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Communication between the Legislator and Society: The Case of Medicine and Healthcare in Romania

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Abstract

Medical legislation has a profound social character and social applicability. Therefore, good quality communication is of utmost importance in what the relationship between the legislator and society is concerned. This study aims at reflecting upon the communication features regarding the relationship between the medical legislator and the society, in the Romanian legal system. Medical laws are dependent on health communication and rely on social justice and jurisprudence. There are certain aspects that affect both the sender and the receiver but also the message in health communication. Nevertheless the study advances a series of solutions that hopefully can improve the communicating status between the given parties and thus contributing to the quality of medical law.

Keywords: communication, public health, delivery of health care, health law, society.

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Introduction

Medicine does not follow uncertain patterns or advance utopias that eventually prove to mislead. Its central pillar is man and consequently it aims at studying man in all his complexity. No wonder that the philosophic literature proposes that medicine should really be one of the fundamental fields of philosophy (Paulescu, 2006). Revolving around the human being, medicine moulds man's existential exponents, and cannot elude the area of the relation functions of the individual. Physiologically, the human being is evidently subject to communication, as it is not at random that many nosologic entities – both physical and organic – start from communication deficiencies. Furthermore, the physician becomes – through his profession – even the confident of those who ask for his help; the relation between the two constitutes the nucleus of interest in the study of medical communication, but still when we speak about medical communication we cannot disregard other parameters that contribute pragmatically and logically to the system of social values of the medical science.

In this paper we intend to approach a side that is often omitted by those who study medical communication, more precisely the communication between *society* and the *legislator* (e.g. the parliament, or any other power which gives or makes laws) in the field of the Romanian medical law. No system based on scientific factors can exist nowadays outside a law frame governing its operation, action limits and coordinates, and finally yet importantly, controlling its activity. It follows that in the absence of precise laws, in any situation we might find ourselves, social chaos, disorder and conflict would rule. The individual would be subject to unjust existence without being defended at least by the common compounds of the natural social law.

Furthermore, it is often said that horizontal relations do not amount to equality and do not eliminate power struggles (Risse, 2000). Therefore the need for a wider perception upon relations and communication is needed. As to what health care is concerned, wider forms of relations and social networks are often unclarified, recognizable being only the horizontal dimension (Morin, 2010). This is why in this paper we are going to emphasize the importance of this vertical relationship, i.e. state to citizen or state to professional.

The reasons for choosing this topic do not include only this metaphysic sphere of the issue. Currently, Romania is facing a legislative crisis that affects the entire medical field. This field is actually impossible to be optimally organized and coordinated, on the background of regulatory practical deficiencies that lead gradually (but certainly) to an obvious threat to some of the subjective fundamental rights of the citizens, especially the rights to *life, health, survival and development*.

Communication between legislator and society. Premises and content

First and foremost, we need to define the direction of this type of communication, as society and the legislative body interchange consecutively the positions of sender and receiver. If the message emitted by the legislator is the norm afferent to the legislative process, the correlative message is more difficult to establish, therefore we must take into account individual and collective factors, mass-media attitudes or parameters of the reception of legal documents: here we refer to jurisprudential hypotheses, statistical indexes regarding litigations or even causes submitted to trials in international courts of law.

The accuracy and accessibility of these messages are the key to the issue relative to the communication channel in question. The medical field legislation has the disadvantage of not being unitary. To date there is no unified medical law act in Romania. This is why, regulatory medical legal statements can only be found dispersed: either independent (for instance the framework law in the sanitary field, Law no. 95/2006 regarding the reform in the healthcare field), or in the form of legal rules of medical character but specific to other law branches, such as financial law or tax law (especially in the field of the State Social Insurance Budget), civil law (for instance in the general theory of obligations), administrative law and labour law (medical professional liability) or criminal law (medical crimes). Secondly, it is imperative to identify specifically the subjects referred to in what this type of communication is concerned; by society we mean the totality of the beneficiaries of state medical services (Romanian citizens or stateless persons residing in Romania), as to the heading of legislative power, it is to be clarified that: the term legislator is typically attributed to the Parliament (as the unique legislating power according to the Romanian Constitution), but according to a more restrained meaning, legislators can also be the Government (through simple or emergency ordinances), the President of Romania (through Presidential Decree), the Local Public Administration Authorities (who receive wider and wider responsibilities and prerogatives along with the decisional administrative decentralization process), and last but not least the Supreme Court of Justice and the Constitutional Court of Romania (through recourses in the interest of the law, and through analysis of the constitutionality of the laws respectively, both types of judicial precedents having exceptionally the character of source of law) (Popa, 2008).

The identification of the parties is of great importance in the context of individualization of the moral and legal responsibilities afferent to any legislative process. Hence, any citizen bears the moral obligation of getting involved actively in the life of society generally, and of the groups to which he or she belongs, particularly; this individual responsibility is fundamental for the group and organization responsibilities, which – being grounded on humanistic, political and religious philosophic principles – represent an extension of the responsibility of

the individual involved (Frunza, 2011). Furthermore, the community is often ethically justified to watch over professional activities as a monitoring process with legitimized authority (Buchanan *et al.*, 2008). To this purpose, we notice that the aforementioned legal relations between state institutions and society are based on profound philosophic, religious and most importantly ethical principles, that are variable in time and space.

Nevertheless, the internationally aknowledged fundamental human rights and freedom empower people to demand justice as a right by itself, through conjunct participation, accountability, non-discrimination and attention to vulnerable groups (Hogerzeil, 2006). In this respect, another way to support uniform individual rights would be through 'impact litigation' cases, where NGOs and lawyers would plead for the protection of the disadvantaged citizens' rights in order to create legal precedents and to increase public awareness about the common needs and rights (Wilson, 2012). The literature in the field sees this as a so called revolution of rights that unfortunately needs a solid organizational base and great financial resources to fund such litigation actions (Epp, 1998). Thus, these paths certainly generate a strong and stable moral basis for any community to act and cooperate as an expression of its fundamental rights. Otherwise, when referring to the sources of medical law as well as to the moral medical principles, we must also take into consideration the patients' unilateral legal acts, issued by virtue of the self-determination principle. These individual directives are private sources of medical law (advance directives) representing perhaps at the same time one of the most authentic forms of communication in the medical field (Ditto et. al. 2001).

Consequently, there is an intricate social, professional and legislative system with multiple valences that cannot exist in default of communication. Especially in the medical field, where the main professional interest is built completely around the individual, the enactment process is thus unconceivable in the absence of feedback from the society. Moreover, one of the defining features of the legal rule is its social applicability – a legal rule cannot exist without a pre-defined socially centered aim, otherwise it would be considered tacitly abrogated by falling into abeyance (Popa, 2008).

In this context, a social situation perceived collectively at a specific time determines the genesis of an enactment process in the field, the enactment being correlated with the specificity of the enacted fact. At this point, we may refer to the other communication sense, namely the post-enactment feedback, which is a process that needs long-term social monitoring and stability of the positive law.

In this respect, we are going to present a number of deficiencies that discredit such a feedback; moreover, they are visibly enhanced when looked at in correlation with the medical field, namely: (1) Discrepancies that emerge when a specific scientific situation is concerned that should be reiterated in the legislative process by persons who are alien to the respective scientific domain on which

they decide - social and especially scientific cooperation is crucial in this regard; (2) The lack of centralization, quality control and feed-back for the information disseminated by the media and subsequently presented as leading trends of the social majority doctrine; (3) The lack of objectivity (due to different interests, preponderantly economical) in the public presentation of a social situation that should serve as a premise in which laws should be issued; (4) The bad faith as regards to the attitude (pride, competition system, negligence) of the direct beneficiaries of the medical legislation (employees in the medical field) highlighted through disinformation (meaning most frequently the lack of information), which leads to the subsequent prejudice of indirect beneficiaries (citizens benefiting from medical services); (5) The budget-related deficiencies represented especially by the discrepancy of the budget distribution between the capital, the municipalities or cities versus the rural environment, being well known that government services may not reach these latter poor populations that are often incapable of accessing state services and in meeting the costs for premium health insurance (Tangcharoensathien *et al.*, 2011); (6) Tremendous discrepancies in health care access between the formal (government or private) and informal (self- or not-employed) work sectors which lead to inequitable health care and financial systems (Annear, Ahmed, Ros & Ir, 2013) and further gaps in communication between state and citizens; (7) The need of those who control the media systems for splash and exclusivity, which leads to the augmentation of certain situations of interest to the detriment of others, which are often more important – important here is granting the right of proper official reply in the mass media; (8) The socioeconomic and demographic differences between Romania and the European Union that are not taken into account along with the adoption of the *communitary aquis*, this leading to the inapplicability of certain regulatory documents or to potential budget-related conflicts (for example the correlation of the life expectation and morbidity with the retirement age or the medical emigration percentage or medical retirement percentage).

Solutions

Attention has been drawn to the multitude and great complexity of the potential causes for the alteration of the message between society and the legislative power, with major impact on the quality of the regulatory documents in the field. In relation to these causes, we need to reveal some practical solutions of social optimization and intervention focused on this communication pattern. These solutions must not refer only to attributes of the emitter and receptor respectively; often it is necessary to improve the message transmission systems, as they could consist in potential disturbing factors that alter the quality of the transmitted information. We refer in this case to the above-underlined subjectivity of the

media information means, to the absence of order and selection of the so called professional information spread on the global communication networks, and last but not least to the lack of sanitary and medical education of the people responsible for the dissemination of these specific information – finally defined as the message of the communication between society and the legislator. It is not to be forgotten that one of the main sources of information discrepancies is the general inaccessibility of law publicity, namely the Official Gazette (Monitorul Oficial al României) of Romania. The structure and the presentation manner (referring here to the compositional density and the specialized character of the content distributed) used in elaborating the Official Gazette are a real impediment in the perception of the regulatory message, not only for citizens alien to the field in question but also for specialists, who often deal with contradictory information or information intricately presented.

Part of the solutions we count on may be included in the following theses that may be considered principles:

- Establishing sanitary and medical mass education programmes controlled by the government enabling the participation of both target population contingents and certain contiguoues professional categories: journalists, public clerks, governmental agents etc.;
- Implementing the applied ethical collective values in the - especially academic - resorting continuously to appreciative methods (Cojocaru, 2005), adapted to the realities in medical profession relations;
- Specialization in medical knowledge of people working in mass media, in order to ensure the optimum information of the population. Enabling public health educational programmes solve many of the health protection challenges (El-Ansari & Privett, 2005) especially in what the role of the mass media is concerned, bearing in mind the possible negative effects of malpublicity, e.g. the internationally dented childhood immunization after the intense adverse publicity (Begg, Ramsay, White & Bozoky, 1998);
- Raising awareness of medical law both among the medical-sanitary personnel and the media trusts, with the purpose of transmitting objectively, clearly and scientifically valid messages of social interest (especially in the context of imminent epidemics/ pandemics, in what the needed prophylactic measures are concerned);
- Excluding as much as possible the emergence of private economic interests when it comes to preserving the public interest over governmental measures in the medical field;
- The urge to public vigilance related to regulatory documents of general applicability in society (e.g. laws regarding health insurances, the access to sanitary services, governmental prophylaxis or screening programmes etc.);

- Stressing the importance of the *ethical dimension* of medical education – the development of research programmes in the field of bioethics and medical deontology with concrete consequences on the acquisition of knowledge regarding medical and administrative law (Ioan, Gavrilovici & Astărăstoae, 2005);
- Developing the concept of *student morality* among medical students, enhancing their role in facilitating the thorough acceptance of medical information in society. Assessing the *moral based thinking* principle can improve the students' attitude towards social ethics and morals (Sanwong, 2010), with a long-term positive impact on the quality of the professional act. As the current prototype student is more and more focused on a comparative assessment of the educational services he/she receives – this leading to higher expectations (Hintea, 2013), addressing to moral thinking could possess a very strong impact on the future professionals' activity;
- Establishing correlations between the legislative initiatives in the medical field and the particular scientific levels reached by researchers in their work. In this respect, an increasingly important factor is international collaboration. Through its pragmatic, epistemological and political benefits, it could improve national research and provide stronger theoretical developments to be later introduced in national healthcare programmes (Rees & Monrouxe, 2012);
- Social information regarding the arbitrage and professional forums in the medical field related to the rights of patients or assimilated categories (legal representative of minors, spouse, next-of-kin of the unable). Such information would also help customizing the doctor-patient relationship, with positive consequences for both parties, generating with minimal financial effort, major benefits as increased addressability, improved quality of care, increased patient compliance and shorter hospital stays (Iliescu & Carauleanu, 2014);
- Implementing in the national legislation the internationally codified legal rules, according to the primacy of international law and human rights (for instance the adoption of the aquis of the OVIEDO Convention from 1997 and the additional protocol from 2005 according to which "considering health requirements and the available resources, parties shall make appropriate decisions in order to secure, within their jurisdiction, a fair access to quality healthcare") – unfortunately, the Convention is signed by 34 member states of the Council of Europe, but ratified only by 22 of them (Turcu, 2010);
- Performing a functionally based (type II) multi-level governance policy in the health sector, that would involve webs of tasks leading to strong allow-

ances between both full or partial authority social actors involved (Ackleson & Kastner, 2011);

- Not the least important of all would be the introduction of financial incentives – a popular form of intervention in national health sectors (Magrath & Nichter, 2012), where donors transfer money or other material goods conditional upon taking a measurable action or achieving a predetermined performance (Eldridge & Palmer, 2009). This could lead to rapid national health improvements in measured indicators of provider performance (Kalk, Paul & Grabosch, 2010), as an expression of feedback between social-professional and decisional parties;
- Constantly aiming towards the inclusion of health law projects among the international multiple party agreements, in order to create coherent and population centered programs for the protection and preservation of the general health condition (Balan, Savin, Balan & Zetu, 2014). This international and multi-national process of legal cohesion should take into account the existing country-specific social realities and the socio-political, economic and psychological practices intended to be shaped (Frunza, Pascalev, Krastev & Ilieva, 2014).

We preferred this systematic presentation because the proposed solutions have a principle value. Thereby they do not exclude each other, the resultant is the possibility to apply them in a coordinate and systematized manner. As far as communication and social interrelation systems are concerned, their improvement does not refer to any change in coordinates, as these systems are established and limited to the social existential parameters specific for a certain moment. A particular aspect reflected in the literature of this field is the relationship between medical legislation and the educational status of the parties in the medical legal context. Hence, the literature underlines the fact that legislation must not exceed the parties' general educational level – on the contrary, education should be above the legal medical rules: the higher the level of education of the involved parties is, the better the legal phenomenon is perceived, leading to higher standards of medical care (Youdelman, 2008). Last but not least, it should be acknowledged that the states and governments have ethical obligations tightly connected to the sovereignty attribute, through which they are responsible for the social and public healthcare issues (Frunza, 2011); therefore they must intervene actively by appropriate enactment ensuring proper life quality to any person.

Conclusions

It is obvious that what must be pursued in this entire social communicational system are the collateral causes that – if optimized (adapted) – would lead consequently to the improvement of the communication biases by facilitating the access and the free expression of the social actors in the medical legislating process; secondarily, the public interest in such a system can be enhanced. Therefore, both the quantity and quality of information are important, as any citizen is entitled to free expression and free conscience, the right to petition and its just settlement. In this respect, the neglect of the individual involvement in a collective communicational system would be nothing but the limitation of the rights of the entire community. In reverse order, without collective social involvement grounded on individual participation, the genesis of legal rules acquires an artificial underlayer often generating vulnerability, discretional control and disparity.

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