these occupations at the university level in Poland has a short history. In addition, attention is drawn to a significant proportion of people over 40 years of age among nurses, which is a particular problem in Poland. Noticeable diversity in the age structure in different medical professions (Table 6) is statistically significant (p <0.000).

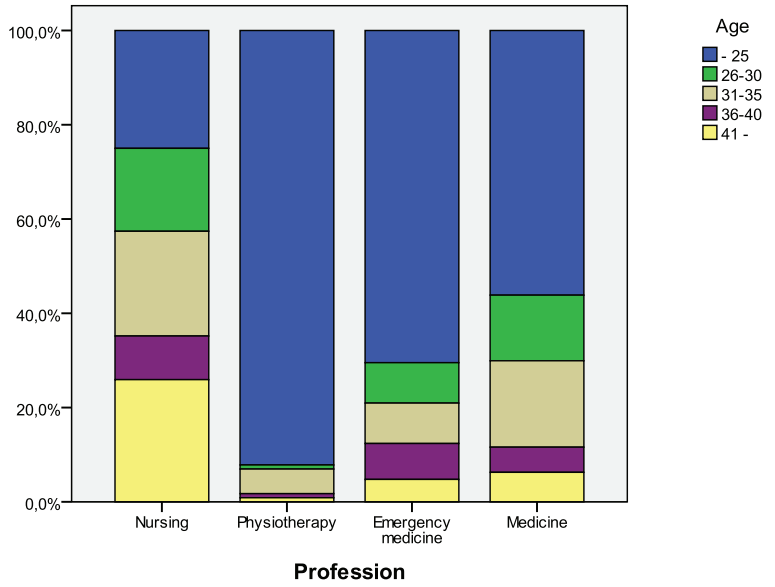

Chart 5. Structure of age among different professions.

Source: The present study

Table 6. Structure of age among different professions.

			Age groups					Total
			- 25	26-30	31-35	36-40	41 -	
Profession	Nursing	N	27	19	24	10	28	108
		%	25,0%	17,6%	22,2%	9,3%	25,9%	100,0%
	Physiotherapy	N	106	1	6	1	1	115
		%	92,2%	,9%	5,2%	,9%	,9%	100,0%
	Emergency medicine	N	74	9	9	8	5	105
		%	70,5%	8,6%	8,6%	7,6%	4,8%	100,0%
	Medicine	N	242	60	79	23	27	431
		%	56,1%	13,9%	18,3%	5,3%	6,3%	100,0%
Total		N	449	89	118	42	61	759
		%	59,2%	11,7%	15,5%	5,5%	8,0%	100,0%

	Test	df	p
Pearson's Chi-square	140,763a	12	,000
N of valid observations	759		

7. Results

7.1. Analysis of documentation

7.1.1. Physicians

Analysis of the documentation showed that the official standards of physicians' education currently effective in Poland assume that the students should possess knowledge and practical communication skills in this area of: communication with patients and their families, taking patient's medical history, learning skills of cooperation with others and managing teams.

These, as it may seem from the above, very laconically presented skills in education to-date, were included in the subject called 'medical psychology' (30 didactic hours during the entire study), where the educational contents and education results were defined as follows:

"*Educational contents: Psychological determinants of health and illness. Psychological pathogenic mechanisms. Psychosomatic disorders. Psychological aspects of pain. Functioning of an ill individual. Process of adaptation to illness. Doctor-patient relationship – difficulties in cooperation. Effects of education – skills and competences: communication and cooperation with a psychologist, recognition of a patient's psychological problems, establishment of an empathic contact, adjustment to own psychological predispositions and emotional limitations while performing the occupation of a physician, carrying on a conversation and patient history taking according to psychological criteria, exerting a beneficial effect of the psychological state of a patient, especially in stressful situations or in suffering due to psychosomatic disorders*" [253].

In the above-complied educational contents and effects of education, a discrepancy between what is taught (contents) and what is expected after completion of the educational process (effects) is clearly observed. The solutions are passed on mainly concerning the solving of traumatic situations (and this is right – a disease is a 'loss', and as such, disturbs human psychological functioning), and with respect to the results of education, apart from skills within the scope of clinical psychology, mental health prophylactic skills are expected. Classes in the *'sociology of medicine'* (30 didactic hours during the entire course of physicians' education) cover only rudimentary information in the area of professional interpersonal communication (elements of behaviour in health and illness). Anthropologic

[253] Standardy kształcenia dla kierunków studiów: kierunek lekarski. < http://www.bip.nauka.gov.pl >.

aspects (classes in '*human philosophy*') did not find reflection in the curriculum, and classes in philosophy were limited to *'medical ethics',* deontology.

7.1.2. Nurses

Analysis of the documentation showed, that the official standards of education for the first-degree studies (Bachelor's Degree) in nursing currently in effect in Poland assume that the graduate should be prepared, among others, for the following:

a. provision of services in the area of health promotion, health maintenance, and prevention of diseases,
b. exercising a general and individualized patient care of the disabled, and end--of- life care of patients,
c. communication with the surroundings at the workplace,
d. establishment of co-operational relationships in health care teams.

The above-mentioned competences are based on interpersonal individual and team communication, and should be the result of education within the scope of general psychology (60 didactic hours). The imparted contents within the scope of communication cover: theories, models and concepts of interpersonal communication, styles of communication, imparting and receiving information.

Graduates of second-degree studies (Master's Degree) within the classes in psychotherapy (30 didactic hours) acquire the following knowledge: types, goals, stages, and psychotherapeutic methods, psychotherapy and psychological assistance, basic therapeutic interventions, therapeutic relationship in nursing care.

The investigated, 20 curricula and syllabuses of schools educating nurses in Poland contained the above-described educational contents in accordance with the obligatory standard, but did not contain separate classes for training skills in interpersonal communication.

7.1.3. Paramedics

Analysis of the documentation showed, that the standards of education for paramedics currently effective in Poland, in the description of qualifications, do not cover as a requirement the skills within the scope of professional medical (rescue) interpersonal communication, but focus rather on general psychological and communication knowledge. Nevertheless, educational contents include records of knowledge concerning the relationship between a medical professional and a patient, with emphasis placed on the difficulties in cooperation. This, however, is only one of many issues undertaken during the didactic hours in psychology.

There is a lack not only of educational contents from the sphere of occupational interpersonal communication, but also interdisciplinary communication [254, 255, 256].

7.1.4. Physiotherapists

Analysis of the documentation showed, that the official standards of education for the first-degree studies (Bachelor's Degree) in physiotherapy, assume that students should *possess psychophysical predispositions to work with the ill and disabled*', as being the result of education within the scope of general psychology (45 didactic hours), and should be prepared, among other things, for the '*understanding of basic human reactions to illness*' [257].

Graduates of second-degree studies (Master's Degree) within the classes in clinical psychology and psychotherapy (30 didactic hours) acquire the knowledge, which should be the basis for acquiring skills of '*perception of psychological problems of patients with various dysfunctions and at various ages, and the effect of these problems on the course and efficacy of rehabilitation*'. All the 20 investigated curricula and syllabuses of schools educating physiotherapists in Poland contained the above-described standard educational contents, but did not contain courses for training skills in professional communication.

7.2. Diagnostic survey

7.2.1. Physicians

The box-plot diagrams (Charts 6,7,8) and Table 7 present the comparison of selected results of the diagnostic survey concerning levels of professional communication competences of physicians and students of medicine in the area of motivation, knowledge and skills.

The level of motivation, knowledge and skills indices, theoretically remain within the range from 0-1. In this case, the difference in 'motivation' level between physicians and students is not statistically significant. On the contrary, in the cases of 'knowledge' and 'skills', both indices are slightly lower in the group of occupationally active physicians than in the group of students, and that both differences are statistically (t-Student tests) significant (knowledge: p=0.007, skills: p=0.011). However, a great variation of observation values and numerous divergent mea-

[254] Rozporządzenie Ministra Zdrowia z dnia 14 czerwca 2007 r. w sprawie doskonalenia zawodowego ratowników medycznych.

[255] Rozporządzenie Ministra Nauki i Szkolnictwa Wyższego z dnia 12 lipca 2007 r. w sprawie standardów kształcenia dla poszczególnych kierunków oraz poziomów kształcenia (…).

[256] Rozporządzenie Ministra Zdrowia z dnia 14 stycznia 2009 r. zmieniające rozporządzenie w sprawie szczegółowego zakresu medycznych czynności ratunkowych, które mogą być podejmowane przez ratownika medycznego.

[257] Rozporządzenie Ministra Nauki i Szkolnictwa Wyższego z dnia 12 lipca 2007 r., op.cit.

surement values cause that the results of the statistical tests should be treated with caution.

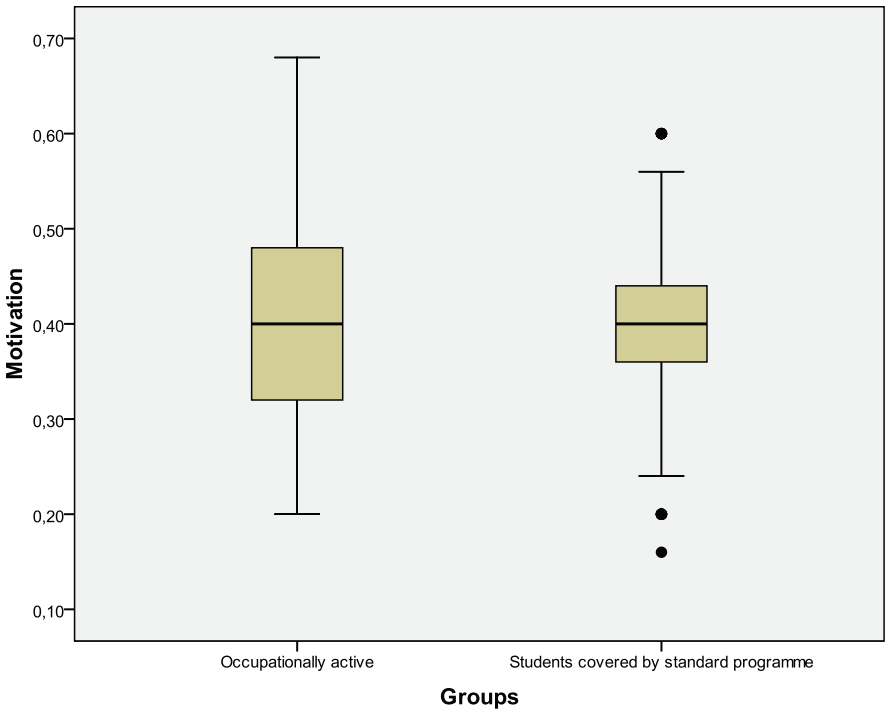

Chart 6. Comparison of motivation levels between physician and students of medicine.

Source: The present study

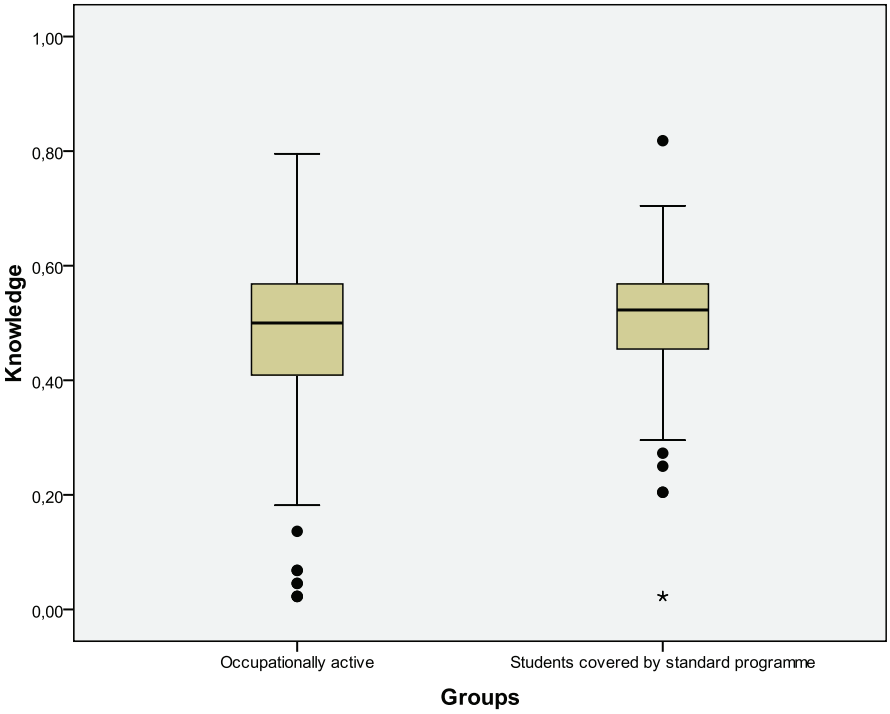

Chart 7. Comparison of knowledge levels between physician and students of medicine.
Source: The present study

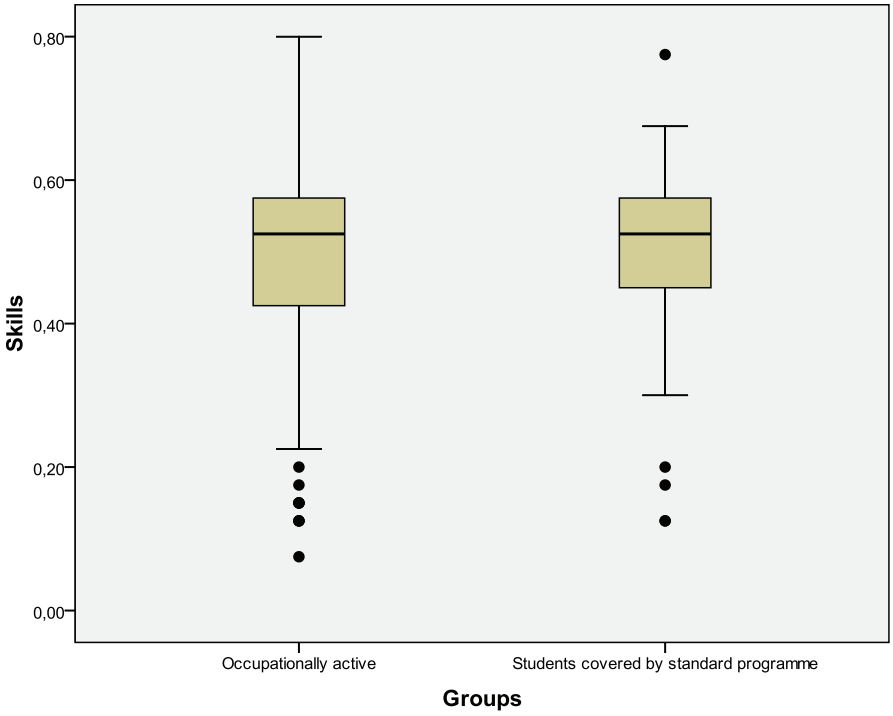

Chart 8. Comparison of skills levels between physician and students of medicine.
Source: The present study

Table 7. Comparison of levels of communication competences between physicians and students of medicine (t-Student).

Scope	Group	N	Mean	Mean difference	Standard deviation	Standard error	Mini-mum	Maxi-mum	t	p
Motivation	Physicians	185	0.4024	0.00254	0.10892	0.00801	0.20	0.68	0.265	0.791
	Students of medicine	246	0.3998		0.08995	0.00574	0.16	0.60		
	Total	431	0.4009		0.09843	0.00474	0.16	0.68		
Knowledge	Physicians	185	0.4754	-0.03344	0.15225	0.01119	0.02	0.80	-2.721	0.007
	Students of medicine	246	0.5089		0.10249	0.00653	0.02	0.82		
	Total	431	0.4945		0.12720	0.00613	0.02	0.82		
Skills	Physicians	185	0.4850	-0.02852	0.13561	0.00997	0.08	0.80	-2.551	0.011
	Students of medicine	246	0.5135		0.09635	0.00614	0.13	0.77		
	Total	431	0.5013		0.11558	0.00557	0.08	0.80		

Source: The present study

7.2.2. Nurses

The box-plot diagrams (Charts 9,10,11) and Table 8 presents the comparison of selected results of the diagnostic survey concerning professional communication competences of nurses in the area of motivation, knowledge and skills, in the compared groups. The mean value of motivation, knowledge and skills levels which, theoretically, remain within the range from 0 to 1, was lower in the group of occupationally active nurses in the study than the value of these levels in the remaining groups – students of nursing who had undergone extra training in professional communication and those who participated in the standard course in general interpersonal communication. The differences with respect to knowledge ($p=0.017$) and skills ($p=0.012$), were statistically significant (ANOVA), and in the case of motivation – highly statistically significant ($p<0.0001$).

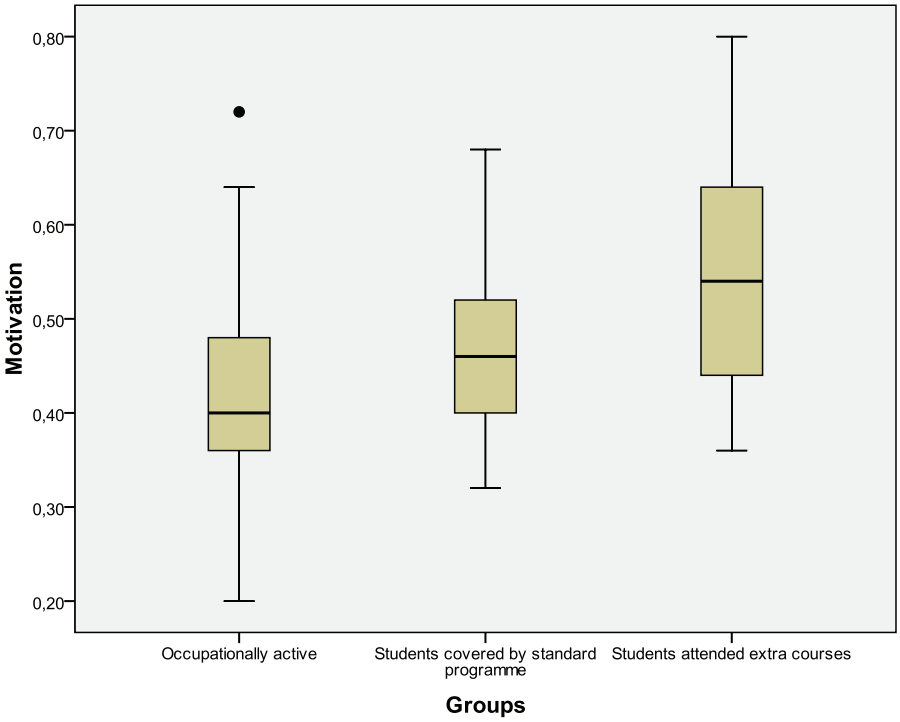

Chart 9. Comparison of motivation levels between observed groups of nurses.
Source: The present study

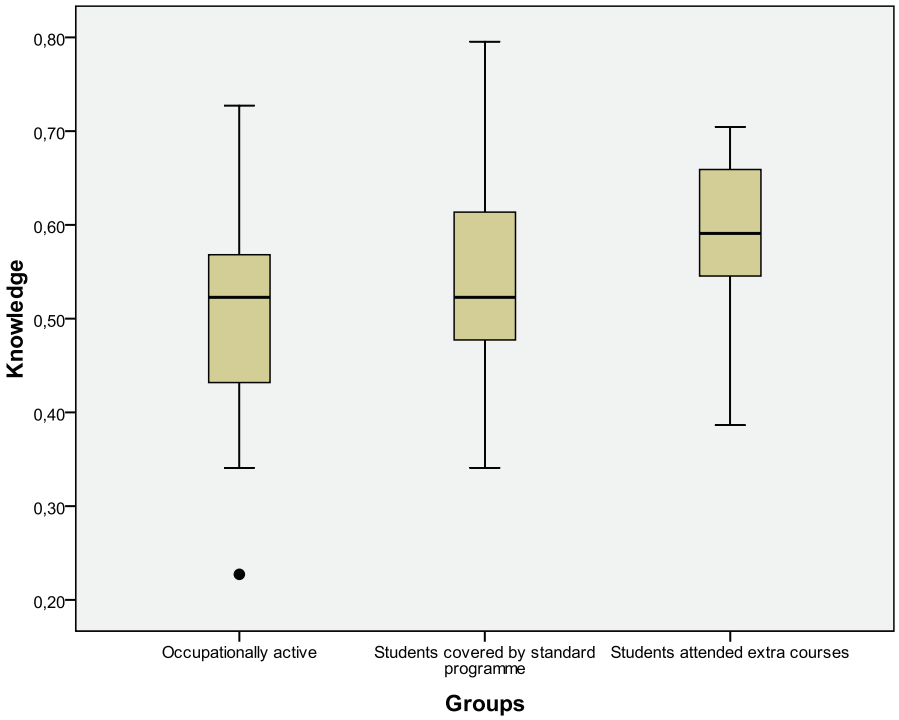

Chart 10. Comparison of knowledge levels between observed groups of nurses.
Source: The present study.

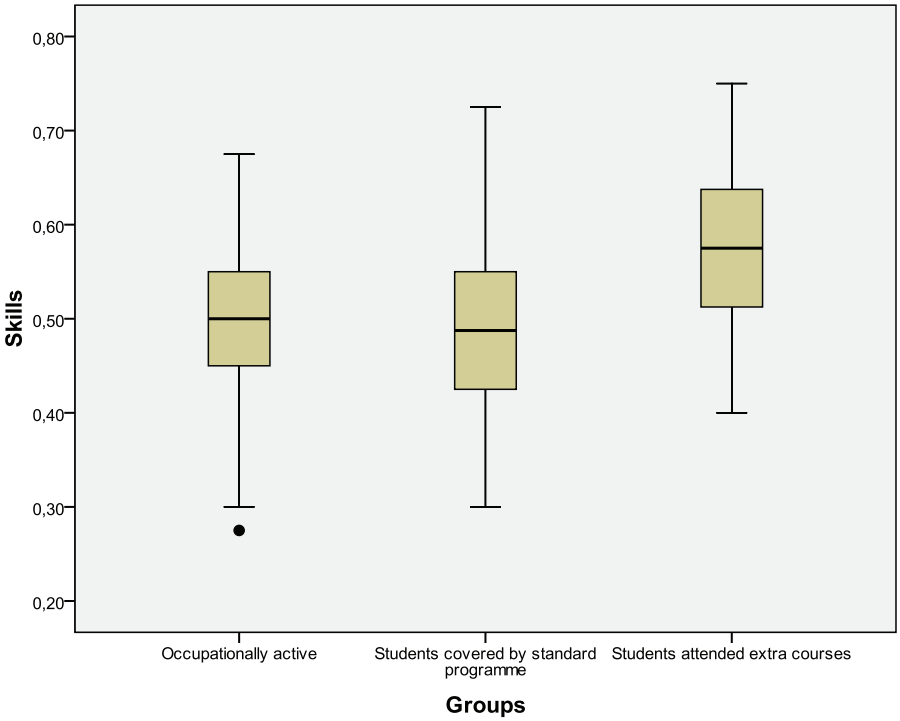

Chart 11. Comparison of skills levels between observed groups of nurses.
Source: The present study.

Table 8. Comparison of levels of communication competences between observed groups of nurses (ANOVA).

Scope	Group	N	Mean	Standard deviation	Standard error	Minimum	Maximum	F	p
Motivation	Occupationally active professionals	42	0.4152	0.11312	0.01745	0.20	0.72	10.589	0.000
	Students covered by standard programme	46	0.4722	0.09107	0.01343	0.32	0.68		
	Students attended extra courses	20	0.5460	0.12124	0.02711	0.36	0.80		
	Total	108	0.4637	0.11498	0.01106	0.20	0.80		
Knowledge	Occupationally active professionals	42	0.5103	0.09865	0.01522	0.23	0.73	4.227	0.017
	Students covered by standard programme	46	0.5430	0.10133	0.01494	0.34	0.80		
	Students attended extra courses	20	0.5864	0.08427	0.01884	0.39	0.70		
	Total	108	0.5383	0.10028	0.00965	0.23	0.80		
Skills	Occupationally active professionals	42	0.4952	0.09647	0.01489	0.27	0.68	4.643	0.012
	Students covered by standard programme	46	0.5033	0.09826	0.01449	0.30	0.73		
	Students attended extra courses	20	0.5713	0.08895	0.01989	0.40	0.75		
	Total	108	0.5127	0.09915	0.00954	0.27	0.75		

Source: The present study.

7.2.3. Paramedics

The box-plot diagrams (Charts 12,13,14) and Table 9 presents the comparison of selected results of the diagnostic survey concerning professional communication competences of paramedics. Among three examined groups, the mean value of levels of motivation and skills, which may theoretically range from 0–1, was lower than the mean values of these levels in the two remaining groups, i.e. students who completed a training course in professional medical communication, and students who participated in a standard training in psychology. Only the mean value of the level of knowledge was higher among professional paramedics, compared to students who completed a standard course. The differences with respect to motivation, knowledge and skills turned out to be statistically highly significant (ANOVA).

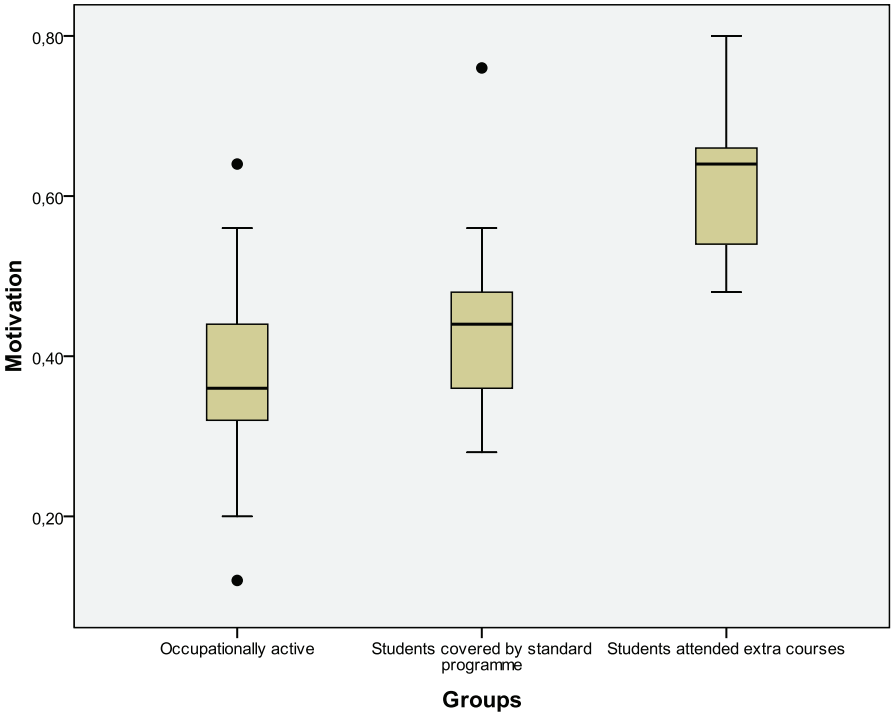

Chart 12. Comparison of motivation levels between observed groups of paramedics.
Source: The present study.

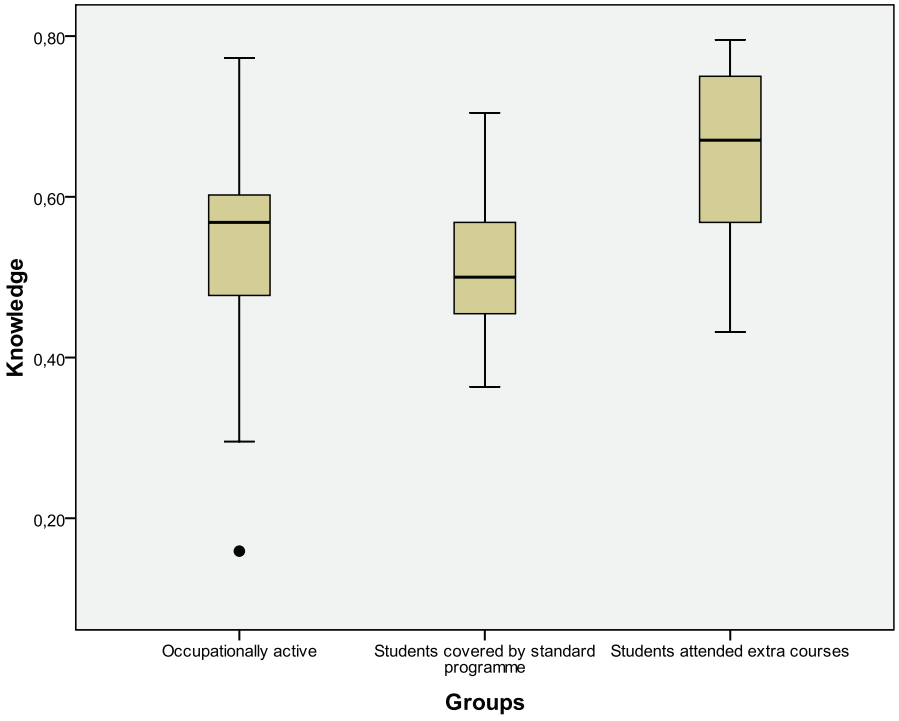

Chart 13. Comparison of knowledge levels between observed groups of paramedics.
Source: The present study.

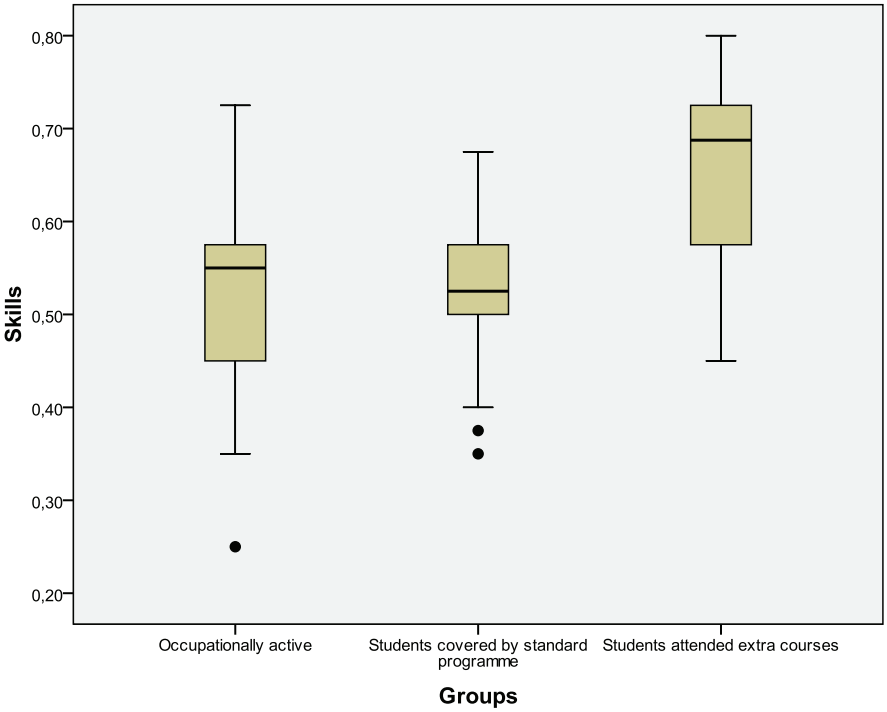

Chart 14. Comparison of skills levels between observed groups of paramedics.
Source: The present study.

Table 9. Comparison of levels of communication competences between observed groups of paramedics (ANOVA)

Scope	Group	N	Mean	Standard deviation	Standard error	Minimum	Maximum	F	p
Motivation	Occupationally active professionals	31	0, 3690	0, 11394	0, 02046	0, 12	0, 64	40, 205	0, 000
	Students covered by standard programme	54	0, 4259	0, 09232	0, 01256	0, 28	0, 76		
	Students attended extra courses	20	0, 6140	0, 08438	0, 01887	0, 48	0, 80		
	Total	105	0, 4450	0, 12958	0, 01265	0, 12	0, 80		
Knowledge	Occupationally active professionals	31	0, 5301	0, 12781	0, 02296	0, 16	0, 77	12, 420	0, 000
	Students covered by standard programme	54	0, 5168	0, 08071	0, 01098	0, 36	0, 70		
	Students attended extra courses	20	0, 6489	0, 11576	0, 02589	0, 43	0, 80		
	Total	105	0, 5459	0, 11416	0, 01114	0, 16	0, 80		
Skills	Occupationally active professionals	31	0, 5218	0, 10660	0, 01915	0, 25	0, 73	13, 790	0, 000
	Students covered by standard programme	54	0, 5333	0, 06851	0, 00932	0, 35	0, 68		
	Students attended extra courses	20	0, 6462	0, 11276	0, 02521	0, 45	0, 80		
	Total	105	0, 5514	0, 10077	0, 00983	0, 25	0, 80		

Source: The present study.

7.2.4. Physiotherapists

The box-plot diagrams (Charts 15,16,17) and Table 10 presents the comparison of selected results of the diagnostic survey. The mean value of levels of motivation, knowledge and skills which, theoretically, remain within the range from 0 to 1. That value was lower in the group of occupationally active physiotherapists than in the remaining groups – students who had undergone extra training in professional communication, and those who participated in the standard course only. The differences with respect to motivation, knowledge and skills were highly statistically (ANOVA) significant ($p<0.000$).

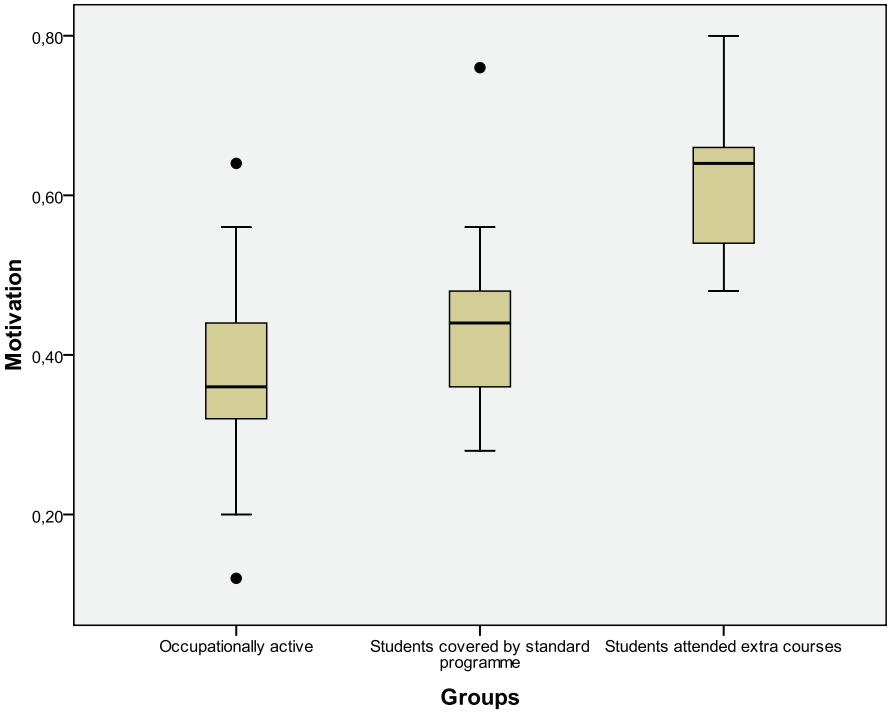

Chart 15. Comparison of motivation levels between observed groups of physiotherapists.
Source: The present study.

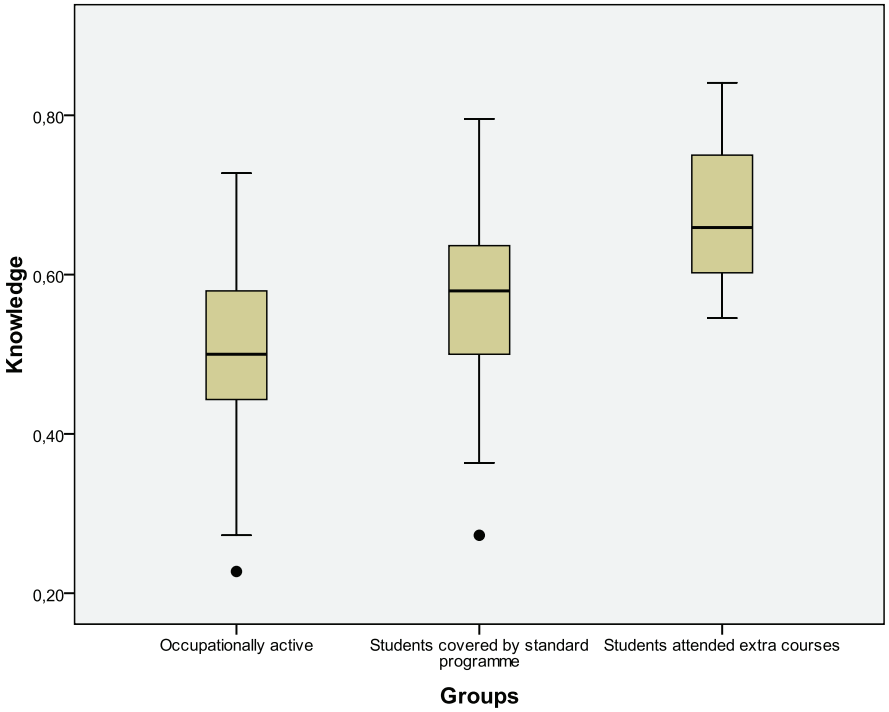

Chart 16. Comparison of knowledge levels between observed groups of physiotherapists.
Source: The present study.

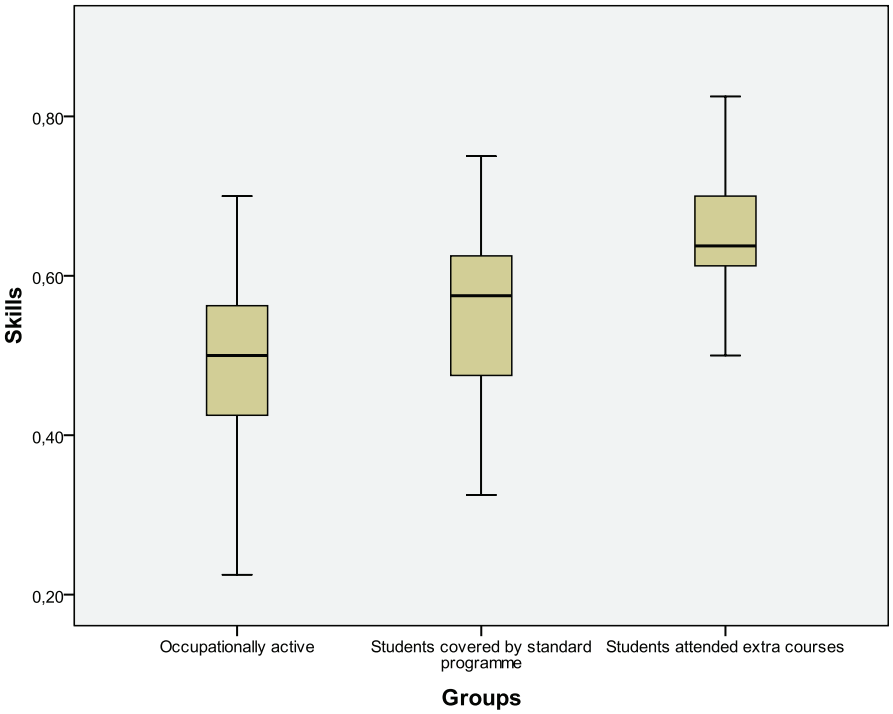

Chart 17. Comparison of skills levels between observed groups of physiotherapists.
Source: The present study.

Table 10. Comparison of levels of communication competences between observed groups of physiotherapists.

Scope	Group	N	Mean	Standard deviation	Standard error	Minimum	Maximum	F	p
Motivation	Occupationally active professionals	35	0.4183	0.10051	0.01699	0.20	0.64	28.236	0.000
	Students covered by standard programme	60	0.4433	0.09411	0.01215	0.20	0.68		
	Students attended extra courses	20	0.6080	0.08954	0.02002	0.48	0.80		
	Total	115	0.4643	0.11592	0.01081	0.20	0.80		
Knowledge	Occupationally active professionals	35	0.5136	0.11486	0.01941	0.23	0.73	14.586	0.000
	Students covered by standard programme	60	0.5739	0.10374	0.01339	0.27	0.80		
	Students attended extra courses	20	0.6705	0.07925	0.01772	0.55	0.84		
	Total	115	0.5723	0.11532	0.01075	0.23	0.84		
Skills	Occupationally active professionals	35	0.4936	0.10750	0.01817	0.22	0.70	16.218	0.000
	Students covered by standard programme	60	0.5492	0.10261	0.01325	0.32	0.75		
	Students attended extra courses	20	0.6550	0.08335	0.01864	0.50	0.83		
	Total	115	0.5507	0.11387	0.01062	0.22	0.83		

Source: The present study.

7.3. Professional self-evaluation

7.3.1. Physicians

Table 11 presents a comparison of the shortcomings in communication competences between the group of occupationally active physicians and group of medical students. The comparison showed that those shortages are significantly different between the compared groups with respect to the following competences:

a. acceptance of a patient,
b. knowledge of assertiveness,
c. knowledge of the role of feedback information in communication,
d. tolerance with respect to patients and their significant others,
e. skills of solving conflicts with patients and their significant others.

Table 11. Comparisons of selected competences between physicians and students of medicine.

Evaluated competences	Results	Groups		Chi²	p
		Physicians	Students of medicine		
Acceptance of a patient	absent	90% (167)	96% (237)	6.628	0.010
	present	10% (18)	4% (9)		
Knowledge of assertiveness	absent	72% (132)	85% (210)	12.009	0.001
	present	28% (52)	15% (36)		
Knowledge of the role of feedback information in communication	absent	84% (155)	93% (230)	10.447	0.001
	present	16% (30)	7% (16)		
Tolerance towards patients and their significant others	absent	79% (146)	67% (164)	7.850	0.005
	present	21% (39)	33% (82)		
Skills of solving conflicts with patients and their significant others	absent	29% (53)	43% (106)	9.458	0.002
	present	71% (132)	57% (140)		

Source: The present study.

7.3.2. Nurses

Table 12 presents a comparison of the selected possessed communication competences between the group of occupationally active nurses and both groups of nursing students. The comparison showed that occupationally active nurses show the greatest shortages with respect to the following:

a. lack of perception of limitation in work with patients (81.0%),
b. knowledge of the role of active listening (47.6%),
c. tolerance with respect to patients and their significant others (71.4%),
d. needs within the scope of communication knowledge (57.1%),
e. needs within the scope of communication skills (52.4%).

Nursing students, who participated in the extra training in nursing professional interpersonal communication showed the least shortcomings within the scope of the evaluated communication competences. The relationships described above were statistically significant or highly significant. Only in the case of knowledge concerning psychological resistance mechanisms, greater shortcomings were observed among student nurses who had undergone a general interpersonal communication course (93.5%), although, also in this case, the shortcomings noted among occupationally active nurses were very high (90.5%).

Table 12. Presence or absence of selected skills among examined groups of nurses.

Evaluated skill	Results	Group			Chi^2	p
		Occupationally active professionals	Students covered by standard programme	Students attended extra courses		
Perception of limitations in work with patients	absent	81.0% (34)	60.9% (28)	55.0% (11)	5.819	0.054
	present	19.0% (8)	39.1% (18)	45.0% (9)		
Knowledge of the role of active listening	absent	47.6% (20)	23.9% (11)	15.0% (3)	8.811	0.012
	present	52.4% (22)	76.1% (35)	85.0% (17)		
Knowledge of resistance mechanisms	absent	90.5% (38)	93.5% (43)	45.0% (9)	26.112	0.000
	present	9.5% (4)	6.5% (3)	55.0% (11)		
Tolerance towards patients and their significant others	absent	71.4% (30)	39.1% (18)	40.0% (8)	10.555	0.005
	present	28.6% (12)	60.9% (28)	60.0% (12)		
Needs within the scope of communication knowledge	absent	57.1% (24)	21.7% (10)	15.0% (3)	16.261	0.000
	present	42.9% (18)	78.3% (36)	85.0% (17)		
Needs within the scope of communication skills	absent	52.4% (22)	19.6% (9)	10.0% (2)	16.030	0.000
	present	47.6% (20)	80.4% (37)	90.0% (18)		

Source: The present study.

7.3.3. Paramedics

Comparison of selected communication competences in the examined groups confirmed that professional paramedics showed the greatest shortcomings in the following areas:

a. acceptance of a patient (93.5%),
b. knowledge of the role of communication, feedback (71%).

Students of emergency medicine who completed a standard course in psychology showed the greatest shortcomings in the following areas:

a. knowledge of empathy (68.5%),
b. knowledge of assertiveness (61.1%),
c. knowledge of psychological self-defence mechanisms (53.7%),
d. knowledge concerning the role of active listening in communication (72.2%).

Students of emergency medicine who, apart from the standard training course in psychology, participated in a professional course in interpersonal communication, possessed the fewest shortcomings within the scope of examined communication competences. The above described relationships were statistically significant or highly significant (Table 13).

Table 13. Presence or absence of selected skills among examined groups of paramedics.

Evaluated skill	Results	Group			Chi^2	p
		Occupationally active professionals	Students covered by standard programme	Students attended extra courses		
Patient acceptance	absent	93.5% (29)	87.0% (47)	55.0% (11)	14.086	0.000
	present	6.5% (2)	13.0% (7)	45.0% (9)		
Knowledge of the role of empathy	absent	29.0% (9)	68.5% (37)	25.0% (5)	17.788	0.000
	present	71.0% (22)	31.5% (17)	75.0% (15)		
Knowledge of the role of assertiveness	absent	16.1% (5)	61.1% (33)	5.0% (1)	28.001	0.000
	present	83.9% (26)	38.9% (21)	95.0% (19)		
Knowledge of the role of feedback communication	absent	71.0% (22)	90.7% (49)	55.0% (11)	12.204	0.002
	present	29.0% (9)	9.3% (5)	45.0% (9)		
Knowledge of resistance mechanisms	absent	48.4% (15)	53.7% (29)	20.0% (4)	6, 807	0.033
	present	51.6% (16)	46.3% (25)	80.0% (16)		
Knowledge of the role of active listening	absent	58.1% (18)	72.2% (39)	20.0% (4)	16.349	0.000
	present	41.9% (13)	27.8% (15)	80.0% (16)		

Source: The present study.

7.3.4. Physiotherapists

Table 14 presents a comparison of the selected communication competences between the group of occupationally active physiotherapist and both groups of students. The comparison demonstrated that occupationally active physiotherapists show the greatest shortages with respect to the following:

a. lack of perception of limitation in work with a patients (71.4%, 25),
b. knowledge of the role of active listening (62.9%, 22),
c. knowledge of resistance mechanisms (100%, 100),
d. lack of perception of needs within the scope of communication knowledge (57.1%, 20),
e. lack of perception of needs within the scope of communication skills (37.1%, 13).

Students who participated in the extra training in interpersonal communication showed the least shortcomings. These relationships were statistically significant or highly significant. Only in the case of 'tolerance towards patients and their significant others', the difference among compared groups was not statistically significant ($p \leq 0.066$). However, also in this case, the shortcomings observed among students who had undergone a standard course (60%), and among occupationally active physiotherapists, were very high (51.4%).

Table 14. Presence or absence of selected skills among examined groups of physiotherapists.

Evaluated skill	Results	Group			Chi^2	p
		Occupationally active professionals	Students covered by standard programme	Student attended extra courses		
Perception of limitations in work with patients	absent	71.4% (25)	40.0% (24)	25.0% (5)	13.452	0.001
	present	28.6% (10)	60.0% (36)	75.0% (15)		
Knowledge of the role of active listening	absent	62.9% (22)	43.3% (26)	0.0% (0)	20.810	0.000
	present	37.1% (13)	56.7% (34)	100.0% (20)		
Knowledge of resistance mechanisms	absent	100.0% (35)	98.3% (59)	40.0% (8)	57.319	0.000
	present	0.0% (0)	1.7% (1)	60.0% (12)		
Tolerance towards patients and their significant others	absent	51.4% (18)	60.0% (36)	30.0% (6)	5.421	0.066
	present	48.6% (17)	40.0% (24)	70.0% (14)		
Needs within the scope of communication knowledge	absent	57.1% (20)	56.7% (34)	10.0% (2)	14.513	0.001
	present	42.9% (15)	43.3% (26)	90.0% (18)		
Needs within the scope of communication skills	absent	37.1% (13)	23.3% (14)	0.0% (0)	9.775	0.008
	present	62.9% (22)	76.7% (46)	100.0% (20)		

Source: The present study.

8. Discussion

8.1. Introduction

Occupational development covers five primary functions:

a. expanding knowledge useful in problem situations, especially in conceptual work,
b. learning based on experiences – acquisition of practical knowledge through observation of oneself and other employees, and implementation of new solutions in the work performed,
c. development of new attitudes and beliefs – change of to-date attitudes, reformulation of the system of values, principles and standards of behaviour,
d. possibility to rebuild occupational qualification – this concerns an individual dimension and refers to the personal competences of an employee, diagnosing these competences and their improvement to a higher level,
e. cooperation and contribution in staff development – imparting knowledge and skills, use of knowledge resources of other workers, mutual learning and acting (coaching, mentoring, peer tutoring) [258].

The communication skills and art associated with health and medical services are neither innate nor automatic. Communication skills are acquired and refined only through practice [259]. Some results suggest that the communication skills training programme could be valuable for reinforcing basic/intuitive communication strategies, assisting in the acquisition of new skills, and ensuring communication supply availability [260].

The results of the research confirm the reports by other researchers that communication competences are not acquired 'spontaneously' during occupational activity, based on theoretical knowledge in the area of general psychology [261, 262, 263].

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The presented research instrument provides a possibility to diagnose educational needs in the area of professional interpersonal communication, and may be useful in constructing group and individual educational programmes. The purposefulness of using such instruments is confirmed by other studies which indicate that the proper approach is to focus on specific communication skills rather than a full suite of skills [264]. Many methods of discovering and developing communication motivations among pre-graduate and postgraduate students are described in literature [265, 266, 267, 268, 269, 270, 271].

Literature reports unequivocally emphasize the importance of education for improvement of communication competences, which should not be approached as permanent values. F. Grucza stresses that: "*both communication competences and interpersonal understanding are of a dynamic character (gradual), and* […] *therefore, the produced (possessed) skills,* […]. *should not be treated as something given once and for all,* […] *if one does not care about these skills they simply shrink and finally disappear*" [272].

A similar phenomenon is presented by L. Beamer, who considers that in order for the expansion of communication competences through education to bring the desired results, it is necessary to continue the educational process in which communication skills should be developed and fostered [273].

The model of education within professional interpersonal communication proved to be significantly more effective in the improvement of total commu-

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nication competences than the model of education within general interpersonal communication. In the case of the general model, the observed levels of total competences with respect to motivation, skills and knowledge remained on the level of 50%, while for professional model – on the level of 60%. This indicates that further improvement in educational methods, techniques and educational instruments is necessary in the area of professional interpersonal communication [274].

8.2. Physicians

Analysis of the educational curricula for the students of faculties of medicine unequivocally indicated that the scope of education in the professional medical communication is very narrow. There is no subject (module, course) dedicated directly to these contents.

Didactics within professional communication skills is a great challenge. Undoubtedly, one of the methods is that of educating through example – doctors possessing communication skills become tutors of the students (the only method practiced at Medical Universities in Poland). However, if they are not capable of analytically passing on what their skills consist of, they become a type of 'magician' in this respect. Their mastery is not converted in a conscious way into the students' skills [275].

This 'magic' is actually a set of well-improved skills which cover self-reflection – including the skill of managing own emotions, active listening, knowledge of psychological defence mechanisms, assertiveness, accurate empathy (not 'co--sensing', but the understanding of a patient's feelings), provision of feedback information, etc.[276].

In addition, in order to effectively teach students, the academic tutor should go beyond personal communication skills, so that from the meta-level, the tutor could indicate to the students specified principles and relationships present in relations with a patient. The teaching of communication competences also requires the skills of deconstruction of all elements of communication interaction, developing of a cognitive approach, as well as, non-linear perception of the reality [277].

Finally, the most important thing is the creation by the academic tutor of a 'safe' educational environment, bearing in mind that the environment of communication are emotions of doctor or student and patient. 'Safe' means the one which

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ensures the maintaining of secrecy of personal emotional reflections, entrusted during the classes to the group and to the tutor (here, the principle of maintaining medical secrecy is reiterated and trained) [278].

The results showing the general state of the respondents' communication competences in all aspects (motivation, skills, and knowledge) were relatively low. This clearly indicated an inadequate educational model (students), and lack of training in professional medical communication (doctors).

As many as 90% of the doctors in the study and 96% of the students of medicine showed, so-called, conditional acceptance towards a patient, i.e. 'I accept the patient, if he/she is […] clean and nice, carries out orders, etc.' Conditional acceptance is evaluation of the patient, and testing if the patient fulfils our conditions. To accept a patient means practically to allow him/her to be as he/she is, with all which constitutes his/her equipment, this also concerns not only the patient's psychical mood, cheerful spirit, but also gloomy discouragement. Only on the ground of unconditional acceptance may develop appropriate professional communication [279].

Neglect in this respect limits the possibilities originating from a good communication. Appropriate doctor-patient communication has high therapeutic potential. It may help in the emotional regulation of a patient, facilitate the understanding of medical information by a patient, and helps the doctor in the identification of a patient's demands, patient's perception of disease, and expectations with respect to the process of regaining health [280].

Simultaneously, the good preparation of the students of medicine and doctors for communicating with patients allows the overcoming of many barriers. Work with patients can brings about many unpleasant emotions (anxiety, fear of conflicts, verbal or physical attacks on the part of patients, patients' non-realistic expectations, and fear of mistakes). The skill to recognize these motions, name them, understand, and ultimately cope with own emotionality, is a part of the communication training [281].

Communication competences also protect students and doctors against dehumanization, which often results from technicalization of medicine, frequent

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experiencing of death, or even an insufficient amount of time devoted to a patient [282, 283].

Each patient is rooted in the social and cultural environment, exerting an effect on his/her attitude towards own health. Shortcomings in communication education very often result in the avoidance by doctors of conversations with patient concerning problems related with the environment, e.g. patient's family environment [284].

A large group of physicians, while they do not cope with the fulfilment of patients' expectations, discourage them from the verbalization of concerns or attitudes concerning own illness. That frequently results in therapeutic failure [285]. The state of communication competences, confirmed by the presented study, may find its justification in other studies, in which self-evaluation of communication competences by doctors was compiled with the evaluations reported by their patients. As much as 75% of orthopaedic surgeons considered that they satisfactorily communicated with their patients, whereas, at the same time, only 21% of the patients mentioned that the communication with doctors was satisfactory [286]. This over--estimated self-evaluation may be the source of disregarding educational needs in the area of communication, and simultaneously, may indicate a poor recognition of the relationships between difficulties in contacts with patients and the level of communication competences.

For counterbalance, it is noteworthy that there are studies which confirm the need, and sometimes the necessity, for improvement in the level of competences in the field of communication with a patient. Physicians, like other people, are not born with excellent communication skills, however, they may possess many talents facilitating education in this area. Their communication skills can be provided exclusively by motivation, education and training, capability for change, as well as awareness of the need for constant training [287].

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Each training in communication competences improves the doctor-patient relations. It should also be remembered that this type of skill expires in time, and therefore should be constantly up-dated [288, 289].

8.3. Nurses

Effective communication is a vital component of nursing care, however, nurses often lack the skills to communicate with patients and other health care professionals. Communication skills training programmes are frequently used to develop these skills. However, there is a paucity of data on how best to evaluate such courses [290, 291].

A number of recent developments in medical and nursing education have highlighted the importance of communication and consultation skills (CCS). Although such skills are taught in all medical and nursing undergraduate curricula, there is no comprehensive screening or assessment programme of CCS [292]. For nursing educators, the utility of development of instruments to measure the effectiveness of teaching strategies and pedagogy for empathy enhancement in practice is important [293]. Some authors use the Empathic Communication Skills Scale (ECSS) and the Empathic Tendency Scale (ETS) to evaluate the empathic skills and the empathetic tendency of nursing students [294].

Measuring patient-centred communication is notoriously difficult. There is need for several measures as proxies for patient centeredness: empathetic behaviours, 'reciprocity', decreased biomedical talk, 'appropriate responses' and length

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291 Mullan BA. Kothe EJ. Evaluating a nursing communication skills training course: The relationships between self-rated ability, satisfaction, and actual performance. Nurse Educ Pract. 2010, 10(6), 374–378.

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of uninterrupted patient talk. Using real patients and assessing their satisfaction with communication may be the ideal method [295, 296].

In addition, the presented results indicate that communication competences acquired during undergraduate nursing education are subject to regression while performing the occupation, and are replaced by defence mechanisms, such as psychological resistance or withdrawal.

The results of the presented study indicate that over 80% of occupationally active nurses did not perceive communication limitations while working with patients, and simultaneously, over 42% of them expressed needs within the scope of communication knowledge, and more than 47% – needs within the scope of communication skills (Table 7). The research, which was conducted to gain insight into the role of European haematology nurses and identify their learning needs, indicates the lack of coherence in the sphere of interpersonal communication. The respondents believed that they were well trained, possessed good communication skills. However, a significant number of nurses (42%), indicated that they had a limited role to play in patient education and only 38% agreed that they played an important role in facilitating patient choice [297].

The need for a systematic supplementation and renewal of communication competences concerns especially psychiatric, oncologic and terminal care nursing

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[296] Sheldon LK. An evidence-based communication skills training programme for oncology nurses improves patient-centred communication. enhancing empathy. reassurance and discussion of psychosocial needs. Evid Based Nurs. 2011, 14, 87–88.

[297] Aerts E. Fliedner M. Redmond K. Walton A. Defining the scope of haematology nursing practice in Europe. Eur J Oncol Nurs. 2010, 14(1), 55–60.

where a psycho-education method can decrease the occupational stress and confidence in dealing with patient depression [298, 299, 300, 301, 302, 303, 304, 305, 306].

Our own studies showed that in the group of occupationally active nurses, the mean values of motivation, knowledge and skills indices were lower than the mean values in both groups of nursing students. Among nursing students these indices were lower in the group provided with a standard education – only within the range of general interpersonal communication. In our study, occupationally active nurses showed the greatest shortcomings with respect to the five of six scopes examined. On the one hand, this denies the thesis that the professional practice itself develops communication competences, however, on the other hand, it reflects the lack of continuing education within the scope of interpersonal communication among occupationally active nurses. Regardless of the nursing specialty, published studies have shown that continuing skills training courses can improve the self-efficacy and has shown a significant increase patient and family members satisfaction [307, 308, 309].

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302 Fukui S. Ogawa K. Ohtsuka M. Fukui N. Effects of communication skills training on nurses' detection of patients' distress and related factors after cancer diagnosis: a randomized study. Psychooncology 2009, 18(11), 1156–1164.

303 Langewitz W. Heydrich L. Nübling M. Szirt L. Weber H. Grossman P. Swiss Cancer League communication skills training programme for oncology nurses: an evaluation. J Adv Nurs. 2010, 66(10), 2266–2277.

304 Shannon SE. Long-Sutehall T. Coombs M. Conversations in end-oflife care: communication tools for critical care practitioners. Nurs Crit Care. 2011, 16(3), 124–130.

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8.4. Paramedics

Professional behaviour is one of the cornerstones of effective emergency medical services (EMS) practice. In the study by Brown et al., the behaviours most highly rated were integrity and appearance/personal hygiene [310]. Dealing with illness, recovery and death require health care workers to manage not only their own emotions, but also the emotions of those around them. However, little is known about the requirements for emotion management on the part of front-line staff [311]. Smith-Cumberland et al. emphasize several important issues including:

a. the impact that emergency medical technicians (EMT) have on the family at the time of death,
b. the EMT's role includes making death notifications and helping meet the psychosocial needs of the bereaved,
c. that these roles and skills are as important as any other part of their professional duties.

Death notifications and interaction with bereaved families require more training in this area [312]. The data showed that EMTs' attitudes toward death changed after exposure to a training programme about death [313].

Williams examined emotional labour in health care and historical influences on paramedic education. In that study, the implications of 'emotion work' for the educational curriculum and the support of student paramedics are discussed, and strategies such as counselling, reflection and personal tutoring are suggested. Mentorship selection and preparation are highlighted, and the need for a cultural change in attitude towards emotion work [314].

The focus on the role of non-technical skills, such as communication, dynamic decision making, situational awareness and teamwork in emergency medicine, has gained importance during recent years. These factors, especially during time-critical and complex treatment of severely injured patients, play an important role for patient-safety and process optimization. Thus, apart from medical

[310] Brown WE. Jr. Margolis G. Levine R. Peer evaluation of the professional behaviors of emergency medical technicians. Prehosp Disaster Med. 2005, 20(2), 107–14.

[311] Ward J. McMurray R. The unspoken work of general practitioner receptionists: a re-examination of emotion management in primary care. Soc Sci Med. 2011, 72(10), 1583–7.

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[314] Williams A. Emotion work in paramedic practice: The implications for nurse educators. Nurse Educ Today 2012, 32(4), 368–72.

expertise and technical excellence, non-technical skills need to be incorporated in trainings [315].

Acute and rapid changes in the patient, the very public view of the care provided, and a need for rapid decision making by paramedics make deliberation – and after the process of communication, revealing the values and interests of the patient or the patient's family – a practical impossibility [316]. However, the dynamics of a rescue action cannot be an excuse for avoiding communication with a patient. Despite the pressure of time, a paramedic can never present the impression of someone acting in hurry, but a person ready to give help, also verbal (supporting, providing information) [317].

8.5. Physiotherapists

All three scopes of interpersonal communication competences (motivation, knowledge and skills), contribute to the occupational professionalism of physiotherapists. Unfortunately, the presented study showed that mean indicators in the group of occupationally active physiotherapists, were lower than the mean values of these indicators in the group of students. This may evidence a regression of communication competences in the course of occupational activity and the lack of continuing education in this area.

The most important competences which, at the same time, are the most difficult to train, are those in the area of motivation, and for an individual, motivation is the driving force for action which, simultaneously, delineates the direction of this action.

The results obtained indicate that both occupationally active physiotherapists and students who had completed a standard course in psychology, have serious shortcomings of knowledge. Without knowledge of what to say or do in specified situations, and knowledge of procedures, based on which this content will be put into practice, one cannot speak about a professional attitude towards patients and adequate contact with others [318].

Lack of 'tolerance towards patients and their significant others' may arise from the erroneous conviction that to tolerate means the same as to accept (see Lat. *acceptatio* – adopt, favour) someone's behaviour or attitudes. Tolerance is just the respect for someone's behaviours and attitudes, which we might not like. Tolerance

[315] Happel O. Papenfuss T. Kranke P. Training for real: simulation, team-training and communication to improve trauma management. Anasthesiol Intensivmed Notfallmed Schmerzther 2010, 45(6), 408–15.

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[318] Morreale SP. Spitzberg BH. Barge JK. Human communication: Motivation. knowledge and skills. Wadsworth Thomson Learning, Belmont, California 2002, 744.

allows the assumption of an open attitude towards a patient, irrespective of his/her habits, appearance, attitudes, behaviours, etc. A physiotherapist must eliminate the feeling of reluctance, which is easy to identify in relation with a patient, must be able to restrain from attempts to influence patients who have different attitudes.

The fundamental cause of the 'lack of perception of limitation in the work with a patient' is the lack of assertive skills, which cover the following:

a. skills of expressing oneself (clearly, directly), within the limits of tolerance for another person,
b. self-respect (reckoning on what one feels and thinks), which allow identification of personal resources,
c. awareness of own capabilities and limitations, i.e. giving oneself the right to make mistakes, and to be the best in various areas.

The preconditions of assertiveness are frankness (openness, truth), acceptance of oneself (acknowledgement of what one feels and thinks), responsibility for own life and life choices, and consequently, not blaming others or the 'circumstances', as well as trust with respect to oneself and the world. An equally important problem is the way of perceiving reality, in which one must excellently cope, thus, the perception and disguising of own limitations reduces the evaluation of own work in the eyes of others. Such ways of thinking about oneself distort reality, and therefore favour occupational burnout [319, 320].

Patients, due to illness (a difficult situation) apply many psychological defence mechanisms (e.g. repression, denial, reaction formation, rationalization, projection) and they change their natural behaviour. Similar defence mechanisms are also applied by physiotherapists in response to occupational stress. Knowledge of these mechanisms, and the skills of coping with them, is indispensable in effective physiotherapist-patient communication.

Shortcomings in the area of communication competences of physiotherapists also concern their 'knowledge of the role of active listening'. As commonly understood, very often 'listening' is confused with 'hearing', which is only a physiological reception of sounds, while 'listening' is when meaning is ascribed to this message and, subsequently, the feedback information is sent. Listening is a very important component of communication competences and may be 'trained' [321].

The shortcomings observed in the competences of physiotherapists also concerned 'needs within the scope of communication knowledge and skills'. Communication is an important area in the curricula of health professional educa-

[319] James R. Crisis intervention strategies. 6th ed. Brooks- Cole/Thompson, Belmont, CA 2008.
[320] Armstrong M. A Handbook of Human Resource Management Practice.11th ed. Kogan Page, London, Philadlephia 2009.
[321] Morreale SP. Spitzberg BH. Barge JK. Human communication: Motivation. knowledge and skills. Wadsworth Thomson Learning, Belmont, California 2002.

tion, however, it has been dealt with as discrete skills that can be learned and taught separate from the underlying thinking [322]. Occupational activity requires a constant supplementation of knowledge and improvement of manual and communication skills. The lack of perception of professional educational needs, i.e. lack of motivation, destroys the possibility of occupational development.

[322] Ajjawi R. Higgs J. Core components of communication of clinical reasoning: a qualitative study with experienced Australian physiotherapists. Adv Health Sci Educ Theory Pract. 2012, 17(1), 107–19.

9. Conclusions and limitations

Results of our studies indicate that the efficiency of shaping communication competences among students of medical/health professions based on education within the scope of general psychology and communication only, is relatively low. That kind of knowledge is not spontaneously translated into the anticipated communication competences while practicing their professions.

In the work of medical/health professionals, not only knowledge and professional (technical/hard) skills are important, but also psychosocial skills (relational/soft). The latter are divided into at least two aspects: competences in the area of interpersonal communication (medic-patient relation), and group communication (e.g. skills of working in a professional team). The presented study indicates a relatively low effectiveness of educational effect of educational programmes in the area of soft (psycho-social) competences functioning at Medical Universities in Poland.

Medical/health professionals should be open to others and cope well in stressful situations. For this reason communicativeness is indispensable, i.e. the skill of constructing relations which lead to an effective, open and kind communication with patients and the medical staff. However, the present studies indicate that under the effect of stressful situations, the relation skills acquired during the education are subject to regression. In their place there appear defence mechanisms such as psychological resistance or withdrawal. In consequence, this leads to withdrawal from appropriate contacts with others.

The method of evaluation of communication competences designed by the authors provides the possibility to diagnose educational needs of occupationally active medical/health professionals in the area of professional interpersonal communication, and may be helpful in constructing group and individual educational programmes. The purposefulness of such instruments is confirmed by other studies indicating that the proper approach is to focus on specific communication skills, rather than a general or full suite of skills [323, 324, 325].

In summing up, as the main postulates the researchers pose the following:

a. In the process of education, separate educational contents should be included in the field of professional communication competences (knowledge, motivation, skills).

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[323] Włoszczak-Szubzda A. Jarosz MJ. Professional communication competences of nurses. Ann Agric Environ Med 2012, 19(3), 601–607.

[324] Włoszczak-Szubzda A. Jarosz MJ. Professional communication competences of physiotherapists – practice and educational perspectives. Ann Agric Environ Med. 2013, 20(1), 189–194.

[325] Włoszczak-Szubzda A. Jarosz MJ. Professional communication competences of nurses – a review of current practice and educational problems. Ann Agric Environ Med. 2013, 20(1), 183–188.

b. Practical communication skills of the students of medicine should be based on the training of skills systemically prepared and implemented, and not only on the basis of patterning relation attitudes of their older colleagues – medical/health practitioners.
c. There is a necessity to apply methods of evaluation of communication competences, diagnosing educational needs of occupationally active physicians, which allows the preparation of courses in professional communication competences adequate to the needs, in the process of postgraduate education.

The presented results concern the current situation in Poland, where the official standards of the education of physicians places more emphasis on general and medical psychology than on professional communication training. One should be aware of the systemic and cultural differences which may considerably limit the scope of experience exchange in such a sphere so sensitive to cultural factors as interpersonal communication. However, it seems that despite international and cultural differences, if there is a lack of practical courses in intra-psychic training, the general psychological and communication knowledge imparted alone, may be used mainly improperly, mostly for 'manipulating' patients or co-workers. This concerns doctors, nurses, as well as paramedics and physical therapists.

10. Abstract

Background: In the work of medical/health professionals, not only knowledge and professional skills (technical/hard) are important, but also psychosocial skills (relational/soft). A dissonance between high 'technical' professionalism and a relatively low level of patient satisfaction with received care is a phenomenon observed in many countries. Many studies show that a low level of patient satisfaction occurs in the case of an inadequate interpersonal communication between medical/health professionals and patients.

Objectives: The primary goal of the presented research was elaboration of the theoretical concept and review of current published studies concerning communication competences of medical/health professionals.

The subsequent goal was evaluation of the level (study of the state) of communication competences of medical/health professionals (physicians, nurses, paramedics, physiotherapists) and determination of the factors on which this level depends. The final goal was analysis of the needs and educational possibilities within the existing models of education in the area of interpersonal communication provided by higher medical education institutions.

Design, setting and participants: The review of literature concerning this situation was based on analysis of the PubMed database. Key concepts were traced related with communication competences of physicians, nurses, paramedics, and physiotherapists. The investigation of these scopes is important from the aspect of understanding the research problems posed, and a potential design for their repair programme. The search was performed without a time filter, therefore, the results concern reports which have been published since the 40s of the last century. In the research process, three methods were used: 1) analysis of documentation (education standards, programmes, curricula and syllabuses), 2) diagnostic survey concerning professional communication competences of health professionals (new designed instrument – questionnaire), 3) testing of professional self-evaluation from the aspect of medical/health professionals – the 20 items adjective check list. The last two instruments were subject to standardization from the aspect of reliability and validity. The study groups covered a total number of 759 respondents in the following sub-groups: 1) occupationally active medical/health professionals (293 respondents), who were covered by a pre-graduate standard educational programme, and not trained in interpersonal communication skills as part of their continuing education, 2) students covered by a standard educational programme (406 respondents), 3) students who, in addition to a standard educational programme, attended extra courses in professional interpersonal communications, as part of the pilot educational programme (60 respondents).

The quantitative data were subjected to statistical analysis with the use of descriptive statistics and hypothesis testing (Chi-square, t-Student, ANOVA).

Results: Most reviewed studies indicate poor effectiveness of shaping communication competences based on standard education in the area of general psychology and communication knowledge, because this knowledge does not convert itself 'spontaneously' into communication competences during occupational activity.

The conducted analysis of the educational curricula showed a very narrow scope of problems concerning professional medical communication. The results indicating the general state of respondents' communication competences within all aspects (motivation, skills, knowledge) were relatively low. This clearly indicated an inadequate educational model (students), and lack of post-graduate training in the area of professional medical communication (physicians, nurses, paramedics, physiotherapists).

Conclusions: The results of studies indicate poor efficacy of shaping communication competences of medical/health professionals based on education in the area of general psychology and general interpersonal communication. Communication competences acquired during undergraduate education are subject to regression during occupational activity.

The education of medical/health students should cover selected classes within the scope of professional communication competences. These classes should be based on the systemically designed training of communication skills. Training such skills only on the basis of patterning relation attitudes of older colleagues – medical/health practitioners, is insufficient. There are methods of evaluating communication competences useful in constructing group and individual programmes focused on specific communication competences rather than on general communication skills. It is necessary to apply a methodical evaluation of communication competences, diagnosing educational needs of occupationally active physicians in this respect. This allows the preparation of courses in accordance with the needs in the area of professional communication competences.

It is necessary to supplement educational programmes for nurses with practical courses in professional interpersonal communication. International experience exchange concerning the shaping of communication competences may be limited due to cultural, organizational and systems factors. However, it seems that despite such differences, if there is a lack of practical courses in intra-psychic training, the general psychological and communication knowledge imparted alone, may be used mainly improperly, mostly for 'manipulating' patients or co-workers. This concerns doctors, nurses, as well as paramedics and physical therapists.

Key words: physicians, nurses, paramedics, physiotherapists, interpersonal communication, education, patient satisfaction

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12. Name index

13. Subject index