Quality in Health Care: Difficulties Due to Ethnic, Cultural and Religious Diversity

Sandra Feliciano

Operation Director, Portugal at Quality and Environmental
Certification Portuguese

ABSTRACT

Objective: To examine the impact of the ethnic, cultural and religious diversity of the new Portuguese society on the quality of health care provided by the national health care system.

Method: The interactions between the following concepts and regulations were analysed: *Health* (World Health Organisation); *Quality* (International Organization for Standardization); *Deontological Code* (Portuguese Medical Order); *Portuguese Health Law; Portuguese Civil and Penal Code* (related to health care practice). Oral interviews were conducted with 30 health care professionals to list the difficulties raised by the diversification of the needs and expectations of the patients and how they were handled. The most relevant situations referred to were analysed by 3 psychologists who identified the potential impact in terms of the mental well-being of the parts involved.

Results: (i) Difficulties in the communication with east-European immigrants. (ii) Disrespect for patient's religious beliefs during treatment. (iii) Insufficient knowledge of basic health science on the part of non-health care professionals with responsibility in health care environments. (iv) Difficulties in the correct interpretation, integration and application of the health concept, codes and law. (v) Diverse negative impact on the mental well-being of the parts involved.

Conclusion: Findings suggest that the ethnic, cultural and religious diversity of the society raise new challenges to the Portuguese health care system, which, although being legally prepared to face it, still needs to improve the planning of its activities in order to assure the correct field implementation of the predefined regulations, minimize the negative impacts and improve the overall quality of health.

INTRODUCTION

Quality in health is a complex theme, which can barely be understood in all its magnitude, without clearly defining first all the concepts involved, knowing the deontology that rules the clinical practice and characterising the target population of that practice.

Speaking of quality in health in the Portuguese case becomes even more complex due to the deep changes that have occurred in this country in the last few decades. Historically an emigration country, Portugal has become an increasingly attractive target for immigrants, which has lead to a deep change in its society. By being host to citizens from all over the world, the Portuguese society has become a lot more cosmopolitan, and is nowadays much closer to the splendour of the ethnic, cultural and religious diversity that characterizes the so called "global village".

Paralleled to the irrefutable advantages in terms of human matureness and development in all its forms, this social opening also brought important challenges: The more diverse the social fabric is in terms of ethnicity, culture and religiosity, the bigger is the spectrum of needs and expectations of its citizens, being the capacity to answer it efficiently, a responsibility we must not run away from, particularly in the health care field, which is, by its very nature, a highly sensitive area.

Therefore, the purpose of this paper is to highlight both the problems involved and the need for deeper studies which would allow not only the full listing of difficulties inherent to this new social reality, but also the full listing of its real and potential consequences, a *sine qua non* condition to promote a informed and conscious analysis on the subject, capable of leading us to efficient solutions.

PROBLEMATICS

What are we talking about when we speak of health and when we speak of quality? And what are we talking about when we try to unify these two concepts and speak of quality in health?

According to the World Health Organisation (WHO) [1], health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. By integrating these three aspects of the human life – physical, mental and social – the concept of health is, by itself, wide and complex, and its complexity is even more accentuated when we try to interact it with the concept of quality. The International Organization for Standardization (ISO) [2] defines quality as the degree to which a set of inherent characteristics fulfils requirements. Taking into consideration that a requirement is a need or expectation that is stated, generally implied or obligatory [3], and that the same organisation noted that the expression "generally implied" means that it is custom or common practice [4], and that requirements can be generated by different interested parties [5], "quality in health" will then be a concept which needs to integrate and harmonize all the different needs

of all the different interested parties, about their complete state of physical, mental and social well-being. Apparently more clearly dissected this way, the concept still maintains a indubitable complexity, due to the subjective nature of its components: Firstly, who are the different interested parties? They are everyone who plays a role - directly or indirectly - in the process: The patients; the health care professionals at different levels (including professionals in other technical areas who work in a health care environment or have responsibilities somehow related to it); and the families and the social group of all previously referred. In brief, the interested parties are all of us — the society. Secondly, what can be considered, consensually, as a "state of complete physical well-being"? The absence of illness? The absence of pain? The absence of discomfort? And what causes discomfort beyond sickness and pain? Hunger? Thirst? Other unsatisfied physiological needs? And to what degree can discomfort, due to that dissatisfaction can be considered absence of physical well-being and, consequently, absence of health? We are already stepping on highly subjective ground and haven't even dared to go further than the physical plan. What then can we say about the concepts of "a state of complete mental well-being", and "a state of complete social well-being"? Venturing a bit further, will it be possible for an individual to enjoy any of these states of well-being, in a complete way, without the support of the other two? Or is there a subtle, but irrefutable, interdependence relationship between them? Moreover: Are the territories of physical, mental and social well-being the only things responsible for the healthy state of the individual, or are there other things involved in this highly complex process, still kept in the shadow of the actual scientific paradigm? Diverse studies [6][7] indicate at least another heavy one: The spirituality. According to Mueller, Plevak and Rummans [6] most patients have a spiritual life and regard their spiritual health and physical health as equally important. Referring to the possibility of the spiritual needs of the individuals being greater during illness, these authors [6] concluded, through comparative analyses of several published studies on this subject, that religious involvement and spirituality are associated with better health outcomes, including greater longevity, coping skills, and health-related quality of life (even during terminal illness) and less anxiety, depression and suicide, and that addressing the spiritual needs of the patient may enhance recovery from illness. Other even more specific studies [7] have showed that intercessory prayer may improve health in patients admitted to a coronary care unit; that Islamic-based psychotherapy speeds recovery from anxiety and depression in Muslims; and that religious activity appear to benefit blood pressure, immune function, depression, and mortality

It may be opportune to introduce a curiosity at this moment: In 1999, the 52nd world health assembly proposed the following amendment to the definition of health as stated in the constitution of the WHO [8]: Health is a dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity. In my personal opinion, the introduction of the terms "spiritual"

and "dynamic" in the definition of the health concept, would, respectively, not only deservedly recognize the importance of the individual's spirituality in this field; but also add theoretical foundation to the "wave shaped" nature of the interdependence relationship between the different aspects of human life that compose the health concept, and of which fragile balance depends its quality.

Although apparently there are no records of the official approval of this amendment, this alternative wording on the definition of "health" has already been adopted in some clinical environments, which would indicate a change in some scientific mentalities, whom seem to be − finally - substituting the former stupefied conservative attitude for a new brave and promising one, much more open minded towards the relationship science-religion, with the obvious benefits for mankind, brought by the harmonic integration of these two concepts, that have been kept apart for so long.

In this context, which difficulties can arise, in terms of quality in health, in a multi-ethnic, multi-culture and multi-religious society?

In abstract terms it is obvious: As the social fabric becomes more diversified, the spectrum of needs and expectations of the citizens who compose it becomes wider, and it becomes more complex to efficiently and consensually answer them all. But in practical terms, we need to characterize the social diversity, to fully list the different needs and expectations inherent to each section, to understand where these differences may create conflicts, and how they can be overstepped, in the actual organisational, deontological and legislative context.

It was a goal of this study to make a first approach to the difficulties inherent to this new cosmopolitan social reality and to try to understand, through an informal approach, if, in their daily interactions with the Portuguese health care services, citizens of different ethnicity, culture and religious beliefs, do, or do not raise-difficulties to a quality clinical practice; and if they do, what kind of difficulties; how are they managed; what kind of feelings they generate; and what are the potential impacts, in terms of mental health, for the intervenients in the process.

METHOD

The methodology used was an informal oral interview to two different groups, each belonging to each study phase. In the first phase, with the goal of listing the difficulties, 30 health care professionals (doctors, nurses and pharmacy technicians) with long-term hospital practice, were interviewed. In the second phase, with the goal of obtaining a technical opinion on the potential impacts those difficulties have, in terms of mental health, three psychologists were interviewed, after having analysed the results of the first phase.

RESULTS

Results of the first phase

The most relevant results of the first phase were grouped by typology and are therefore presented as cases:

Case 1: The Romani[1] and the patient's visits

Due to their big families and near-anarchic attitude towards rules created outside their own culture, the gipsy ethnic group generates some difficulties in the patient's visits management, as most hospitals only allow a limited number of visitors per patient. It was noted that this fact generates situations more funny than worrying - i.e. unauthorized entrance of extra visitors in the patient's bedroom; extra visitors that hide under the patient's bed when a doctor or nurse comes inside the room; and similar bizarre situations – and the usual way health care professions handle it, is by identifying the group leader and by talking only with him. Once his agreement in following the hospital rules is achieved, he will, by his turn, assure that all the others will also follow it. No negative feelings were referred as a consequence of these situations. The health care professionals seemed quite familiar with this kind of situation and apparently have already learned how to handle it with diplomacy and with a sense of humour.

Case 2: Communicating with East-European immigrants

An increasing number of citizens from East-European countries have been emigrating to Portugal in the last decade, seeking better economical conditions. A great majority of them arrive in the country without a previous knowledge of the Portuguese language or of any other European language (i.e. English, French or Spanish) that may facilitate their communication with the Portuguese health care professionals. This generates difficulties to the correct diagnosis and treatment of their health problems. This situation was referred to as worrying, and the way to deal with it is diverse, and mostly based on the creativity and good will of the participants: Apart from informal gesture language, there are cases in which the patients appear at the hospitals accompanied by a "interpreter" – usually a fellow compatriot that already learned the Portuguese language; there are cases in which the hospital units, by coincidence, have among their teams a health care professional of the same nationality, those ones being constantly requested to serve as interpreters instead of accomplishing their clinical duties; and one case was referred to, in which a gynaecologist is constructing, together with the help of her patients, a lexicon "Portuguese-several East-European languages" of gynaecological symptoms, to help her during clinical practice. The feelings referred to, as a consequence of this situation, were empathy (the health care professional thinking how they would feel if they were in a foreign country without speaking the language and in need of health assistance);

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[1] Individuals of Gipsy ethnic background

frustration (they want to help and don't know how, they spend a lot of time making efforts to communicate with these patients and then get all their work delayed and the other patients waiting longer than necessary to be observed); insecureness (they are afraid of making errors in diagnosis treatment plans due misunderstandings in the communication, etc.).

Case 3: Lack of professional training

The first situation I am about to report under this title was referred by one of the individuals interviewed and not only had major consequences, but it is also paradigmatic of the challenges a multi-culture society has to face, and of the *in extremis* situations we can see ourselves involved in, when we do not face these challenges with a high sense of responsibility: Recently, in an intensive care unit (ICU) of a Portuguese hospital, several patient's deaths occurred in a unusual pattern. Albeit that death is not an unusual situation in an ICU environment, the unusualness of this situation was due to the fact that several patients have died exactly in the same day of the week, in consecutive weeks, and all of them were settled in the same bed of the unit, when the deaths occurred. In a desperate attempt to understand the reason for all these deaths, the hospital administration ordered the installation of a video camera in the unit. The recorded tape showed that the new cleaning lady sent by the cleaning service company subcontracted to assure the hospital cleaning, was unplugging the ventilator to plug the vacuum cleaner, and then plugging the ventilator again after her cleaning task was performed. As incredible as this may seem to all of us – educated among a culture that allowed us to acquire a minimum of general knowledge and that trained us to be able to perform inductive and deductive thinking by ourselves – the lady in question, born, raised and educated in a remote village of an African country, had no conscious of the consequences of her action. The feelings referred as generated by this situation were incredulity and perplexity (*"how can such a thing happen in the XXI century?"*).

Still under this title, and although a bit out of this study's scope (as it is not due to ethnic, culture or religious diversity), another situation was reported - fortunately without major consequences – but that is, by its nature, worth recording, and to say the least, quite worrying, for it indicates the lack of technical knowledge on the part of some of the Portuguese hospital top managers. In his first weeks in charge, the CEO of a Portuguese oncology specialized hospital, produced two situations that rapidly have become jokes in the whole country, although being real. In the first situation, in his first week in charge and after analysing the hospital accounting results from the previous year, this man presented himself in a board meeting sincerely insulted, and requesting all the doctors for an immediate justification for the high costs the hospital had incurred in medicaments belonging to the antineoplasic[2] drug group (which had

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[2] Medicament that destroys neoplasms or malign cells, that avoids or inhibits the growth and

totalled 75% of the costs spent on all drug groups together), relying on his previous experience as a hospital manager – as justification - he was very aware that the costs spent on this specific drug group, was never above 25% of the total value spent by a hospital, on drugs). In the second situation, this same man rejected a request from one of the ICU of the hospital, for the substitution of three ventilators, based on the argument that he had personally visited that unit the week before, and had noticed the air conditioning was functioning in perfect conditions. The feelings generated by these situations were of shame, social injustice and political criticism (*"If I was him I would have already resign", "this is a typical situation of "jobs for the boys""*, etc.).

Case 4: The Jehovah's Witnesses[3] and the blood issue

The interpretation the Jehovah's Witnesses take of the Christian holy book (Bible) does not allow them to give or to receive blood. Although nowadays "the state of art" in clinical practice already allows bloodless surgical procedures – through the use of coagulating drugs – as well as alternatives to blood transfusions – through plasma expansion drugs – the use of these methods, as a patient's option, is not correctly implemented in the health care services, at least not in a systematic and efficient non-bureaucratic way, which results in a long, complicated and expensive process for the patients who require it, and also subjects them to the personal opinions, cooperative spirit and good will of the health care professionals involved, as their approval is always necessary and mandatory for the application of these methods. It was noted that the ways in which these situations are handled vary, due to the nature of each clinical situation: In emergency situations, where the patient is unconscious and the doctors do not have access to his religious belief or personal choice in the blood issue, the patient always receive blood, if the doctors consider it necessary. Also in emergency situations, but in those cases where either the patient, a member of his/her family or a patient's document clearly states the patient's choice not to receive blood under any circumstances, doctors usually choose to ignore the information, and give blood to the patient anyway, if they consider it necessary. Exception is made here for the rare situations where the doctor shares the same religious belief or personal choice of the patient, or at least if he is sensitive to the issue, due to having close relatives or friends whom share that choice or belief. Furthermore, it was also noted that when blood is given against the patient's will, usually that information is not conveyed to the patient, meaning the health care professionals lie to patients and assure them erroneously that no blood was given to them. In the situations of planned surgery, where there is sufficient time to formally request the use of the previously

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dissemination of tumours.

[3] Although the refusal of blood issue has become identified with this particular religious belief, it is important to note that the problem is more widespread, as nowadays there are a significant number of citizens who refuse blood as a personal non-religious based option.

mentioned alternative methodologies – coagulant and plasma expansion drugs – as the final decision depends on the agreement of all the hierarchical chain of doctors involved in the situation (surgeon, department director, unit director, hospital CEO), the patient is subjected to a long wait, that can either end in the approval of his request, which allows the buying (at his own expenses) of these kind of drugs in the hospital pharmacy[4], or to the rejection of his request, which always leads, as was referred to by the individuals interviewed, to the "escape" of the patient, in the sense of their no-show at the surgery appointment. The health care professionals interviewed suppose that these escaping patients will try to start a new clinical process in another hospital, hoping for better luck. The feelings referred as generated by this situation were guilty (they feel guilty for lying to the patients and for giving them blood against their will; and also for the potential consequences the delays in surgery may have on the patient's health when they run away); lack of understanding (they are not able to understand the religious beliefs of the patients and therefore find it difficult to get empathic with them and their options); defensive indifference (*"if they don't want to be treated there is nothing I can do about it"*); and legal fear (*"I am not going to risk my career by stepping on medical deontology and laws just to satisfy their crazy ideas!"*; *"If one happens to die in my hands I will end up in court facing their family in a legal process!"*; etc.)

Results of the 2nd Phase

The psychologists interviewed dedicated their attention to the situations described in case 2 and case 4, as the other two cases did not revealed much psychological substance to be studied (case 3 is a exceptional situation, and case 1 is already easily handled by the professionals). From their reflections, the following technical opinions emerged:

Introduction

Most human beings respond aggressively when frustrated (i.e. when they feel their normal life interrupted as well as their projects, hopes and wishes); when they are in pain or any kind of physical or psychological suffering; and when they feel their territory invaded (yes, exactly as it happens with the animals, with the particularity that in the human case, this "territory" includes not only our body but also the symbolic territory of our personal beliefs). Based on this fact, any kind of disease, particularly when it involves hospitalization, usually generates aggressiveness, doubts and anxieties. Furthermore, among those that are considered as the hardest human life experiences – suffering; experience of the absurd; isolation; and confrontation with the idea of death – the situation of hospitalization usually subjects the patient to all of them simultaneously, for which it is quite easy to understand how hard to handle this

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[4] The plasma expansion drugs are only available at hospital pharmacies, for which it is not possible to buy them in a public pharmacy.

may be, in emotional terms. If we add communication difficulties and the disrespect for the territory of personal beliefs, the degree of stress, as well as the traumatic potential, grows considerably, and consequently, the risk for the development of anxiety disorders, depressive states or even psychotic crises is much higher, particularly if they are already latent in the individual. The possibility of the arising of impulsive acts auto and/or hetero aggressive is also clearly greater. The only attenuating factors referred by the psychologists were the previous knowledge of the patients about the difficulties to be faced (even if that knowledge is not always realistic) and the support supplied by their social/religious group.

Potential impacts, in terms of mental health, for the patients referred in case 2

➢ Feelings of abandonment and disintegration;

➢ Feelings of insecurity towards the diagnosis, treatment and in their own capacity to ask for, and obtain help in a emergency situation, or if their condition gets worse;

➢ Decreased cooperation in the treatment due to the low understanding of the reason and typology of it;

➢ Good clinical recovery sometimes jeopardized, due to the low level of expectations towards the correctness of the diagnosis and treatment plan;

➢ Feelings of marginalization, fragility and insurrection for being subjected to different conditions compared with other foreigners with wealthier economical conditions and better protection (i.e. holders of international health insurance contracts that assures their repatriation and treatment in their native countries);

➢ The feeling of not belonging, as a consequence to the sensation that the hosting country does not consider them as equal citizens, may facilitate the choice for delinquent activities, such as exploitation and deceit, towards those who are nothing but *"the others"*, who geographically host them and use them as cheap manpower, but do not protect or assume them as real citizens, with equal rights, even if they are, in numerous instances, more highly qualified than their hosts;

Potential impacts, in terms of mental health, for the health care professionals referred in case 2

➢ Cognitive dissonance (although easily attenuated by the several justifications at their disposal);

➢ Feelings of impotence and incapacity;

➢ Higher stress level due to the difficulties in establishing a diagnosis and in getting relevant data to enable a reliable treatment plan, as well as difficulties in getting relevant data to follow the patient's reaction to the treatment and their clinical evolution.

Potential impacts, in terms of mental health, for the patients referred in case 4

➢ Feelings of humiliation and lack of understanding from others;

- Feelings of inferiority due to the lack of interest demonstrated by the health care professionals;
- Feelings of mistrust and insurrection (towards a system they depend on, but that does not respect them)
- Feelings of the need for secrecy and lies (about symptoms and clinical conditions);
- Feelings of isolation, exclusion and depreciation towards their pairs (not only the society in general but also its own social/religious group, by not having respected the inherent codes – in the cases of default blood transfusion);
- The relationship with their own body may be heavily affected in the cases of default blood transfusion, as according to their beliefs their body will be seen as something impure, due to the fact that in its veins now circulates something that should not be there and because that compromises, in a irreversible way, their soul's survival in the eternity.
- If the religious belief is sufficiently strong, dissociative symptoms may arise, as well as suicidal ideas – both probably censured by the religious belief – which leaves them with even greater feelings of ambivalence, impotence and suspension/paralysation towards life;
- Aggressive behaviour and/or auto-aggressive acts – partially dissimulated, partially conscious;
- Depression, due to repression.

Potential impacts, in terms of mental health, for the health care professionals referred in case 4

- Cognitive dissonance (although easily attenuated by the several justifications at their disposal);
- Animosity and less time invested in a patient that "does not want to be treated" and that "raises so many difficulties to their work";
- Conscience problems and philosophical doubts for being autonomously taking decisions against the patient's will;
- Feelings of insecureness;
- Higher level of stress due to emotional overcharge;

CONCLUSION

This study showed, as Kemper and Barnes have already warned about the American society [9], that whether or not it is apparent, cultural and spiritual diversity exist in many clinical encounters, both with patients and with colleagues, and these issues may cloud other concerns, contribute to inadequate or misleading communication, and affect lifestyle and therapeutic choices, for which reflecting on the ways cultural

backgrounds, religious beliefs and complementary medicine[5] affect physicians, colleagues and patients, may enrich, clarify, deepen, and improve the effectiveness of our clinical practice.

This reflection - to be informed and conscious – will need to be based on the results of an extensive study, made on a wide sample of individuals, a sample that can be representative of all the ethnic, cultural, and religious minorities present in the society, to permit them all to be heard, particularly those who are passive by nature – e.g. the Tibetan Buddhists, that although not having been referred in the interviews, also feel serious difficulties in integrating their religious beliefs into contemporary medical practice, mainly concerning the end of life and after death period: In accordance with the Tibetan Buddhist tradition, there is a period of time after the biological death, before the conscious of the individual manages to definitely leave the body. In this period, which can take from a couple of hours to several days, the body should not be touched or removed, as that may jeopardize the process and cause discomfort or even suffering to the conscious, for which any intrusive procedure should also be avoided, which is almost impossible to assure nowadays, particularly in the cases where the death occurs in a hospital environment.

The question of death is, by the way, of great pertinence for social-ethical discussion in terms of the contemporary health care organisational pragmatics. The modern western societies took death away from family homes, and transferred it to hospitals, transforming it in a mostly solitary event, as the health care professionals disinvest in the patient in this phase, because hospitals are not prepared to deal with death situations [10] - at least not in a humanized way. According to Parkes [11], dying is a social event that concerns not only the moribund, but also his family and those around him in such a way, that one can say that the mortal affection invades the family - for if the torments of the patient are close to an end, the torments of the family are only beginning. Or in other words, and according to Gomes [10], if for the moribund the death means the last experience of a life course, the ultimate growing crisis, for those who are left behind, death is also a crisis: a crisis of change, that may promote growing and evolution, but that can also promote illness. Because it is a biological process that is also culturally and socially constructed [12], each culture determines and models the process of dying. The ceremonials, the rites and all the symbolic elements used by the society to signal the transitional moments of the life cycle, is what enables them to control and reduce the anguish generated by those moments [10].

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[5] Although it was not referred in this research, the abolishment of the prejudice towards complementary medicine is of great interest, not only to prevent potential complications due to simultaneous medication from both systems (conventional and complementary medicine) without the awareness of neither physicians, but also due to the benefits that can be awarded by the integration, or at the least the communication between both systems

This also means that, if the health institutions are prepared to respect and promptly attend to those needs in a serene way, they will be better able to occasion more comfort and afford a better quality of life to terminal patients, and to minimize the risk of negative impacts on the health of the patient's mourning family

Due to the pertinent nature of the cases revealed by such an informal and short study, and also the growing cosmopolitan tendency of the Portuguese society, there are no doubts about the necessity for an urgent intervention in this field. Furthermore, all parties involved showed interest in finding more adequate solutions to change the current situation, which is understandable, as they are all being affected by it, mainly in terms of mental health, which is a true paradox towards the health concept definition: After all, we are assuring the state of complete physical well-being of the patients to the detriment of their state of complete mental and social well-being. And, if the previously referred proposed amendment to the health concept definition is approved, this paradox will be even bigger, as we will have to add the aspect of spiritual well-being and of the dynamics between all the four types of well-being.

Although the health care professionals use the argument that they put the physical well-being of their patients in first place due to the actual medical deontology, that argument seems to be the result of a lesser knowledge of the interaction of that code with the health concept definition. In fact, the Portuguese medical deontology refers, in its article 41st [13], the scrupulous duty of respect towards the religious, philosophical and ideological options of the patient as well as towards his/her interests. But the difficulty felt by physicians in articulating different articles of the code in their daily practice is understandable, as the same code also states in article 33 [13], that physicians should only take decisions based in their own science and conscious, not being allowed to subject their decisions, in the course of their clinical duties, to technical and deontological orientation from strangers to the medical profession,

In the same way, the physician's legal fears, as pointed out in case 4, would also seem to be unfounded. The medical deontological code points out, in article 47 [13] that although a physician should respect the human life, the non-administration of any kind of non-initiated therapeutic, when that happens in result of a free and conscious option of the patient, or his legal representative, is not considered euthanasia. The base XIV of the Portuguese health bases law [14], refers to, in its turn, the statement that patients have the right to receive or refuse the health treatment that is proposed to them, as well as the right to be informed about their state and alternative treatments, and also the right to present a complaint about the way they are treated, and to receive compensation for damages suffered. Finally, article 156th of the Portuguese penal code [14], reveals that the realization of interventions or treatments without the patient's consent is punished with a financial penalty and/or a maximum of 3 years penal detention. Even though there are exceptions to the above penalties, these specify that, in the cases where the consent has been obtained for a specific intervention or

treatment, and another one has been performed instead, based on the "state of art" and the medical experience, to avoid a danger to the patients life, body or health, the penalties are only not applicable if there are no signs that can lead to the conclusion that the consent would have been refused by the patient. Maybe this is the reason for physicians to omit the information of the blood transfusions they perform by default on their Jehovah's Witnesses patients? Or maybe this is only a sign of the physician's misinformation, together with their difficulties in integrating all the codes and legal regulations into their daily practice?

Also paradigmatic of the inefficient wording of the actual Portuguese medical deontological code, in what concerns the protection of the interests and auto determination of physicians and patients simultaneously, is the impasse situation that can be generated by the interactions of some of its articles[6] [13]: On the one hand, physicians must respect the options of the patient and only perform medical practices - with their full and informed consent, but, on the other hand, they must not be subjected to the interference of strangers to the profession and must stay autonomous in their clinical decisions and remain fully responsible for their acts, reasons for which physicians are legitimately allowed to abstain from practices that are against their own conscious. Nevertheless, the possibility to refuse assistance to a patient, depends on the existence of another physician that is wiling to assure the continuity of the medical care to that patient. The following question may be academic, but is pertinent: In the absence of another physician willing to practise the medical acts refused by the first one, the continuity of the medical care assistance to the patient is assured by whom? And expressed in which medical acts? The ones in accordance to the physician's conscious or in accordance to the patient wishes and consent?

According to Esperança Pina [14], although the informed-consenting concept is one of the most important progresses of contemporary medical ethics, as it transformed the patient in a free and responsible person, capable of consciously assume his illness and his treatment, by accepting, refusing, or choosing one of the several options that are proposed to him. In practice however, conflicts will undoubtedly arise between the principle of beneficence and the principle of autonomy.

According to Filipe [15], the respect for the patient is expressed through the recognition of his right for autonomy, and the doctrine of informed-consent must rely on the principle, that each human being has the right to decide about himself and his situation, in accordance with his own values and objectives. The same author [15] also states that this doctrine must find its best reflection in a relationship of trust and good communication between patients and health care professionals, if we want to assure the best foundations for a serene and efficient therapeutic.

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[6] Interaction between articles 4th, 30th, 33rd, 35th, 36th, 37th and 38th.

As one can easily conclude, the problems targeted by this study are not only complex in their essence, but also in their resolution, in the sense that this demands organizational and attitudinal changes; as well as legislative, normative, deontological and conceptual clarifications. The actual Portuguese national health plan [16] does not refer to this situation in a specific and deep way, and although the admirable content of the "letter of the patient's rights and responsibilities" recently published by the Direcção Geral de Saúde [17], there is still a lot to do in the theatre of life, until the actors – all of us – achieve the awareness that, in regarding health care, not everything that is possible should be done, to avoid a exaggerated multiplication of the excesses of the scientific technicalities, if we wish to humanise the clinical pragmatics [14].

Nevertheless, we should not allow the complexity of the problem to stop us from trying to solve it, and it is suggested that the ministry of health nominates and empowers a committee to perform the following tasks:

1. Collect and analyse actual data to characterize the Portuguese social fabric;
2. Go to the field and fully list the needs and expectations of each ethnic, cultural and religious section towards the medical practice;
3. Promote an open and prejudice-free dialogue between representatives of all interested parties to enable the negotiation of the differences and the achievement of a possible consensus;
4. List and propose potential necessary conceptual, deontological, normative and legislative changes;
5. Provide information, training, support and supervision to the field implementation of the necessary organizational and attitudinal changes, in the Portuguese health care system and institutions.

Paralleled to the above mentioned fundamental tasks, some temporary "rescue" measures are suggested, to give a immediate partial response to some of the problems detected:

➢ The distribution of bilingual lexicons in the hospitals and other health care institutions;
➢ The creation of a symbolic code of the most common disease symptoms;
➢ The allocation of interpreters that can assure simultaneous translation in the emergency units of the health care institutions;
➢ A definition of what the minimum requirements are necessary for technical competence and general knowledge of all the professionals contracted and subcontracted to perform tasks in a health care environment;
➢ Development and implementation of procedures that will assure a close verification and validation of the requirements mentioned above;
➢ Mandatory professional training for those who do not achieve the predefined minimum requirements;

➤ Development and implementation of procedures that will simplify the bureaucratic process to access alternative surgery techniques (i.e. bloodless surgeries) by patients who conscious and legitimately choose them;

➤ Loading of the magnetic band of the health care system user's cards with relevant information about each user (i.e. blood type; known allergies; chronic diseases and inherent medication; other continuous therapeutic such as oral anti-conception drugs, vitamins and other drug supplements; devices and proteases such as pace-makers, intra-uterine-devices, anti-conception-implants, ocular and dental proteases, etc.; personal options of the user concerning blood transfusions and organs donation, etc.) to facilitate the access of health care professionals to the pertinent data that will enables them to personalise and humanise the clinical practice of medicine

"It is never too late to be who you might have been"
(George Eliot, 1818-1880)

If we make an effort to fight the indolence of conservativeness, and manage to keep in mind that societies are dynamic, and so are the needs and expectations of its citizens; to realise that the best solution today will probably be obsolete in a near future; if we manage to keep an open mind, and be constantly alert to new realities that will enable us to evolve accordingly and permanently adapt to the conditions and resources available, (as stated in a directive in the Portuguese health policy defined in base II of the health bases law [14]); we will certainly have taken an important step to increase the quality level of the health care provided to all the citizens, all of whom are legitimately entitled - as stated in the base V of the same law – to demand a public health service that is organised and focused on their interests [14], and consequently we will have managed to position the culture of the Portuguese health care institutions a bit closer to the concept of social responsibility as defined by the Ethos institute [18]: A socially responsible institution is one which possesses the capacity to lesson and to learn from the interests of all interested parties and is able to incorporate them in the planning of its activities, in order to attend to the needs of all, and not only of some or of the majority.

After all, isn't this the ideal of universality on which the concept of a public health care service is based?

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