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ETHICS MANAGEMENT IN HEALTHCARE INSTITUTIONS FOR RESPECTING HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES

Specialty 331.03 SOCIAL MEDICINE AND MANAGEMENT

Summary of the Thesis of Habilitated Doctor in Medical Sciences

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The thesis for habilitated doctor in medical sciences and the thesis summary can be found at the Medical Scientific Library of the Public Instittution *Nicolae Testemițanu* State University of Medicine and Pharmacy of the Republic of Moldova and on the National Agency for Quality Assurance in Education and Research (ANACEC) ANACEC website. (www.anacec.md)

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CONTENT

CONCEPTUAL LANDMARKS OF RESEARCH

The topicality and importance of the topic. Ethics in healthcare institutions is not limited to the formal declaration of values, postulates and theoretical principles. It must become an integrated part of daily activity, in management decisions and behavioral norms, which are not always covered by laws. The ethics must become a component part of institutional policies and management strategies [1], for practical application of the tools useful in resolving conflicts [2, 3, 4].

The core values of ethics are practically identical to general human values. Respect for human life and dignity, tolerance, compassion, fairness, justice, and non-discrimination, etc. – these are the values of fundamental human rights. At the same time, communication with patients and their information, protection of confidentiality, dignity, and patient autonomy, safety, and quality of medical acts – are fundamental rights, but also the professional values declared in the oldest ethics treaties. The permanent and consistent application of these values in the daily practice of employees of healthcare institutions remains a permanent challenge of the medical services management. Without an approach through actions and an effective regulatory framework, many of these values may remain at a theoretical idealistic level, in declarative form. As long as the institution does not create conditions and an environment for promoting ethical values and an ethical climate and culture, managers' desire to have employees with correct behavior will remain only at the level of expectations and desires.

Within healthcare institutions, various relationships occur daily with partners and beneficiaries. At the base of these relationships are values, rights and obligations. The content and form of these human connections directly influence the quality of the medical act performed by healthcare workers. The managers of healthcare institutions will always strive to achieve a high standard of quality and satisfaction, which is a mandatory condition for the profit of the institution, maintaining a beneficial image and resilience in the competition of the healthcare service market [5]. Thus, for the survival of the institution, no less important are the moral components of employees' behavior, as well as the factors that determine their decisions in daily professional activity [6,7].

To achieve an effective interconnection and combination between these broad fields (ethics, law, quality), the specialized literature proposes a much more differentiated approach to the management process of organizations, identifying new possibilities and ways of organizing and monitoring the life of an institution [2, 8, 9]. Thus, recognizing the priority place of ethics in the good organization and governance of healthcare institutions, gradually, from the general management, a new branch emerges that begins to directly deal with the development and application of monitoring, prevention, and resolution tools for ethical problems, dilemmas, and conflicts within the institution, namely – *ethical management* [10, 11, 12]. This area provides for the organization of the concrete actions dedicated to promoting ethics within the institution, measures that impose standardized conditions for employees to react correctly, from an ethical and legal point of view, in situations involving risks of violating the rights of beneficiaries of medical services. The satisfaction of patients and their families is appreciated in terms of benefit and profit, the lack of litigation and a good image in the community, which makes managers pay much more attention to the behaviors of their employees. In this context, ethics management tools are promoted as mandatory conditions for effective management, including: ethical leadership, ethics codes and programs, ethics committees and ethics advisors, culminating in the ethical audit of the institutions [2, 3, 4].

The ethical context of the institution becomes a concern for the managers of healthcare institutions of our country, given the conditions imposed, on one hand, by financing based on contracts with the National Health Insurance Company, and on the other hand, by ever-increasing competitiveness in relation to private and public institutions, but not least, by the growing expectations of the population regarding the quality of medical services provided. Thus, managers need relevant support to cope with

the challenges of current activity, conditioned by limited resources, human resources crisis, and a constant struggle for survival [9]. At the same time, the institutionalization of ethics in healthcare institutions is greatly influenced by paternalistic approaches (soviet) specific to the last century, with a low application of contemporary management principles. Ethics is perceived at a formal and theoretical level, and less at the level of practical application. The necessity of developing effective managerial tools for the institutionalization of ethics becomes evident, which could improve the behavior of employees to correspond with the trends of contemporary society. The conducted research has identified the benchmarks of the process of ensuring the ethical dimension in healthcare institutions, as well as the mandatory perspective of respecting human rights, which is an imperative of the last century at the international level, especially in biomedical fields.

Purpose of the research: The multidimensional evaluation of ethics management in healthcare institutions within the health system of the Republic of Moldova to determine the level of ensuring the conditions that lead to the respect for human rights in the organization and provision of health services.

Research objectives: (1) Studying the theories of ethics management in organizations, as well as international experience in institutionalizing ethics in healthcare institutions. **(2)** Evaluating the ethical context of healthcare institutions for compliance with the principles and values of fundamental human rights. **(3)** Analyzing the factors that influence the ethical decision-making process in healthcare institutions. **(4)** Identifying the level of compliance with human rights in the organization and provision of services in healthcare institutions. **(5)** Identifying effective ethical tools for organizing and promoting the process of institutionalization of ethics in healthcare institutions. **(6)** Developing an ethical audit grid and recommendations for applying ethics management tools in healthcare institutions to reduce the risk of human rights violations in the organization and provision of health services.

Scientific novelty and originality: The completed work is a pioneering study for the Republic of Moldova by applying the concept of *ethics management* as part of the organizational management of healthcare facilities in our country, based on the particularities of the national cultural and legal context, as well as the concept of *institutionalizing ethics* applied to healthcare institutions, based on the *business ethics* model. A comparative analysis of the managerial tools and mechanisms proposed at the international level for ensuring the ethical and legal aspect of professional relationships within organizations has been conducted, identifying their specifics in the context of healthcare institution activity, taking as a basis the principles of business ethics, the values of fundamental human rights alongside the traditional values of professional ethics canons.

For the first time in the healthcare system of the Republic of Moldova, organizational aspects, organizational culture, and the ethical climate of institutions have been addressed as mandatory conditions for ensuring the universal rights of both employees and patients, with new key concepts analyzed being *ethical culture* and *ethical safety*. In this context, the notion of satisfaction becomes important not only for the field of quality management but also for ethics and legislation. The ethical behavior of employees will lead to the correct fulfillment of job responsibilities and increased satisfaction of healthcare service beneficiaries, who will perceive these situations as full respect for their rights. The research highlights in detail the logic of this interconnection and the role of the manager in the correct organization and ongoing monitoring of the process of institutionalizing ethics.

At the national level, gaps in organizing the ethical and legal aspect of the health service provision process in institutions have been identified for the first time in hospitals and primary healthcare institutions through the lens of the 14 fundamental rights of the patient, which stem from the concept of human rights. It should be noted that the work makes, in an original way, a clear, scientifically argued differentiation between the *concept of patient rights* and that of *human rights* applied in medical care, the latter being widely promoted at the international level through the normative framework dedicated

to fundamental human rights. The values of fundamental human rights are identified with those described in ethical postulates, with a clear narrative explaining that the ethical context of an organization ensures the respect for human rights.

An innovative subject of the research is the analysis of the factors influencing the decision-making process of employees in performing medical activities, with a pioneering analysis of the risk of the *phenomenon of dual loyalty* among medical workers and, respectively, the emergence of undesirable behaviors (morally and/or legally incorrect) that would be contrary to the patient's benefit and would violate certain fundamental rights of the patient. The presence of these situations in clinical practice and the measures for remedying and preventing them are presented and described in detail in the work.

The thesis includes a comprehensive study of the activities of institutional ethics/bioethics committees, which were established in 2004 and have never been subjected to any national evaluation.

For the first time in the Republic of Moldova, the concept of *ethical auditing* applied to healthcare institutions is addressed, with evaluation criteria developed to determine the ethical context of employees' activities and the level of respect for human rights in performing and organization of the healthcare servicies within institutions. Subsequently, the set of criteria developed is used for quality assessment in the accreditation process of the healthcare institutions in the country, being included in the standards of the National Council for Health Assessment and Accreditation (CNEAS).

The scientific problem solved in the thesis: The study scientifically demonstrated the interconnection between the process of institutionalizing ethics and the level of respect for human rights in healthcare institutions in the country, appreciating the specific tools of this field, necessary to improve the management of institutions. The paper demonstrates, based on evidence, that traditional formal approaches to the role and place of ethics in the healtcare institutions are ineffective in ensuring desirable behavior of employees, which would lead to high indicators of beneficiary satisfaction. A detailed analysis is made of how irregularities and inconsistencies in respecting fundamental human rights, both of patients and employees, are directly dependent on the *ethical culture* and *safety* in the institution – new notions promoted at the conceptual level in the field of organizational management.

The management tools and mechanisms are identified and scientifically substantiated, which should be implemented in healthcare institutions in order to institutionalize ethics as an applied field and, respectively, to reduce the risk of violation of fundamental rights, with increased satisfaction of both employees and beneficiaries of healthcare services. Thus, this research can be applied to promote the imperative of continuous development of the quality of healthcare services, being adjusted to the expectations of the population, but also to international standards resulting from the protection of fundamental human rights, declared through documents developed by the WHO, UN committee, Council of Europe, ECtHR, etc.

The research of the real situation in the healthcare institutions of the country, based on a scientifically argued methodology, from the perspective of organizational ethics and the values of fundamental human rights, identified the level of implementation of *institutional ethics management* tools, which gave us the opportunity to formulate practical recommendations for the improvement of this field. At the same time, an *ethical audit grid* was developed and, respectively, a renewed set of criteria for the accreditation process of healthcare institutions in the country.

Theoretical significance and applied value of the work: The research represents a comprehensive study of the process of administering healthcare institutions from the perspective of organizing and ensuring their ethical dimension, which is promoted as a mandatory context necessary for the promotion and observance of human rights in the provision of medical services. The study highlights the *management of ethics* in the institution as a newly highlighted field, a component part of

organizational management, with its own practical tools, which must be applied by managers of healthcare institutions in order to institutionalize ethics in the institution's management process.

The results of this study can constitute the basis for the implementation of a new set of quality criteria to be applied in the process of evaluating and accrediting medical and healthcare institutions, both hospital and primary healthcare institutions.

The ethical audit grid developed in this research can serve as a practical tool for assessing the ethical dimension of the institution, which can be used by every manager interested in knowing the gaps and ethical issues within their institution, respectively, to initiate strategic actions to remedy them in order to improve the quality of services provided by its employees. Thus, the research results can serve as a benchmark for developing institutional policies related to employee satisfaction, service quality and institution performance.

The conclusions and recommendations of the research can be used to improve the activity of healthcare institutions in the country, becoming part of the continuing training courses in the field of organizational management dedicated to health managers, as well as in the training of students and residents in courses dedicated to the application of human rights in healthcare.

Summary of the research methodology: The study conducted is a logical continuation of the professional and research activity carried out by the author over the last 25 years of professional activity in the field of health management, ethics, bioethics and medical legislation. An observational, descriptive, selective and cross-sectional study was conducted between January 2022 and December 2023. An extensive analysis of the latest theoretical and scientific-practical concepts was carried out, by studying 275 bibliographic sources, including international and national normative acts. The research included both the qualitative and quantitative components. To carry out the quantitative research, 3 representative samples were determined consisting of: 1070 employees of hospital and primary healthcare institutions, both public and private (managers, doctors and nurses, non-medical staff (sample 1); 134 members of institutional ethics/bioethics committees (sample 2); evaluation of ethics committees from 80 medical institutions (36 from primary health care facilities and 44 hospitals) (sample 3). Data collection was carried out through (1) questionnaires for employees of medical institutions; (2) questionnaire for members of bioethics committees in medical institutions; (3) the institutional ethics/bioethics committee evaluation grid. The questionnaires were transposed into the *google.forms template* to increase access to all employees of medical institutions and to provide the possibility of an anonymous open response, to reduce the risk of influence from superiors. The data were processed using Microsoft Excel, Epi Info7.2.5 and the Python programming environment.

The qualitative research component included in-depth individual interviews and focus group discussions. 50 individual interviews were conducted with managers of hospital institutions and primary health care facilities. 7 focus group sessions were conducted, of which 3 sessions were with members of bioethics committees, 2 sessions with employees of hospital institutions and 2 sessions with employees of primary health care facilities. Both the semi-structured individual interviews and the focus group discussions were conducted based on interview guides developed by the researcher.

The study was approved by the Research Ethics Committee of the *Nicolae Testemițanu* SUMPh (Notice no. 1 of 16.02.2022). Data collection took place between March – August 2022.

Implementation of scientific results: The results of this study were implemented in the teaching and scientific activity of the School of Public Health Management during the period 2016-2020, by teaching the courses "Human Rights in Health"; "Quality Standards for Respecting Human Rights"; "Bioethics"; "Integrity in Healthcare Institutions" for managers of healthcare institutions. In 2021, the research results formed the basis for the development of the course "Human Rights in Health" intended for the students of the *Nicolae Testemițanu* SUMPh within the Department of Forensic Medicine. The

research results are put into practice through the bioethician activity initiated within the Municipal Clinical Hospital "Sfanta Treime" in Chisinau. Based on the conducted research, a monograph "Values, Ethics and Rights in the Management of Medical Institutions" was published, which is an essential theoretical support for managers of healthcare institutions in the process of institutionalizing ethics and implementing ethics management tools in organizations as mandatory conditions for respecting the fundamental rights of the institution's employees and service beneficiaries.

The criteria included in the *Ethical Audit Grid*, developed by the researcher, were taken over in the development of new accreditation standards for healthcare institutions in the country, namely the chapters that refer to respecting patient rights in the provision of medical services.

As a result of the research, 2 Innovator Certificates and 9 Implementation Acts were obtained.

Approval of scientific results: The results of the study were presented at the following scientific forums in the country and abroad: The International Scientific Conference "The Best Interest of the Child: Sociocultural, Normative and Jurisprudential Approach", USM Chisinau (September 30 - October 1, 2022); The Seminar "Medicine and Theology", Section "The Impact of Contemporary Medicine on Professionals in the Field", "Babeș-Bolyai" University Cluj Napoca, Romania (April 4-5, 2022); The International Conference "Ethical Values in the Today's Society" Transilvania University of Brașov, Romania (May 5-8, 2022); The Cluj Conference on Forensic Medicine, 5th edition, Romania (September 29 - October 02, 2022); The Forum on Social Responsibility in Health, Chisinau (September 30, 2022); The XVIIth National Conference on Bioethics with international participation UMF "Gr.T. Popa" Iași, Romania (December 8-10, 2022); The Conference "Medicine and Theology" XXII Edition, "Babeș-Bolyai" University Cluj Napoca, Romania (April 4, 2023); The Dermatology Conference "Gh. Năstase Days", 2023 edition, UMF "Gr.T. Popa" Iași, Romania, (March 29 - April 1, 2023); The International Conference "Ethical Values in Today's Society" Transilvania University of Brașov, Romania (May 4-6, 2023); EHMA Conference 2023 "Health Management sustainable solutions for complex systems", Rome, Italy (June 5-7, 2023); The National Congress of Anesthesia and Intensive Care 2023, Chisinau (September 7-9, 2023); The XVIII National Conference on Bioethics, UMF "Gr.T. Popa" Iași, Romania (December 7-9, 2023); The National Conference with international participation: "Private and public dimensions in medical law", USM, Chisinau (December 14, 2023); The XIX National Conference on Bioethics, UMF "Gr.T. Popa" Iași, Romania (December 5-7, 2024); The "European Patient Rights Day" Forum, April 18th, 2024.

The thesis was discussed and approved at the meeting of the School of Public Health Management of the *Nicolae Testemitanu* SUMPh (minutes no. 4 of 11.10.2024) and at the meeting of the Scientific Seminar 331 Public Health, specialties: 331. 03. Social medicine and management; 331.04. Healthy lifestyle (minutes no. 13 of 12.11.2024).

Publications on the topic of the thesis: The results are published in 50 scientific papers, including one monograph, 5 chapters in collective specialized books, 7 articles in journals from the Web of Science and SCOPUS databases (including 5 with IF), 7 articles in recognized foreign scientific journals, 1 article in journals from the National Register of specialized journals, 4 articles in scientific collections, 2 articles in international scientific collections, 1 theses in international scientific conferences (abroad), 9 published scientific studies, 3 textbooks, 3 course materials, 4 guides and 3 chapters in guides, a Standard Operating Procedure.

Summary of the thesis sections: The thesis is presented on 270 pages of core text, includes: introduction, 8 chapters, general conclusions and practical recommendations, annotations (in Romanian, English and Russian), bibliography from 275 sources, 8 tables, 146 figures and 11 annexes.

Keywords: ethical culture, ethical safety, ethical climate, organizational ethics, institutionalization of ethics, ethical programs, ethical leadership, business ethics, ethical decisions,

ethics management, ethics committees, ethical audit, patient rights, human rights, dual loyalty, moral responsibility.

THESIS CONTENT

1. ORGANIZATION OF ETHICS IN INSTITUTIONS – THEORETICAL FOUNDATIONS AND CONTEMPORARY VISIONS

Healthcare institutions are very complex structures, in which a multitude of relationships with different actors are established. First of all, problems related to clinical ethics, research ethics, bioethics, religious ethics arise daily, which include the complexity of the doctor-patient relationship, the relationship with the patient's relatives, etc. [13]. At the same time, healthcare institutions manage funds, are involved in contractual relationships with employees, have relationships with various partners and are interested in their image in society. Therefore, in order to have a moral institution, in addition to the postulates of traditional medical ethics, there is a need to address special topics, such as those related to business ethics, manager ethics, ethics in relations with employees and partners, as well as the institution's responsibility towards society. Some authors [14] identify three main categories of organizational ethics problems: (1) ethical problems arising in direct clinical activity; (2) ethical issues with far-reaching organizational implications; (3) ethical issues related to the business aspects of healthcare organizations. It becomes important to analyze the ethical complexity of balancing the objective of organizing quality care for patients with other important objectives, such as the financial sustainability of the institution, staff satisfaction and public accountability.

In order to prevent slipping under the influence of material, financial or any other kind of pressures, which could lead to the violation of rights, it is important for managers to understand the essence and value of ethics applied in the institutional practice [15]. As a solution, the principles of *business ethics* are proposed, which approach the problems of the institution through the lens of four areas, proposed by Weber (2001), namely: (1) the area of *fundamental human rights*, which must be respected for each individual, regardless of position, status or merit. (2) *the personal interest of individuals* that depends on each person's choices, individual decisions on what is considered personal good and what they want; (3) *the interest of the organization* determined by the institution's administration and founders; (4) *the public benefit*, which is reflected in the well-being of the community [16]. A manager will need specialized skills to be able to face such complex challenges. Or, according to international practices, he/she will need to have developed and implemented a series of tools that will help him/her to manage ethical issues at the institution level, in order to build and maintain a moral institution, increased performance, high satisfaction of employees and of beneficiaries [17].

The organization of a moral institution is the subject of analysis of many authors. Rossouw and van Vuuren formulate five ways of managing ethics in an organization – morality management modes (MMM), i.e. predominant (preferred) strategies of organizations to manage their ethics, namely: *immorality, reactivity, conformity, integrity* and *total alignment* modes[18]. Managers should determine the mode that characterizes their own organization, define existing gaps and problems, in order to develop an institution with a high degree of morality. Speaking about the process of organizing moral issues at the organizational level, it is logical to approach the concept of *institutionalization of ethics*, which should be understood as the *ethics management* in an organization. This concept has an increasingly broad reflection in the literature dedicated to organizational management. Arguments are increasingly being made in favor of the fact that ethics should become a fundamental area of the organizations` policy [19]. If at the end of the last century the emerging field of organizational ethics was discussed [7, 8, 20], today the topic of *organizing (managing) ethics* is increasingly addressed, rather than that of the *ethics of organizations*.

Ethics management deals with the development of tools that contribute to the ethical development of an organization, as well as methods that determine in which direction the organization should develop [10, 11, 12]. This area involves analyzing the current ethical situation, determining the desired situation, and deciding on the measures to be taken to be consistent with other components of management [10]. For the organization of ethics it is necessary to create an "ethical infrastructure" [21], through which an advanced model of morality management could be developed [18].

The organizations are recommended to adopt an *ethics program* well distributed in time and with distributed responsibilities, in order to create an ethical climate and culture, prevent unethical behavior, and promote the ethical behavior [22]. The process of governing and managing the *ethical performance* of an organization through an ethics program is based on four pillars, namely: (1) institutionalizing ethics; (2) assessing ethical risk; (3) developing ethical standards; and (4) reporting on ethical performance. Thus, the institutionalization of ethics aims to integrate ethical standards into the strategies of an organization and build an organizational culture with the help of an ethics program [23].

Several components of ethics programs are proposed [10, 12, 22], such as: developing own codes of ethics; ethics training; auditing activities; channels for reporting ethics issues; ethics consultations, etc. It is important to objectively and correctly determine the existing way of managing ethics in the organization in order to develop and implement realistic measures that would allow promoting and respecting human rights in the provision of medical services, preserving the image of an institution with high moral values, in which both the interests and rights of the patient and the general human values of a society are protected – an institution in which employees want to work.

2. MATERIALS AND METHODS

General characteristics of the research

The study is a logical continuation of the professional and research activity carried out by the author over the last 25 years of professional activity in the field of health management, ethics, bioethics and medical legislation. An observational, descriptive, selective and cross-sectional study was conducted between January 2022 and December 2023.

Research methods

The following research methods were applied: historical and systemic analysis, concept transfer method, meta-analysis, analysis of the dynamics of phenomena and processes, inductive and deductive methods, statistical methods. By applying multiple methods of data collection, systematization, calculation and comparison of statistical indicators, it was possible to formulate conclusions regarding the phenomena and processes subject to analysis. Among these methods, we list the following: statistical observation; processing and systematization of statistical data; analysis of links between variables.

The literature analysis was carried out by reviewing innovative theories and cutting-edge approaches in the field. The main databases through which the search and selection of articles and bibliographic resources were carried out were the following: SUMPh Repository, PubMed Central, MEDLINE, Scholar Google, Research Gate, The Directory of Open Access Journals, BioMed Central, PLOS – Public Library of Science, FreeBookCentre, HINARI. At the same time, specialized official pages were accessed, which offer specific online resources such as the portals *Human Rights in Patient Care*, *Journal of Medical Ethics, HEC Forum, Journal of Business Ethics*, etc.

Statistical processing methods

Data processing included their quantitative and qualitative verification, coding and grouping. The following statistics were determined during data analysis: relative sizes with confidence intervals, indicators of central tendency, correlations, etc. Descriptive statistics for discrete data were performed by estimating absolute and relative frequencies, completed with 95% confidence intervals (CI95%). To

perform the multivariate analysis, the dependent variables being dichotomous, logistic regression was applied with the estimation of the B coefficient, Standard Error (S. E.), Wald statistic, degrees of freedom (df), odds ratio (OR, Exp(B), as well as the confidence interval for the odds ratio. The collected data were processed using IBM SPSS Statistics software, version 27 Statistics Professional Authorized User License and Python, version 3.12.3, the latter allowing for a reproducible statistical analysis. For the numerical variables, the following descriptive statistics were estimated: minimum value, maximum value, mean value with standard deviation, median value with interquartile deviation. For the dichotomous variables, absolute frequencies, relative frequencies were estimated, completed with 95% confidence intervals for the relative frequencies. The visualization was achieved using barplot and heatmap graphs. For all applied statistical tests, the threshold value (α) was considered to be 0.05.

The Quantitative research includes 3 representative samples:

Sample 1 - 1070 employees of hospital and primary healthcare institutions, both public and private (managers, doctors and nurses, non-medical personnel). The questionnaire consists of 57 questions, structured in several parts, in accordance with the research objectives. The questionnaire included nominal variables – with closed-ended response options, with single or multiple answers, as well as with an open-ended response option. It was pre-tested on 5 employees from healthcare institutions, 2 of whom were managers. The questionnair was transposed into a *google.forms* template to increase the access to all employees and to reduce the influence from superiors. Since the questionnaire included only mandatory questions, only completed questionnaires without missing values were collected, thus the application of the correction for the non-response rate was not mandatory. Since the simple random sampling method was applied, the *deff* index is considered equal to 1.

Physicians constituted 2/3 of the respondents – 64.5%, middle staff – 31.8%, and non-medical staff – 3.7%. The number of surgical specialists (27.7%) is close to that of therapeutic profile respondents (24.4%), followed by respondents from primary care (16.9%), obstetricians and gynecologists (11.1%), pediatricians (10.0%) and oncology specialists (5%). The youngest respondent was 21 years old for nurses and 24 years old for doctors, and the oldest participants were 68 years old for nurses and 73 years old for doctors. The group of respondents with work experience of over 21 years constituted 48.6%, of which 16.2% were employees with work experience of over 35 years. Practically, every 5th respondent (22.2%) had work experience of 11-20 years.

Sample 2 - 134 members of bioethics committees (73.0%) out of the total of 183 estimated members of committees of healthcare institutions in the country. The questionnaire consists of 25 questions with closed-ended response options, with single or multiple answers, as well as with an open-ended response option. The link for the questionnaire in *google.form* was sent to the chairmen of the bioethics committees, who disseminated it to the members of their committee. The questionnaire was pre-tested on 5 members of hospital committees.

More than a third of participants (38.8%) were members of bioethics committees of district hospitals, 21.6% were members of bioethics committees in primary health care institutions, 19.4% were members of the republican hospitals committees and 17.2% from municipal hospitals. About 3% of respondents were members of bioethics committees of private institutions. The group of doctors prevails (76.2%), of which 28.4% are representatives of the institution's management body. Nurses constituted 10.4% of the respondents, and the remaining 13.4% were distributed among representatives of non-medical specialties such as: lawyers, psychologists, pharmacists, statisticians, social workers, priest.

Sample 3 - assesment of bioethics committees. The evaluation grid was developed by the researcher and sent by e-mail to the administrations of 125 healthcare institutions (84 hospitals and 41 municipal or district primary health care institutions), of which 80 (64%) institutions responded (36

from primary health care and 44 hospitals). The grid contains 15 closed questions, being completed by the chairman of the administration of the institution.

The Qualitative research was carried out through in-depth individual interviews and focus group discussions, based on an Interview Guide developed by the researcher. 50 individual interviews were conducted with managers of hospitals and primary care facilities of different levels. The sampling for the research was done deliberately, the institutions being selected based on the results of surveys regarding the most appreciated hospitals (www.spitale.md) and institutions that were frequently involved in media scandals. The managers of institutions with similar capacity were intentionally selected, in order to be able to make comparisons of their approach to ethical issues. Conducting a large number of interviews (50) minimized the risk of pre-conceived answers, the groups of answers specific to certain phenomena being identified. As a validation technique, the data triangulation method was applied, which allowed verifying the accuracy and stability of the results produced.

Seven focus group sessions were held, of which 3 sessions were with members of the bioethics committees, 2 sessions with employees of hospitals and 2 sessions with employees from primary health care. Each session lasted between 30 and 90 minutes, with 9-12 participants. For the selection of participants, the following variables were taken into account as criteria: staff of different levels –doctors, nurses and non-medical staff, representatives of different services (primary health care and hospital), members of the institutional bioethics committee, etc. The *phenomenological analysis* was chosen for data processing, which allowed for the identification of major topics and key issues.

3. AN ETHICAL ENVIRONMENT FOR RESPECTING HUMAN RIGHTS

The research results allowed us to assess the level of institutionalization of ethics in healthcare institutions in the country, by evaluating the specific tools of this process.

Codes of ethics

The presence and role of codes of ethics as a tool of ethics management were evaluated through the opinions of the study respondents. More than half of the respondents – 56.6% (CI95% 53.7, 59.6) indicated that in the institutions where they work there is no separate code of ethics and is applied the Code of Ethics for Medical Workers and Pharmacists (approved by Government Decision No. 192 of 24.03.2017). Practically, a third of the respondents 30.4% (CI95% 27.6, 33.1) do not know about the code of ethics of their own institution. Only 13% (CI95% 11.0, 15.0) indicated the presence of an institutional code of ethics (Figure 1).

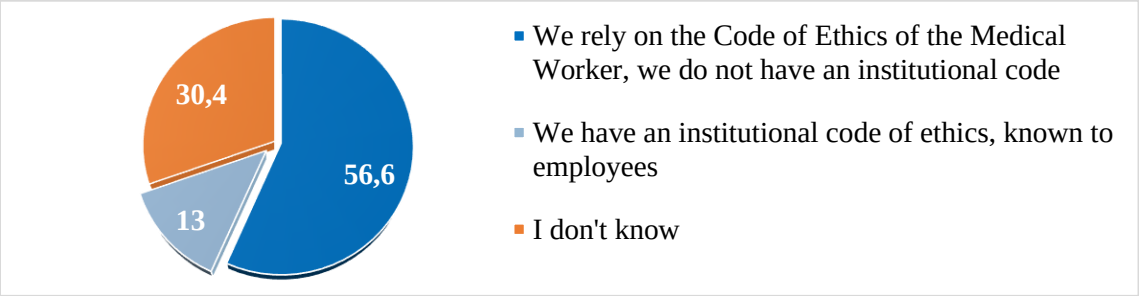

Figure 1. Presence of code of ethics, %, respondents' opinion.

Some managers deny the importance of institutional code: "*Why would we need a separate code, if there is already a good one, at the national level? Employees should at least respect that one*!" (II31).

Only a quarter of the respondents – 25.5% (CI95% 22.9, 28.1) considered that the institutional values are known and promoted by *all employees*, while 40.5% (CI95% 37.5, 43.4) considered that *only some employees* know institutional values, and 34% (CI95% 31.2, 36.9) *could not provide* any opinion.

28.5% (CI95% 21.9, 35.9) of people with over 35 years of work experience and only 21.7% (CI95% 15.2, 29.3) of employees with less than 5 years of experience are convinced that *all employees* of their institution know its values. An alarmingly high number of respondents stated that *no one* in the institution ever communicated to them about any values – 25.9% (CI95% 22.0, 30.2) are employees of republican hospitals and 23.1% (CI95% 17.5, 29.4) employees of municipal hospitals. This indicator is much lower in private institutions (Figure 2).

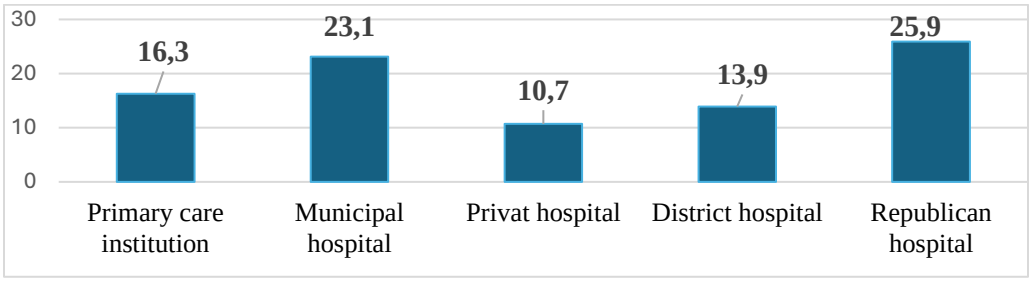

Figure 2. Respondents who noted that ***no one*** informed them about the institution's values, by institution type, %.

At least one in 4 oncologists – 29.6% (CI95% 18.0, 43.6) admits that *no one* has informed them about the values and ethical principles of the institution in which they work, followed by the group of surgical respondents – 27.0% (CI95% 22.2, 32.5), and of therapeutic profile – 22.5% (CI95%17.3, 27.8).

Some participants mistakenly believe that it is not necessary to be informed about certain additional ethical aspects, because the medical profession would already mean sufficient knowledge of all ethical aspects. "*I don't need such discussions, I was well educated by my parents!*" (II15); "*These values are still taught at university, we don't have to tell them when we hire somebody!*" (II31). It becomes obvious that the extensive amount of specific knowledge that a medical worker needs for ethical analysis and decision-making in the clinical activity is not understood.

Ethics training

The development of ethical competencies of employees is a very important component in increasing the ethical culture of an organization. Only 38.5% (CI95% 35.6, 41.4) of respondents believe that they have a team with high moral values and sufficient capacity for ethical analysis. Every third respondent – 33.7% (CI95% 30.9, 36.6) believes that the employees of their institution need additional training and negatively assessed their ability to recognize and resolve moral dilemmas (Figure 3).

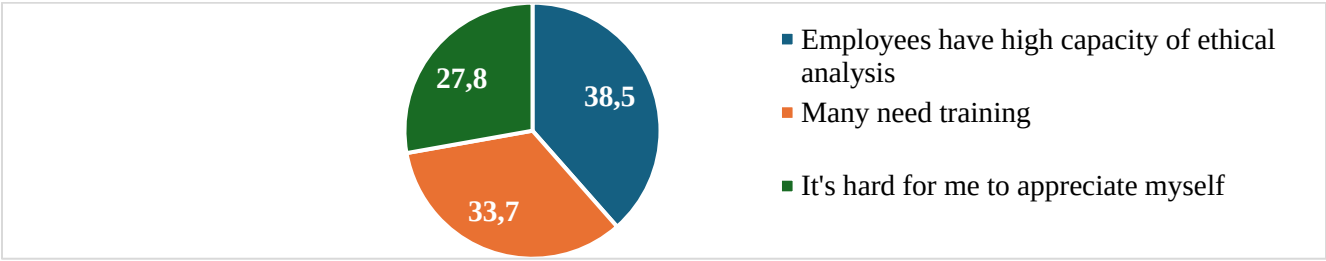

Figure 3. Appreciation of employees' ability to conduct ethical analysis, %.

"Everyone decides according to their own visions... We don't have a specific culture, so we can lead ourselves according to some models!" (II48).

Making a self-assessment of their own knowledge necessary to manage ethical issues, only a little over a third of employees 36.2% (CI95% 30.4, 36.1) confirmed that they possess the necessary knowledge to make ethical decisions. 43.2% (CI95% 36.8, 42.7) of respondents consider that they have

insufficient knowledge and would like additional training. The group of those who state that they need *extensive* training 10.1% (CI95% 7.5, 11.0) was equal to that of respondents who could *not appreciate* 10.3% (CI95% 7.7, 11.2), probably not understanding what knowledge they are being asked about (Figure 4).

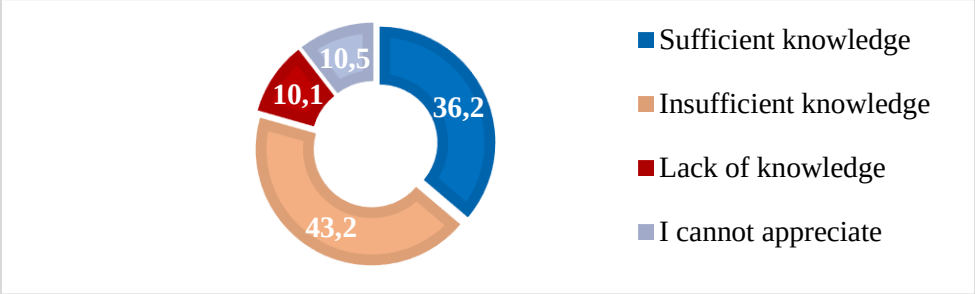

Figure 4. Assessment of one's own level of knowledge necessary for ethical decision-making, %.

Being much more frequently involved in ethical decision-making, doctors are the most critical in assessing their own knowledge in the field of ethics, practically half wanting to know more – 48.6% (CI95% 44.6, 52.6), compared to nurses – 32.9% (CI95% 27.9, 38.3) (Figure 5).

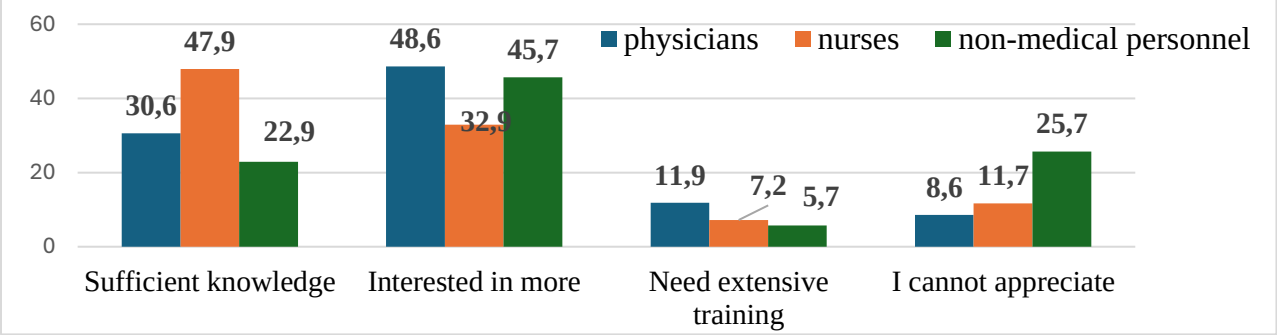

Figure 5. Assessment of one's own level of knowledge in the field of ethics, by profession, %

It is alarmingly high the number of doctors who consider that they *have not received any training* in the field of ethics at the university level – 30.8% (CI95%28.1, 33.6) and through residency – 50.2% (CI9% 47.2, 53.2) where the foundations of the ethical analysis of the clinical case should be laid. One in five doctors – 21.2% (CI95% 18.8, 23.7) have not had such training at work, and some – 13.7% consider that, even if there was some training, it was useless to them (Figure 6).

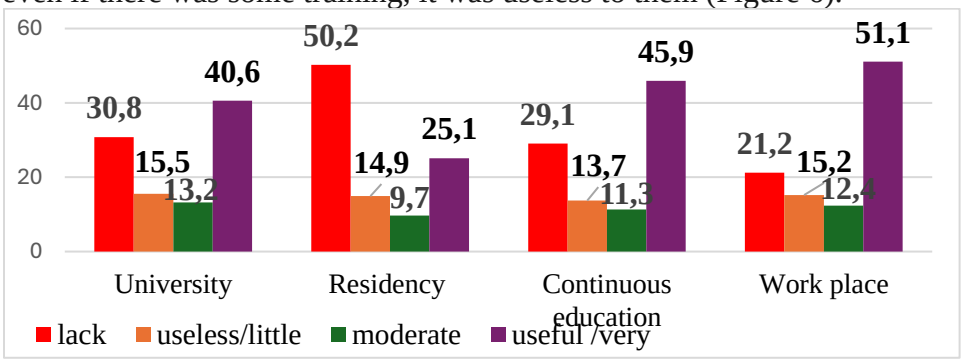

Figure 6. Training of doctors in the field of ethics, %.

The role of climate in establishing organizational ethics

109 doctors – 5.2% (CI95% 4.3, 6.2) indicated that *envy* is a present in their institution, 132 doctors – 6.2% (CI95% 5.2, 7.4) noted *indifference*, 142 doctors – 6.7% (CI95%5.7, 7.9) recognized

that the interest in *personal profit* prevails in the institution, and the *unhealthy competition* was marked by 144 doctors – 6.8% (CI95%5.8, 8.0), *favoritism* – by 165 doctors – 7.8% (CI95% 6.7, 9.0). Strongly negative assessments were also selected, such as *fear* – 97 doctors – 4.6% (CI95%3.7-5.6) and 50 nurses – 4.9% (CI95% 3.7, 6.4) and *hate* – 29 doctors – 1.4% (CI95% 0.9, 2.0) and 4 nurses. Some employees admitted that corruption also prevails in the institutions where they work – 36 doctors – 1.7% (CI95%1.2, 2.4) and 14 nurses – 1.4% (CI95% 0.8, 2.3). Even though the rates for negative values seem to be comparatively small, the absolute numbers show us that there is cause for concern regarding the ethical environments in the country's healthcare institutions.

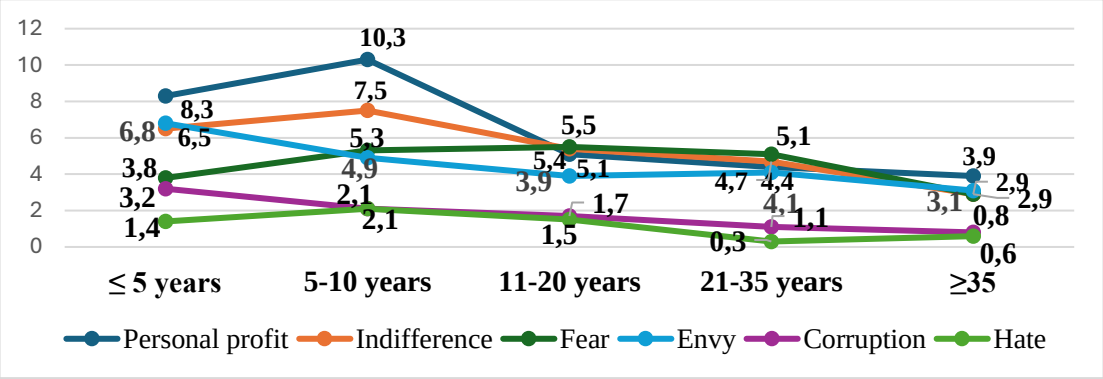

Figure 7. Selected negative values, by respondents' work experience,%.

The positive assessment of the institution` values increases with the respondents' work experience (Figure 7). For example, *profit* was mentioned by 10.3% (CI95% 7.9, 13.2) of people with 11-20 years of experience and only 3.9% (CI95% 2.4, 5.9) of those with more than 35 years of experience (Figure 7). While corruption is mentioned less frequently in the quantitative research, in the qualitative study, both in individual discussions and in focus groups, this phenomenon is mentioned much more frequently. Some respondents mentioned that in their institutions bribery is considered a norm, and employees justify their request for informal payments: " *That's the way it is! Everyone takes it, why shouldn't I take it too?!*" (FGis2). The corruption is already infiltrated at the sub-cultural level.

"*At Easter a patient comes with a lamb and a bottle of wine, how can I not take it? Everyone takes it ...*" (II13). *"In our hospital, everyone knows what their fees are, some less, but some exaggerate a bit ..."* (II8). *"I'm sure the bosses know very well who and how much they take... but they turn a blind eye... They pretend not to know... but they know very well, and they don't do anything...*" (II27).

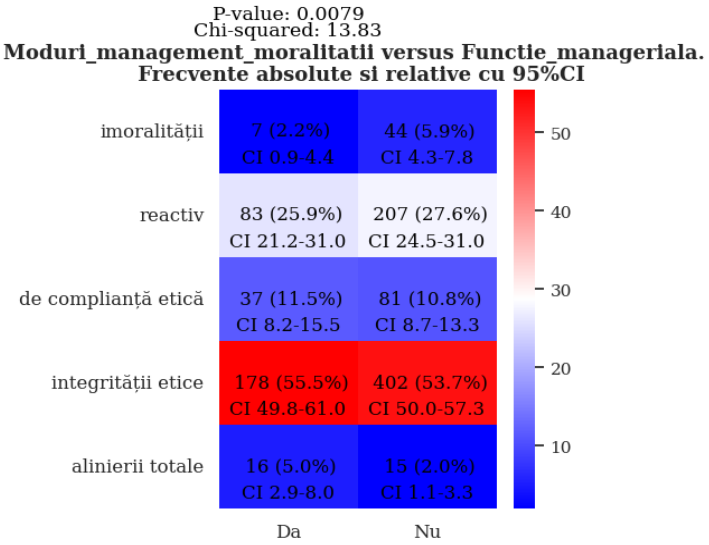

Figure 8. Assessment of the management of morality in the institution, by function, %, abs..fig.

Respondents were given the option to select the moral management mode of the institution in which they work (Figure 8). The ***immoral mode*** was selected by 51 people – 5.2%, who advocated for the characteristic of an institution in which a climate of unhealthy competition prevails, where everyone thinks about their own benefit and profit. Every fifth respondent – 20.6% selected the **reactive mode** of morality management for their institutions, confirming that all employees understand that something is not going well, but nothing concrete is being done, the moral values are declared formally.

Promoting ethical behavior

Almost a quarter of employees – 24.7% (CI95% 22.2, 27.3) believe that measures to promote ethical behavior in their institutions are *insufficient* and *superficial*. A group of 22.1% (CI95% 19.6, 24.6) could not provide an assessment, probably because they are little familiar with the management measures that could influence employee behavior. (Figure 9).

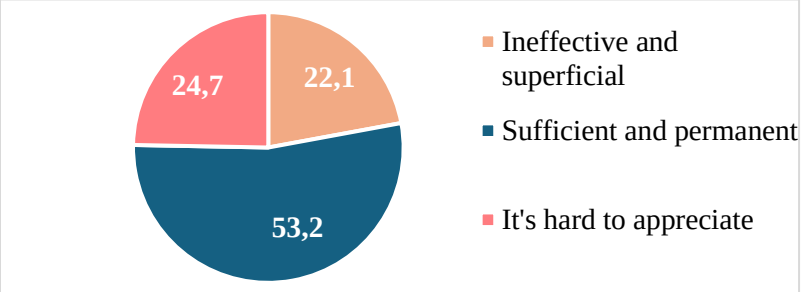

Figure 9. Appreciation of the measures taken to promote ethical behavior, %.

Doctors are much more critical than nurses regarding the measures taken by the institution's administration in case of ethical problems. 19% (CI95% 16.1, 22.1) of doctors and 14.1% (CI95%10.6, 18.3) of nurses believe that everything will end only with *noisy discussions*. Penalization is also more frequently mentioned by doctors – 29.7% (CI95% 26.3, 33.3) than by nurses – 25.6% (CI95%21.0, 30.6) (Figure 10).

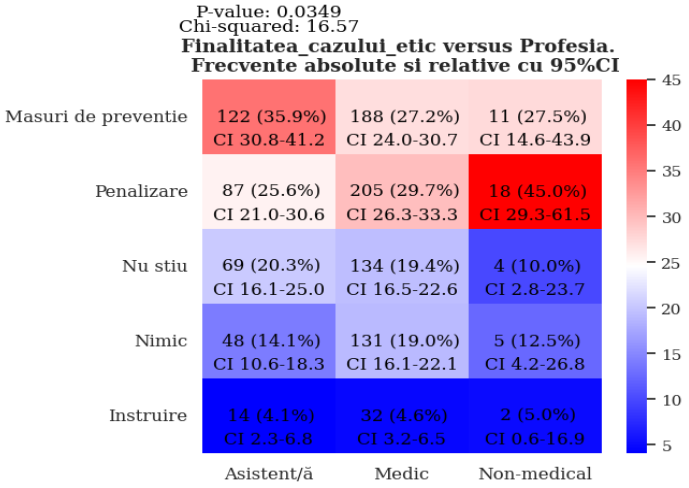

Figure 10. Finality of the case of unethical behavior, by profession of respondents, %, abs.fig.

Only one in three physicians – 38.1% (CI95% 31.0, 45.6), 33.0% (CI95% 27.3, 39.0) of specialists in therapeutic fields and 33.6% (CI95% 25.2, 42.8) of obstetrician-gynecologists believe that in their institution the cases of unethical behavior are completed with preventive measures. While oncologists – 22.2% (CI95% 12.0, 35.6) and surgeons – 22% (CI95% 17.4, 27.1) are much more skeptical about this subject.

4. REDUCING THE RISK OF HARM IN INSTITUTIONS

Trust and ethical safety

Most often, ethical issues in clinical practice are discussed during regular work sessions with immediate superiors – 59.8% (CI95% 56.9, 62.8), as well as at scientific meetings – 13.1% (CI95% 11.1, 15.10). Every second respondent – 51.5% (CI95% 48.5, 54.5) prefers to discuss ethical issues in interpersonal communication with colleagues. However, 79 respondents – 7.4% (CI95% 5.8, 9.0) mentioned that ethical issues are not discussed in any form in their institution. Less than half of the respondents – 42.9% (CI95% 39.9, 45.9) mentioned that they discuss ethical issues in personal meetings with managers. Managers of the private institutions are perceived as much more willing to discuss ethical issues with their employees than those in the public sector (Figure 11).

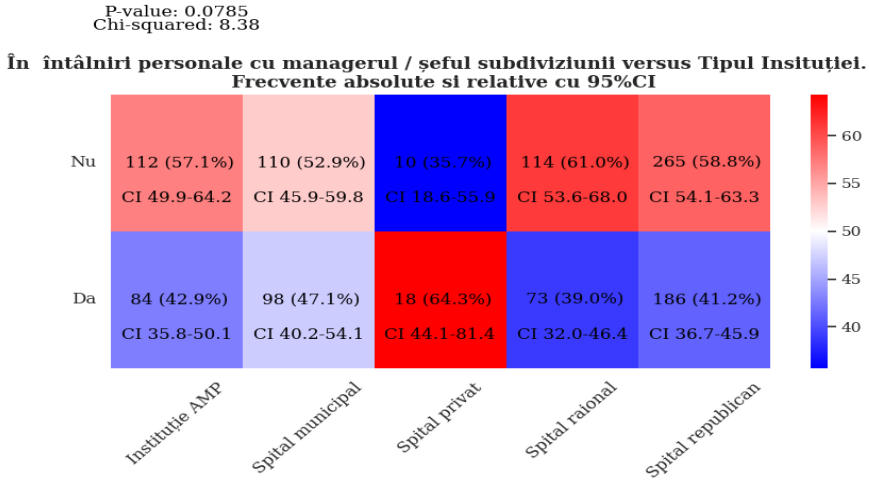

Figure 11. Managers' openness to discussing ethical issues with employees, %, abs.fig.

Trust is a mandatory precondition that disposes employees to open up and acknowledge problems they face at workplace. The research identified that, in some institutions, it is not the tradition of dialogue when an ethical problem is identified. More than 2/3 of the respondents (69.5%) admitted that they do not see a problem in addressing their immediate superior. However, every fifth respondent 20.5%, is convinced that no one will help them and will try to cope with their own strength. Some believe that opening up the problem could have unpleasant consequences, being considered unprofessional (5.7%) or being scolded and penalized (4.3%) if they acknowledge the problem (Figure 12).

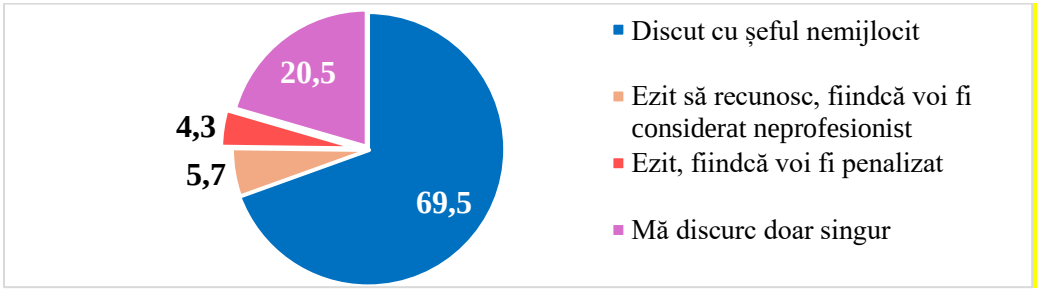

Figure 12. Recognition of ethical issues at work, %.

Non-medical staff (82.9%) and nurses (73.5%) are much more willing to report and discuss ethical issues they encounter in their professional activity, compared to doctors (66.3%). Every third doctor (33.7%) will hesitate, for various reasons, to raise an ethical issue in their practice (Figure13).

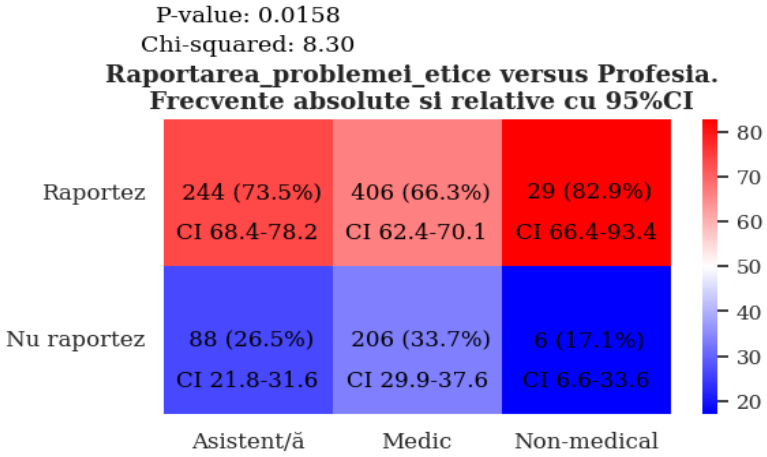

Figure 13. Recognition of ethical issues, by profession, %.

Are not willing to report ethical problems they face 31% (CI95% 24.1, 38.5) of respondents with over 35 years of experience and 31.8% (CI95% 23.9, 40.6) of those with less than 5 years of experience.

Employee satisfaction

More than half of the respondents (57.2%) highly appreciate the image of the institutions in which they work, qualifying it as a *good* image – 40.3% (CI95% 34.2, 40.0) or *very good* one – 16.9% (CI95% 13.3, 17.7). Every third respondent – 35% (CI95% 29.4, 35.0) refrained from giving a concrete assessment of their institution, preferring to consider it *no more special than others* in the country. 62 respondents (6.2% CI95% 4.4, 7.2) rated their institution's image as *poor* and 15 respondents (1.5% CI95% 0.7, 2.1) gave it a *strongly negative* assessment (Figure 14).

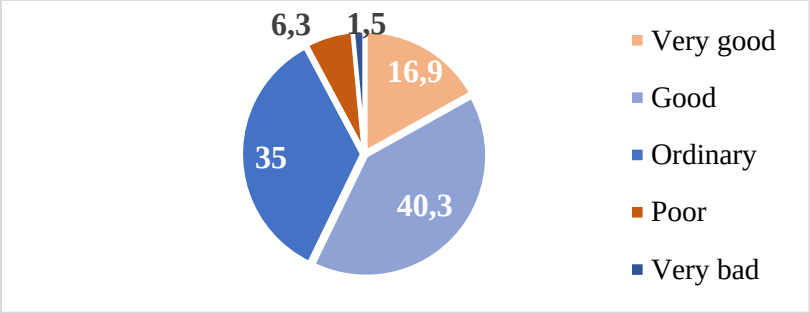

Figure 14. Opinions regarding the image of the institution where they work, %.

It is alarming that employees try to justify negative situations, on the one hand, having a sense of loyalty to a team, on the other hand, recognizing that, from a moral point of view, things are not going well: "*Everyone does it like this, everyone is just as bad, why should we stand out?*" (II37).

The fact that many of the respondents frequently offer an "ordinary" appreciation for their institutions is, somehow, an excuse for the unsatisfactory aspects that they may notice, but they reconcile themselves with them. Employees of private institutions appreciate the image of their institution at a much higher level, compared to those in public institutions (Figure 15).

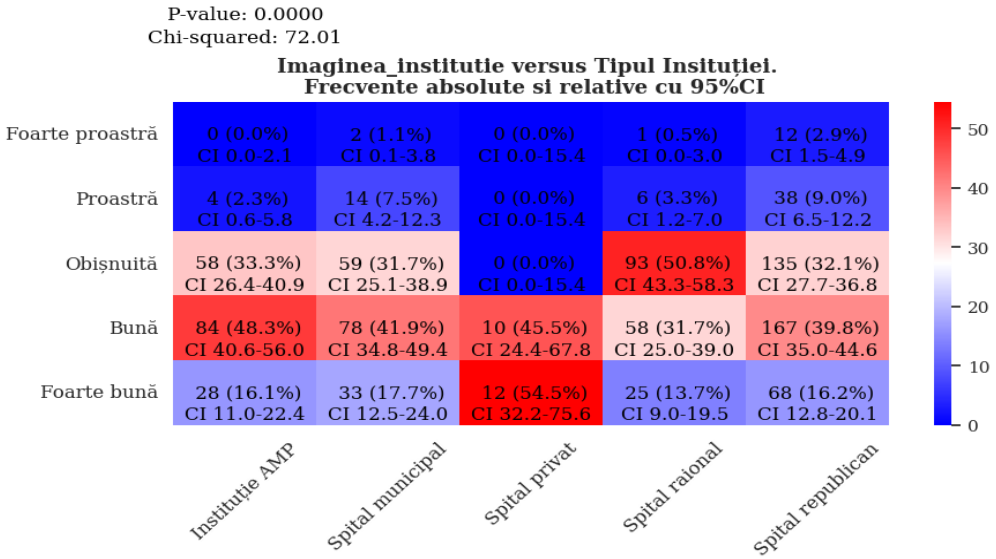

Figure 15. Appreciation of the institution's image, by type of institution,%, c.a.

One in five doctors participating in the study – 20.1% (CI95% 17.2, 23.3) and 15.6% (CI95% 11.9, 19.9) nurses are dissatisfied with the fact that their institution does not assess employee satisfaction. This response is evidence that human resources management is insufficiently organized in the healthcare institutions, and the lack of employee satisfaction assessment is a risk of increasing staff dissatisfaction and demotivation, which can seriously affect the quality of services provided (Figure 16).

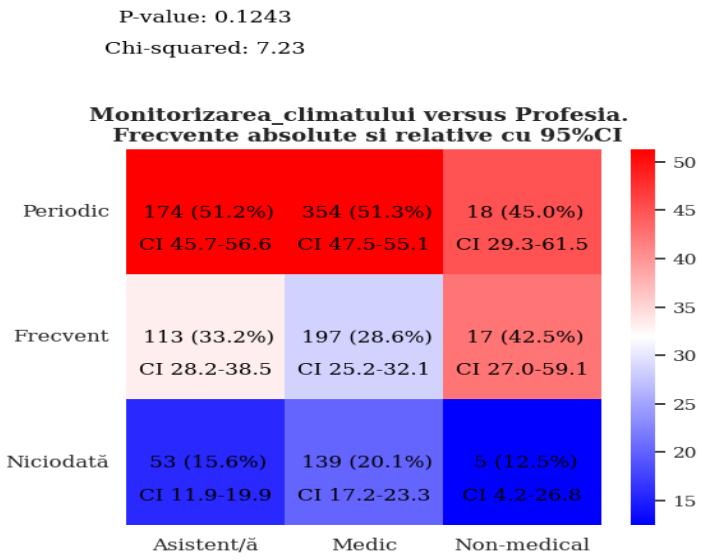

Figure 16. Employee satisfaction assessment, respondents' opinion by profession, %, c.a.

The greatest dissatisfaction with the lack of employee satisfaction assessments by the institution's management is determined in republican hospitals – 23.3% (CI95% 19.5, 27.5) and municipal hospitals – 18.3% (CI95% 13.3, 24.2), among obstetricians and gynecologists – 31.9% (CI95% 23.7, 41.1), surgeons – 22.6% (CI95% 18.0, 27.8) and oncologists – 20.4% (CI95% 10.6, 35.5). During the discussions, we noticed very frequently that managers discuss and highlight the respect of patient rights and much less attention is paid to the violation of medical workers' rights: "*We feel unprotected at work. We have no rights, only obligations! The manager looks at us like slaves and God forbid if there is any complaint... But sometimes we also want to complain, but no one hears us and is not interested in the problems we face" (II35).*

Respecting the psychological contract between employee and employer

Some participants expressed disappointment with the relationship they have with their employer. For example, some employees mentioned that they were "body and soul" for their institution, making certain sacrifices, many unpaid overtime hours, etc. Respectively, they expected actions of gratitude, which were not demonstrated*: "I missed many family events, because I had to write urgent reports or respond to requests from the ministry...." (FGamp2); "I never refused when the boss asked me to replace someone..." (FGis1).* However, it seems that the employees' expectations of being appreciated for the sacrifices made and the dedication shown were not satisfied, thus they considered that the unwritten psychological contract they had with the institution was not respected*: "When I had my 60th birthday, they sent someone from the unions with a bouquet of flowers and a cardboard diploma" (FGis2); "Nobody cared that I was sitting at work with a handful of pills in my pocket and during the lunch break I was doing my intravenous perfusion" (FGamp1).*

At the same time, the managers believe that they do everything necessary for the employees, but they do not always have the expected attitude from them*: "I created adequate working conditions, I gave them good repairs, but they still do not change their attitude..." (II31); "At every meeting we talk about how they should behave, we give them training, and all in vain..." (II18); "We still turn a blind eye when they receive "their" patients with VIP status, we understand that we are all human, but some people don't appreciate this positive attitude on our part anyway" (II17).*

The phenomenon of professional burnout – burnout

The participants confirmed that many of the medical workers in the institutions where they work perceive themselves as exhausted and, probably, could have been diagnosed with burnout, however, there are no specialists in the institution capable of doing this. Many told us that, even if there is a psychologist at the institution level, that specialist does not have any activities aimed at diagnosing burnout among the employed staff: *"I think that all of us at some point were in burnout. Some somehow managed to get out, others were left with chronic things... Some are on antidepressants.." (FGis1); "Nobody cares that you are not feeling well." (FGamp2); "You don't feel like smiling when you can barely stand on your feet..." (FGamp1).*

Reporting errors

Participants in the qualitative research confirmed that in our healthcare system there is no correct culture regarding errors that can occur in practice. For fear of punishment, many errors are hidden, covered up, not recognized, and our medical community is not yet ready to recognize the truth and the mistakes made. Participants confirmed that the lack of an adequate culture of reporting errors leads to employees' fear of not being punished. *"Errors are discussed in large meetings, when there are serious cases, with resonance. Usually, the one who made the mistake – is crucified..." (II21); "The error is already reported when there are serious negative consequences – death, severe complications or the patient's petition. In other cases ... voluntary recognition of errors is not really practiced" (II39).*

It was repeatedly expressed that it is necessary to create, at the legislative level, a correct procedure for reporting malpractice. The study confirmed that, in the local health system, reporting mistakes is left more to the individual choice of each employee. 12.59% (CI95% 10.6, 14.6) of the respondents indicated that they would not get involved if they noticed that a colleague had made a mistake, considering that this was not their duty. Reporting a colleague's mistake was undertaken only by a small group of respondents – 14.1% (CI95% 12.1, 16.3), while the majority – 73.4% (CI95% 70.7, 75.9) prefer to discuss the problem personally with the colleague, without subsequently resorting to it. Here the feeling of *guild loyalty* becomes evident, which implies the risk of hiding or covering up the mistake. Most frequently, the hesitation to report the error is related to the unwillingness to create problems for the colleague, since it is certain that reporting will result in penalties: "*Errors are hidden because many employees are old-school, not adapted to our times. Errors should be discussed in order not to repeat them, but not to penalize, as it used to be*…" (comment in the questionnaire)

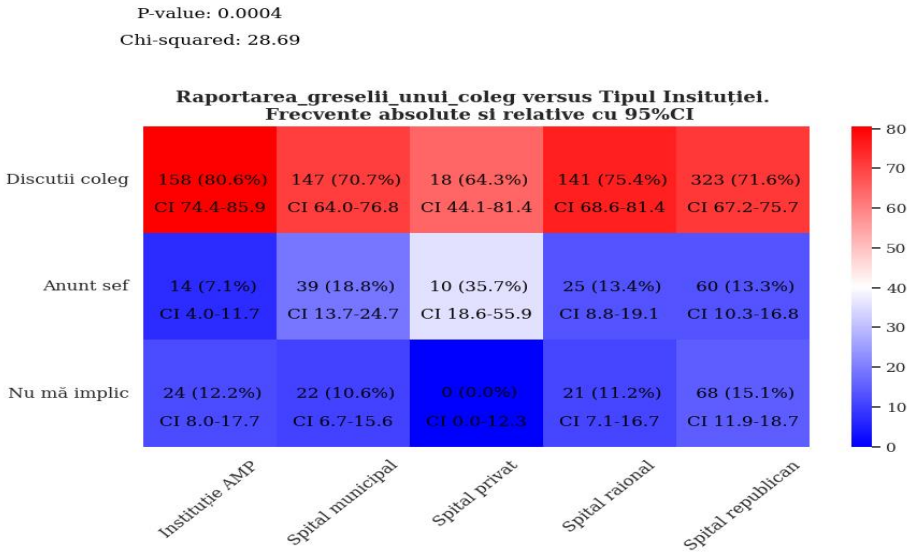

Figure 17. Attitude towards reporting mistakes, by type of institution, %, abs.fig.

Doctors from republican hospitals are more willing – 15.1% (CI95%11.9, 18.7) not to react to a colleague's mistake, compared to those from district hospitals – 11.2% (CI95% 7.1, 16.7) and municipal hospitals – 10.6% (CI95% 6.6, 15.6). Such situations will not be encountered in private hospitals where the rate of those who will notify the head is 35.7% (CI95% 18.6, 55.9). This difference indicates the presence of clear procedures for reporting mistakes in private institutions (Figure 17). Oncology doctors (24.1%) are most willing to ignore a colleague's mistake compared to other specialties (Figure 18).

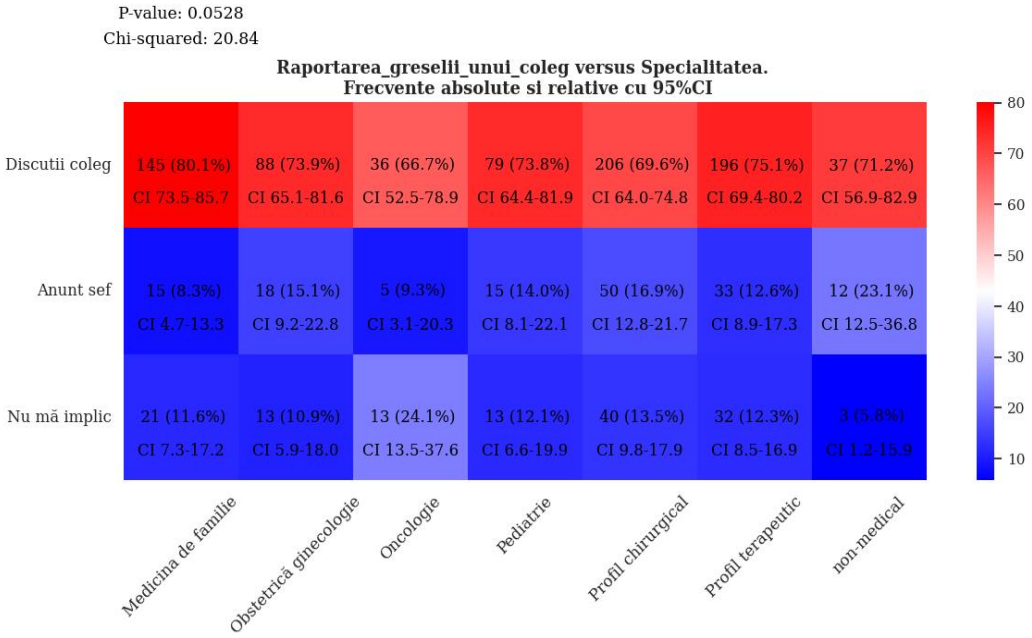

Figure 18. Attitude towards reporting mistakes, by specialty of respondents, %, abs.fig.

Rational use of medicines (RUM)

The research identified inadequate supervision of the RUM process within healthcare institutions. In discussions with hospital managers, we encountered statements that demonstrated an indifferent attitude towards this topic, which is not perceived as a priority. The managers themselves do not understand the importance of the pharmacologist or clinical pharmacist specialist in ensuring the quality of the medical act and patient safety: "*We do not have a pharmacologist in the institution, but I will tell you honestly – I did not even think that we need such a specialist" (II96); "What is the use of opening a position, if it remains vacant for years and no one comes to hire. I canceled it and hired another specialist, who I needed*" (II17).

Qualified specialists in the field of clinical pharmacology who strictly monitor the process of rational use of medicines are employed in the private hospital institutions. Thus, it becomes evident that, at the national level, there are gaps in the perception of the RUM issue even among decision-makers in the health system, including among the management of the healthcare institutions. In order to ensure the quality and safety of the medical act, it is necessary that the continuous training of personnel in URM topics be a mandatory process.

5. VALUE-BASED DECISIONS

Frequency and types of conflicts in institutions

Employees need a scale of values as a starting point in the decision-making process. To do this, decision-makers must take into account the perceptions and values of those affected by the decision and explore, including, the underlying, hidden values. Since the activity of providing medical services is multidimensional, conflicts can arise in the process of relating to different actors – colleagues,

administration and patients and their families. From figure 19 we observe that *conflicts with colleagues* represent the most frequent ethical problem mentioned by respondents. More than a quarter of respondents (29.4%) *frequently* or *sometimes* encounter ethical problems with the administration. It is important to note that respondents mention problems with the *patient's relatives* more frequently than with the patient himself. This aspect is probably related to the vulnerability of the sick person, who prefers to refrain from conflicts. While relatives, being worried, may have claims, sometimes even exaggerated, towards the medical staff. At the same time, this is an indicator of gaps in the communication process within the institution and indicates the need to develop institutional procedures and implement algorithms for empathetic communication.

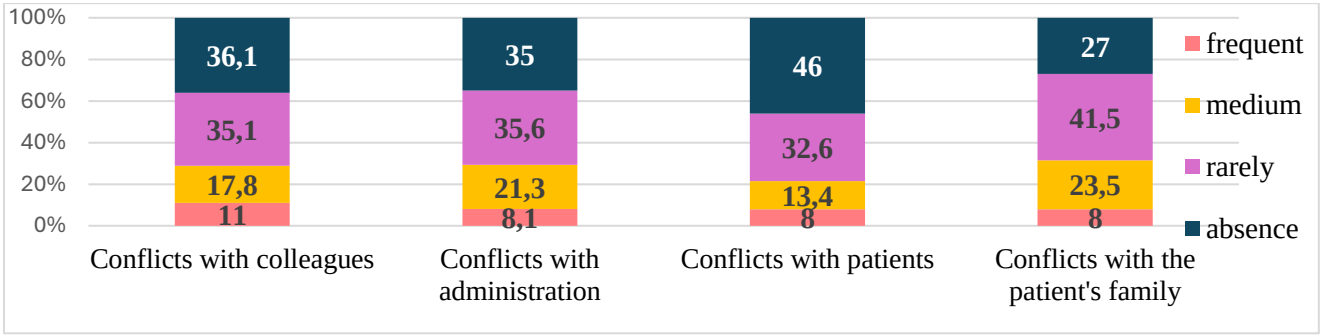

Figure 19. Presence of ethical issues in the professional relationships of respondents,%.

Medical workers frequently find themselves in situations where their own views on concepts such as *the end and beginning of life*, *dignity*, *medical secret*, *respect for life*, etc., may be at odds with those of the patients involved, their relatives or even the cultural context of society. About a fifth of respondents *frequently* or *moderately* encountered problems related to the end of life (20.8%), conflicts related to human reproduction (16.7%) and involvement in clinical research (9.2%).

More than half of the respondents (68.4%) indicated that they had encountered situations of *inappropriate influence* from their bosses (giving preferences to some patients, limiting resources, influencing decisions, etc.), where 21.8% (CI95% 18.3, 25.7) mentioned that they encounter such situations *often* or *very often*. Practically, every fourth doctor (23.4%) claim that this phenomenon is encountered *frequently* and *very frequently* in the institutions where they work (Figure 20).

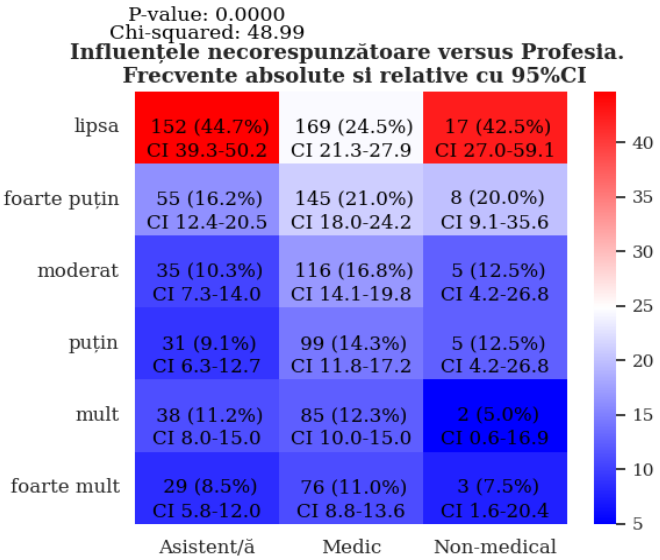

Figure 20. Perception of inappropriate influences, by profession, %, abs.fig.

Decisions influenced by employees' dual loyalty

The study identified a very large number (74.4%) of those who admitted to having had situations of conflicts of interest in professional relationships. Almost half of the doctors (47.2%) reported this phenomenon from *very much* – 9.3% (CI95% 7.2, 11.7), and a lot – 15.1% (CI95% 12.5, 26.1) to *moderate* – 22.8% (CI95% 19.7, 26.1).

A third of respondents with less than 5 years of experience (33.6%) encountered conflict of interest cases *frequently* – 14.7% (CI95% 9.3, 21.6) or *very frequently* – 18.9% (CI95% 12.8, 26.3) and 28% (CI95% 20.8, 36.1) encountered them *sometimes*. While among those with more than 35 years of experience, 7.0% (CI95% 3.7, 11.9) encountered such cases *frequently*, and a *lot* – 11.0% (CI95% 6.8, 16.7) and *sometimes* – 12.2% (CI95% 7.7, 18.1) (Figure 21).

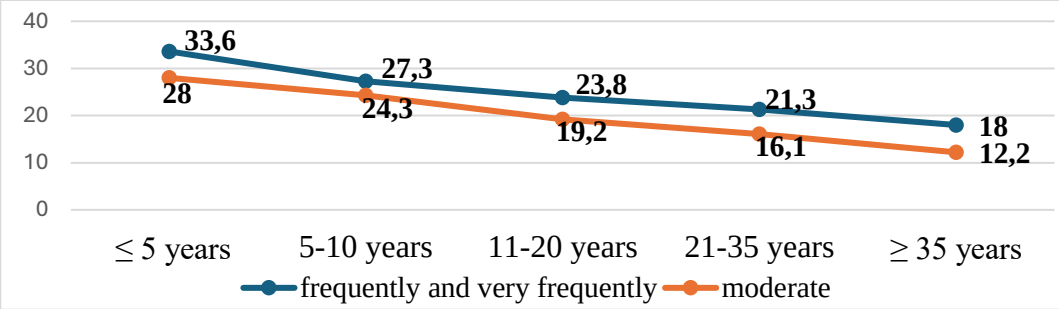

Figure 21. Perception of conflicts of interest, by work experience, %.

About a quarter of the participants 26.1% (CI95% 23.5, 28.8) reported that they had ethical dilemma situations in deciding for the good of the patient or the economic interests of the institution in which they work, confirming that the manager asked them to save institutional resources to the detriment of the patient. About a quarter 23.3% (CI95% 20.8, 25.9) of the medical workers included in the study stated that they act in the interest of the insurance company, even if they understand that the imposed conditions contradict the patient's benefit. Practically, every third respondent (35.3%) mentioned that they faced ethical dilemmas because they could not provide the patient with fair access to expensive investigations and treatments (Figure 22).

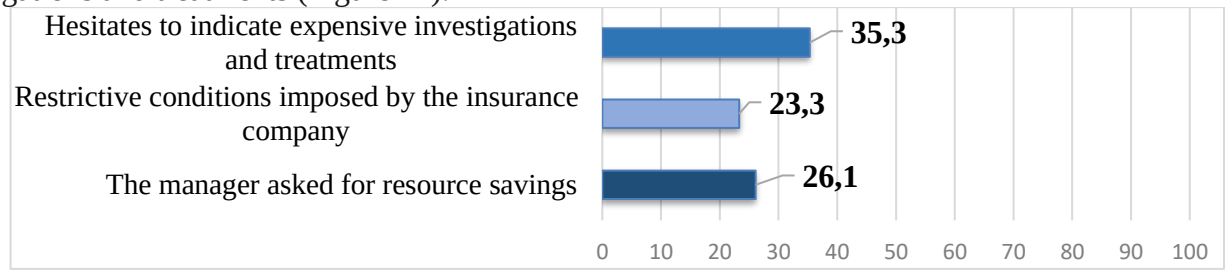

Figure 22. Influence of economic conditions on doctors' decisions, %.

Dual loyalty can also occur in the context of relationships between colleagues in the medical field. Thus, 13.9% (CI95% 11.9, 16.1) of the respondents admitted that they had cases when they had to take the side of a colleague against the interests of a patient. "*Everyone thinks – but what if next time I find myself in such situations? We have to protect ourselves... Nobody does harm intentionally... it happens sometimes...*" (FGce1). Many employees prefer, for reasons of convenience or personal interest (in a selfish sense), to overlook the problems they observe, invoking the narrative "*and why should I make enemies?"* (FGce2, FGis1).

Managerial behavior as an ethical model

In many healthcare institutions, problems are identified with reference to the image of managers, at different levels, which, respectively, affects the degree of trust for these people. The most critical

attitude towards the behavior of the managerial body is expressed by doctors (Figure 12). Only 42.9% (CI95% 39.2, 46.7) assess the behavior of the manager as *worthy to follow*, and 45.1% (CI95% 41.3, 48.9) give this qualification to the immediate heads of the section / department where they work. A lower degree of trust is offered by doctors to deputy directors – 37.2% (CI95% 33.6, 41.0). The same trend is observed among nurses who, comparatively, offer a higher degree of trust to the institution manager – 57.6% (CI95% 52.2, 63.0) and the head of subdivision – 59.1% (CI95% 53.7, 64.4), but less to the vice directors – 52.2% (CI95% 46.6, 57.5).

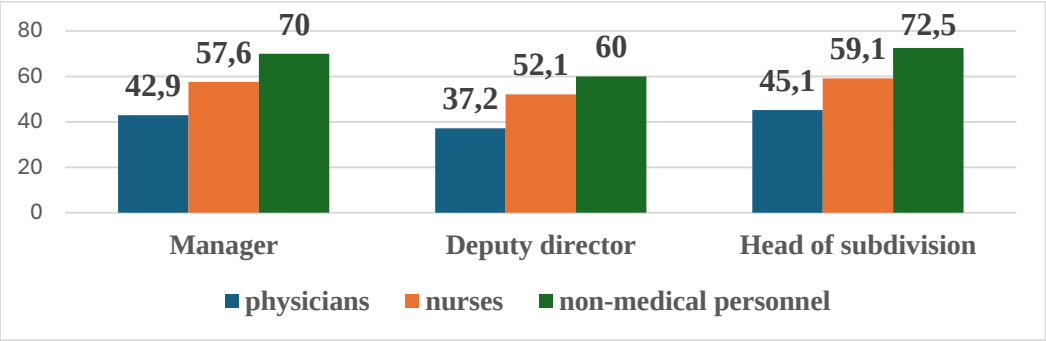

Figure 12. The "worthy to follow" assessment given to the managerial body, by profession, %.

For the most part, the management body was highly rated, which is an advantage for the institutions. However, we should not ignore the number of those who rated the behavior of their managers with low scores. When there is no *model of the correct manager* in the institution, it is difficult to build an ethical institutional culture.

During the individual discussions, we also identified negative opinions towards certain people in the management body of the institutions. Most frequently, this was expressed towards certain deputy directors, as it was considered that they are appointed to the position not according to the principles of a competitive and fair selection: "*Our vice director walks around the institution very arrogantly and acts like the boss, he constantly shouts. Nobody respects him and he wants to impose himself through fear!*" (II25). "*The fish is rotten at the head! Don't you see what is written in media? How can you believe them anymore?*" (II11).

Some respondents question the integrity of the management body of the institution in which they work. Many respondents mentioned problems with reduced transparency of managerial decisions. 28.3% of the responding doctors and 21.7% of the nurses identify problems in this regard, appreciating the *total lack, very little* and *little* transparency in their institution (Figure 24).

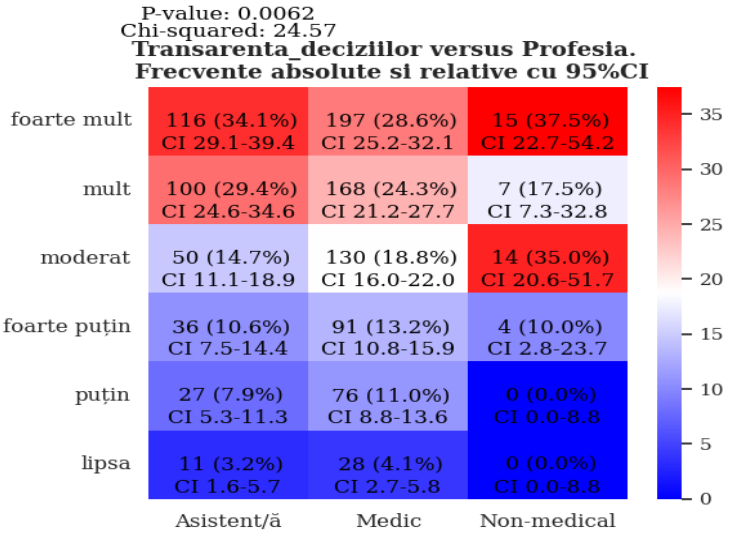

Figure 24. Appreciation of the transparency of the manager's decisions, by profession, %, abs.fig.

Another indicator that signals the presence of problems of trust of employees towards the managerial body is the perception of *favoritism*. This phenomenon is most often mentioned by employees of municipal institutions – 39.4% of respondents report it as *a lot* and *very much* (Figure 25).

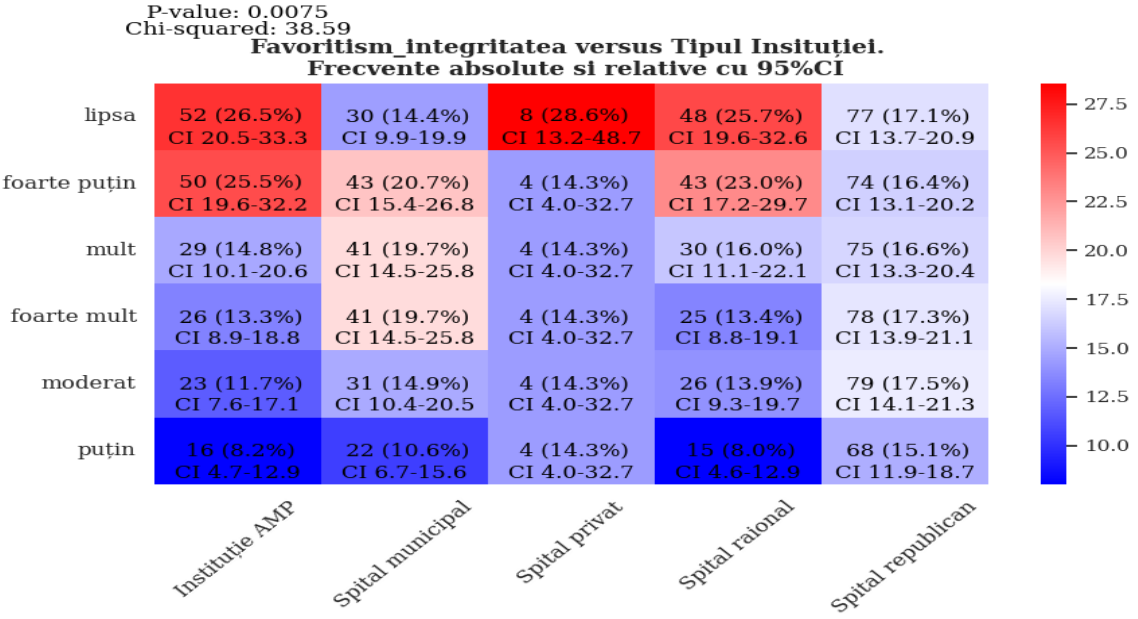

Figure 25. Perception of favoritism, by type of institution, %, abs.fig.

Many participants questioned the application of the meritocracy principle in the medical institutions where they work or have worked in the past. "*If you don't have connections and relatives, you have no chance of advancing or getting a good job!*" (II35). "*That's how it is with us – those who are protected, in favor of the boss, and those who are workaholics... we are very offended by this differentiated attitude. As if we are not all people...*" (FGamp1).

Opinions were expressed that not all managers are sufficiently interested in the subject of ethics in the institution. This indifference demotivates employees who, in the same way, relax regarding this aspect: "*Some people think - if the bosses don't care, why would I care?!*" (FGce3).

Some hospital managers admitted that they prefer to pass the ethical issue to the ethics/bioethics committee, considering that this area does not belong to their responsabilty: "*When we have an ethical issue, conflict with patients or petition, we send it to the ethics committee, let it be clarified! I don't even want to get involved!*" (II9); "*Ethical issues are discussed at the ethics committee. It's their job, I have enough other responsibilities!*" (II18). Ethics is appreciated as a secondary factor and an additional problem which, respectively, is reflected and transmitted to employees at the institution level. It is obvious that the correct behavior and involvement in organizing the ethical dimension of the organization requires managers to have a high level of ethical competences. The lack of such competences and skills reduces the degree of their involvement in ethical issues, the reason being confusion, misunderstanding and the erroneous believe that ethics is just a philosophical theory, without practical utility.

6. INSTITUTIONAL BIOETHICS COMMITTEES

Absolutely all evaluated institutions (100%) have created such committees. However, we have identified that the opinions of employees on this subject are different. Only 44.1% (CI95% 41.1, 47.1) of the respondents appreciated the bioethics committee as a *important and useful structure*. The number of those who *do not know about the activity* of this committee is alarmingly high – 18.9% (CI95% 16.5, 21.2), to which could be added the number of those who *could not determine*– 20.8% (CI95% 18.4, 23.3); 16.2% (CI95% 14.0, 18.4) considers that this structure is *irrelevant and formal* (Figure 26).

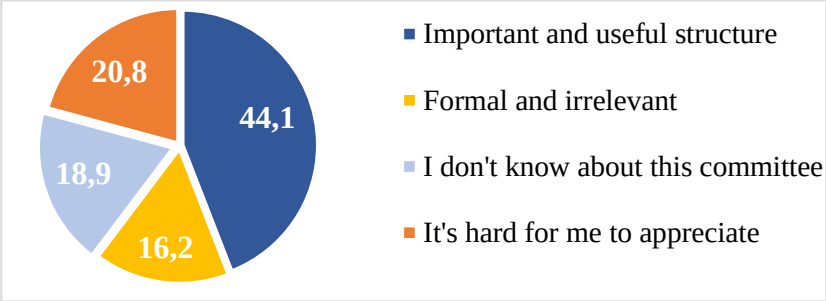

Figure 26. Usefulness of the institutional ethics/bioethics committee, employee opinion, %.

Even some members of these committees themselves are skeptical about the necessity of the committees they are part of. One in five members of the ethics committee included in the study – 18.9% cannot assess the usefulness of these committees or consider them to be formal structures, just for checking off in the accreditation process, not understanding their purpose. Pediatricians – 59.8% (CI95% 49.9, 69.2) and family doctors – 53.6% (CI95% 46.0, 61.0) appreciate the usefulness of the bioethics committee the most, while only 29.4% (CI95% 24.4, 38.5) of obstetrician-gynecologists and only 31.5% (CI95% 19.5, 45.6) of oncologists consider this structure useful. Have had the experience of addressing the institutional bioethics committee18.1% (CI95%15.3, 21.2) of the responding physicians, 12.1% (CI95%8.8, 16.0) of the nurses and 15.0% (CI95%5.7, 29.8) of the non-medical personnel included in the study. At the same time, 24.2% (CI95%21.3, 27.6) of the responding physicians *did not know* that they could address the bioethics committee for consultation. Some respondents consider that the competence and structure of the bioethics committee of their institution do not inspire confidence: "I did not call, it is formal, from the same bosses team, without knowledge in the field. I do not think they can professionally approach ethical issues" (II16). Opinions were also expressed that the members of the bioethics committee "*are appointed by the bosses to favor their decisions*" or "*are the director's people who will defend him*" (answer from the questionnaires).

Only a third of the respondents – 35.3% (CI95% 32.5, 38.2) are convinced that the committee members *have sufficient knowledge* in the field of ethical/bioethical analysis. At the same time, one in five respondents – 22.2% (CI95% 19.8, 24.7) *does not know who the committee members are*, and one in ten employees 10.4% (CI95% 8.3, 11.9) is convinced that the members of the ethics committee in the institution where they work *do not possess the necessary knowledge* to have such duties. (Figure 27).

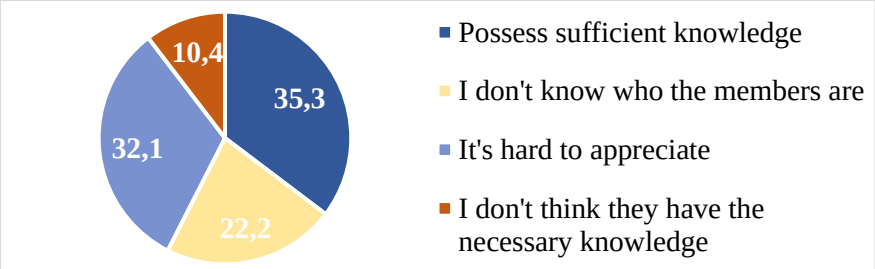

Figure 27. Assessment of the competence of the bioethics committee members, %.

The respondents who were members of the committees demonstrated an adequate level of self-criticism in assessing their own level of knowledge in the field of ethics/bioethics. Two-thirds of the respondents – 66.4% admitted that their level of knowledge is from *moderate* to *insufficient*. Every fifth member of the institutional committee (20.8%) *has no training in the field of ethics*. Had taken continuing education courses specifically dedicated to medical ethics 20.9% respondents, and 40.3% mentioned that they received training in the field of clinical ethics through faculty education. Several persons believe that they have the necessary knowledge following self-education or training in legislation (Figure 28).

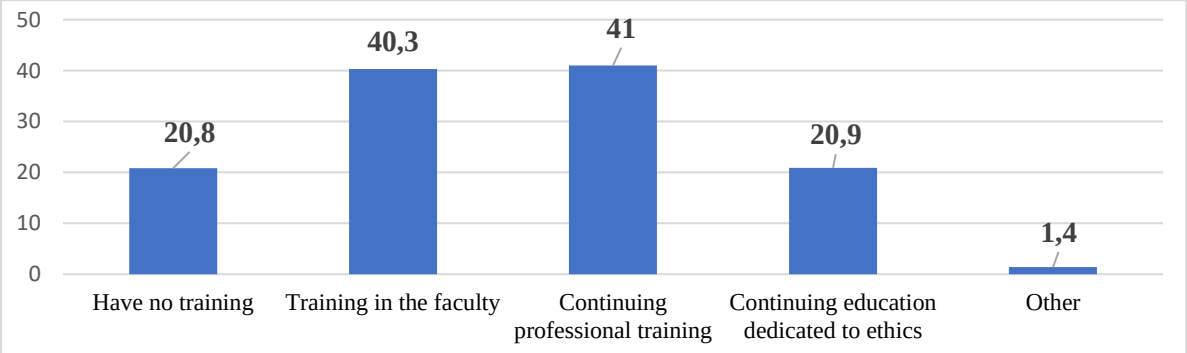

Figure 28. Training of members of institutional ethics/bioethics committees, %.

The majority of ethics committee members (72.4%) said they would like to receive periodic on-the-job training, and 56.7% indicated that they would like certified courses specifically dedicated to ethics/bioethics committee members. The conducted research has identified a number of gaps in the organization of these instruments in the country's medical institutions. The committees are involved, for the most part, in cases that refer to the disciplinary aspect in relations between employees and much less or not at all in discussing bioethical issues and ethical deliberations.

7. RESPECT FOR PATIENT AUTONOMY AND DIGNITY

The communication process in the institution

The communication process is much better appreciated by respondents from private institutions (Figure 29). During discussions with research participants, this problem was frequently mentioned: "*The regulations state 15 minutes for the patient. If there is a queue at the door, twice as long as the norm, of course you don't have the necessary time*" (FG 2).

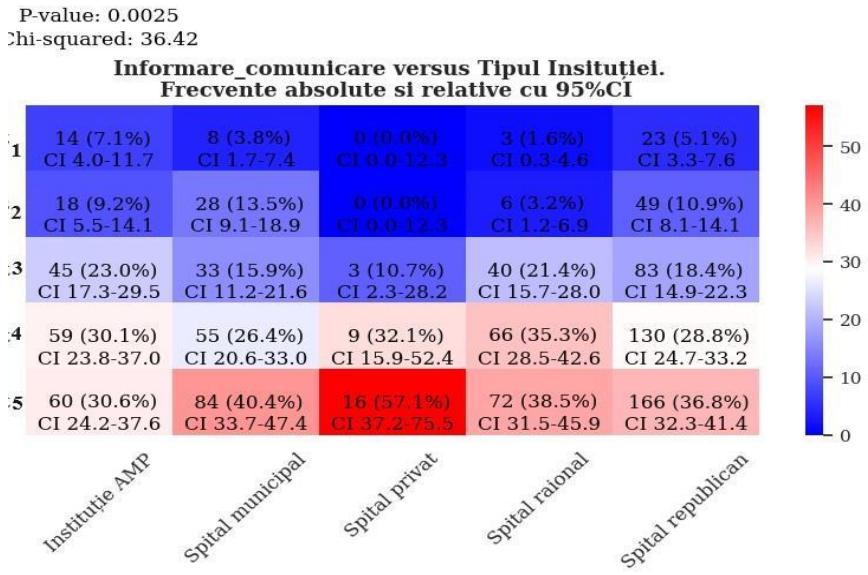

Figure 29. Appreciation of the communication process, by type of institution, %, abs.fig.

The most common problems encountered in organizing the communication process are those related to ensuring sufficient time dedicated to a patient, 20.5% of respondents consider the organization of this condition to be *insufficient* or *very little.*

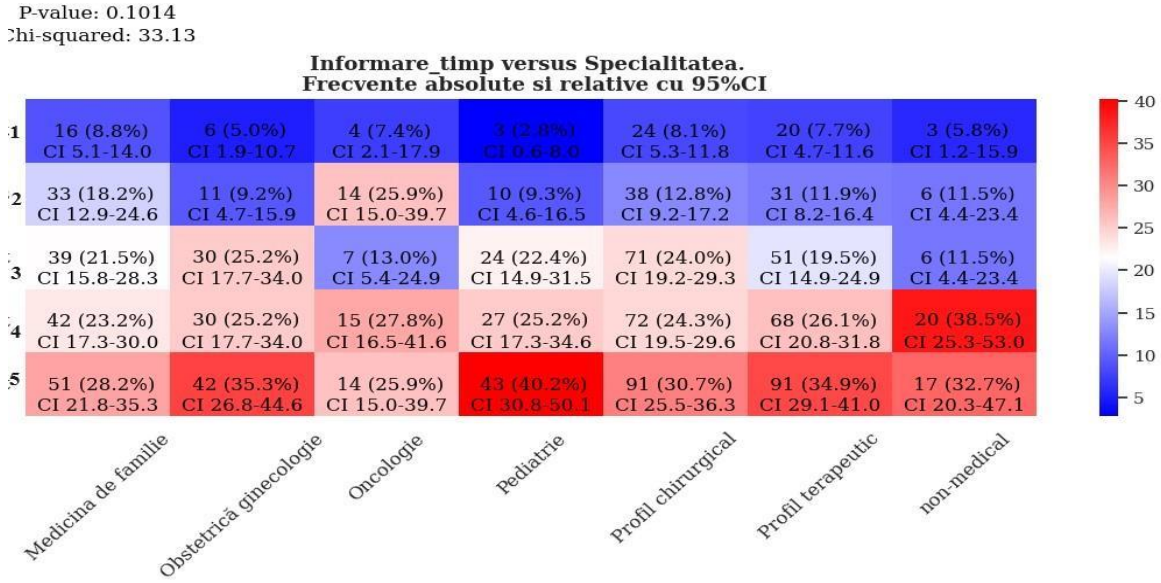

Figure 30. Perception of time allocated to communication with the patient, by specialties, %, abs.fig.

The staff from primary care frequently indicate insufficient time in communicating with patients. More than a quarter of family doctors (26.5%) rate the time allocated to communication in the institution where they work as *insufficient* (1-2 points). This assessment is given by a third (33.3%) of oncologists (Figure 30). This fact is frequently confirmed in the qualitative study. "*When you have 3-4 operations a day, you don't feel like communicating. You can't resist being like the books say*" (II 41).

Most respondents noted that they have no problem talking to Russian-speaking patients. It is alarming that 6 doctors mentioned that they would refuse to communicate with a foreign-speaking patient (Figure 31). Thus, it is obvious that concrete procedures are needed in institutions to standardize

such relationships between medical workers and patients, in order to avoid violating the patient's right to information, as well as access to health services.

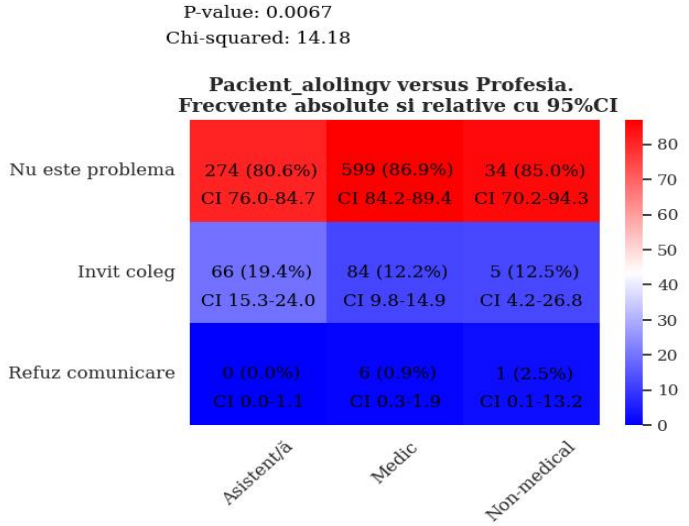

Figure 31. Communication with the foreign-speaking patient, by profession, %, abs.fig.

Every third respondent (30.9%) mentioned that they *frequently* – 17.2% (CI95% 15.0, 19.5) and *very frequently* – 13.7% (CI95% 11.8, 15.9) faced ethical dilemmas and difficulties in situations of communicating serious diagnoses and bad news (Figure 32).

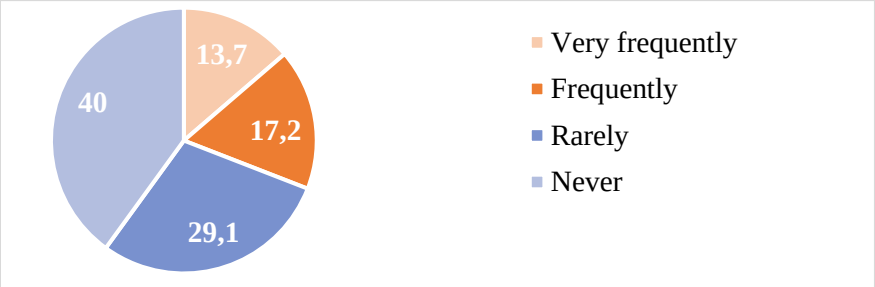

Figure 32. Ethical difficulties in communicating serious diagnosis, respondents' opinion, %.

A manager should ensure that standardized algorithms for communication in various specific situations are implemented in the institution (communication of bad news, conflict management, communication with relatives, etc.), there are instructions provided for the involvement of the psychologist, clear procedures are applied regarding communication with the foreign-speaking patient, etc. The lack of these mandatory components in the quality management can lead to ethical issues and conflicts that can turn into lawsuits, as they can result in the obvious violation of human rights.

Presence of informed consent

In many healthcare institutions, traditionally, is used the informed consent form developed in 2010, which does not meet the rigors of such a document, because it contains too general statements, and does not provide the patient with the specific information regarding the intervention or procedure to be performed. This was confirmed to us in focus group discussions, as well as in individual discussions. More than half of the respondents – 56.7% (CI95% 53.8, 59.7) admitted that their institution only has the informed consent model that is signed upon admission, according to the Ministry of Health Order [180]. Only 25.6% (CI95% 23.0, 28.2) of the respondents mentioned that they have implemented *standardized informed consents* (Figure 33).

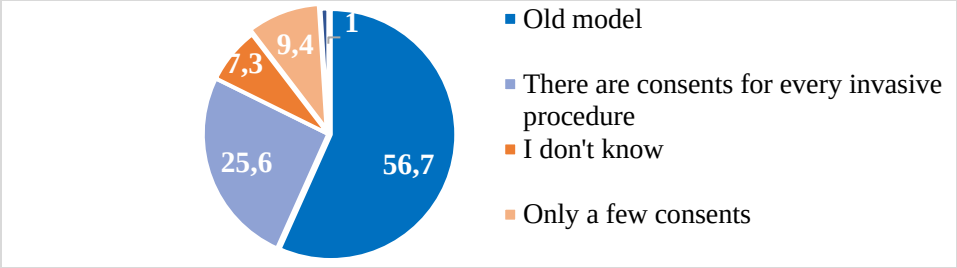

Figure 33. Types of informed consent applied in healthcare institutions in the country, %.

Most participants did not know the essence and role of standardized informed consents. Some, being accustomed to the manner of total vertical control, receiving decisions from central authorities, considered that only the agreement developed by the Ministry of Health could be implemented: "*We sign the agreements that we received from the ministry. They will tell us others – we will sign those*." (II19); "*Who should sit and develop them? I perform operations all day, I have no time to write*!" (II24).

40.6% (CI95% 37.6, 43.5) respondents indicated that they *did not have any difficulties* related to signing the informed consent. In the rest, the respondents noted that they *face difficulties in collecting informed consent*, from *very rarely* – 38.6% (CI95%35.7, 41.5) and *rarely* – 14.2% (12.1, 16.3), *sometimes* – 5.5% (CI95% 4.1, 6.9), to frequently and very frequently – 1.2% (12 people). Oncology specialists most frequently face problems in collecting informed consent.

During the focus group discussions, the doctors recounted many cases when patients refused hospitalization or even medical intervention, even if it was not for their benefit and, subsequently, many returned to the medical institution being already with complications or in much more serious conditions. In the quantitative research, more than half of the respondents (79.1%) confirmed that in their institutions the patient's refusal to treatment is discussed in detail and counseling is offered. However, 140 respondents – 13.1% (CI95% 11.1, 15.1) were more reserved regarding this topic, rating this statement only 3 points out of 5. While 84 respondents rated the patient refusal counseling process *very poorly* in the institutions where they work.

Many doctors do not know how to properly proceed when faced with a patient's refusal, in order to be legally protected, in case the patient's health condition worsens later: "*Does he want to leave? We'll let him go... we won't tie him up. It's his full responsibility. But the law here is such that after this, if the patient gets worse, we're still responsible! Is it all our fault? Then how should we proceed to protect ourselves?*" (FGis2).

Family doctors frequently mentioned the practice of receiving refusals from parents to vaccinate their children. "*We don't know how to deal with parents who refuse to vaccinate their children. We explain to them, but in vain! On the other hand, we constantly receive reprimands from our bosses for having a low vaccination rate! We also need to be somehow protected from these refusals*." (FGamp1)

The study also identified gaps in the organization of communication with the patient's legal representatives. 29.9% of respondents indicated problems (selecting the options *insufficient - moderate*) in delegating the patient's decision to his legal representative or relatives (Figure 34).

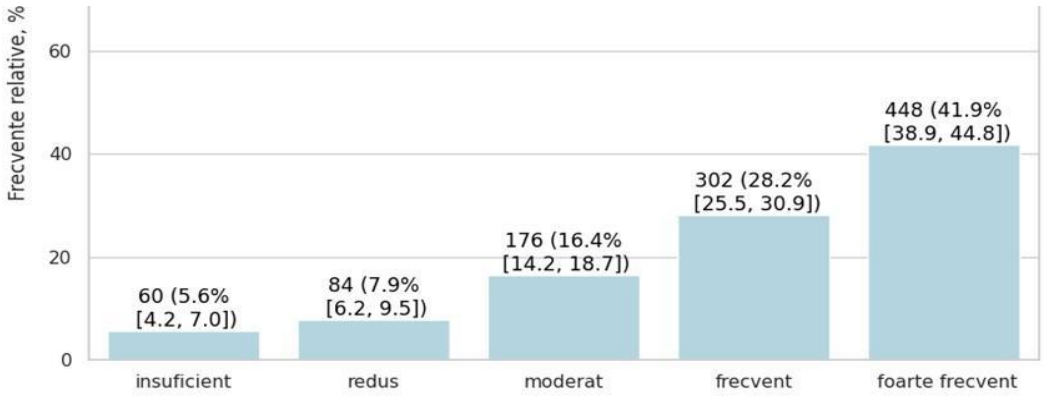

Figure 34. Application of a procedure for delegating patient decision-making, %

The most common confusion reported by respondents to the qualitative study was related to the determination of the person empowered to make decisions for the patient. Respondents told us about various situations when they witnessed arguments between relatives, with reference to the further tactics for the patient.

Risks of confidentiality violation

Only in half of the institutions – 53.8% (CI95% 46.3, 52.2), respondents consider that there are minimal risks for the violation of confidentiality. It is alarming that 1 in 10 respondents – 9.3% (CI95%6.8, 10.2) believe that there are major risks of confidentiality violations in their institution, which is considered a very serious institutional problem. Every fifth respondent – 20.3% (CI95% 16.3, 20.9) admitted that they sometimes faced problems with the patient, which arose due to insufficient conditions for maintaining confidentiality in their medical institution (Figure 35).

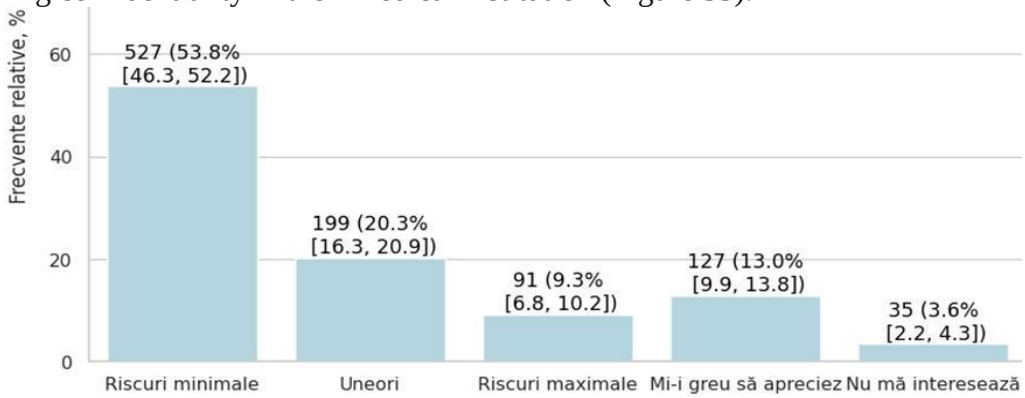

Figure 35. Assessing the risks of breach of confidentiality, %.

This was also confirmed to us in the qualitative component of the research. "*To be able to talk to the patient in private, you need conditions... In our institution it is impossible. There are 3 doctors in the office, someone is always coming in and out... it's like a train station!*" (II28)

"*There are situations when you feel like you're backed into a corner... When relatives insist on telling them what the patient has. And you understand that you can't. Then they make a fuss. They complain to the bosses...*" (II40)

Doctors from surgical profiles – 12.4% (CI95% 8.7, 16.9) and oncologists – 10.9% (CI95% 3.6, 23.6) most appreciate major risks of confidentiality violations in their institutions (Figure 36).

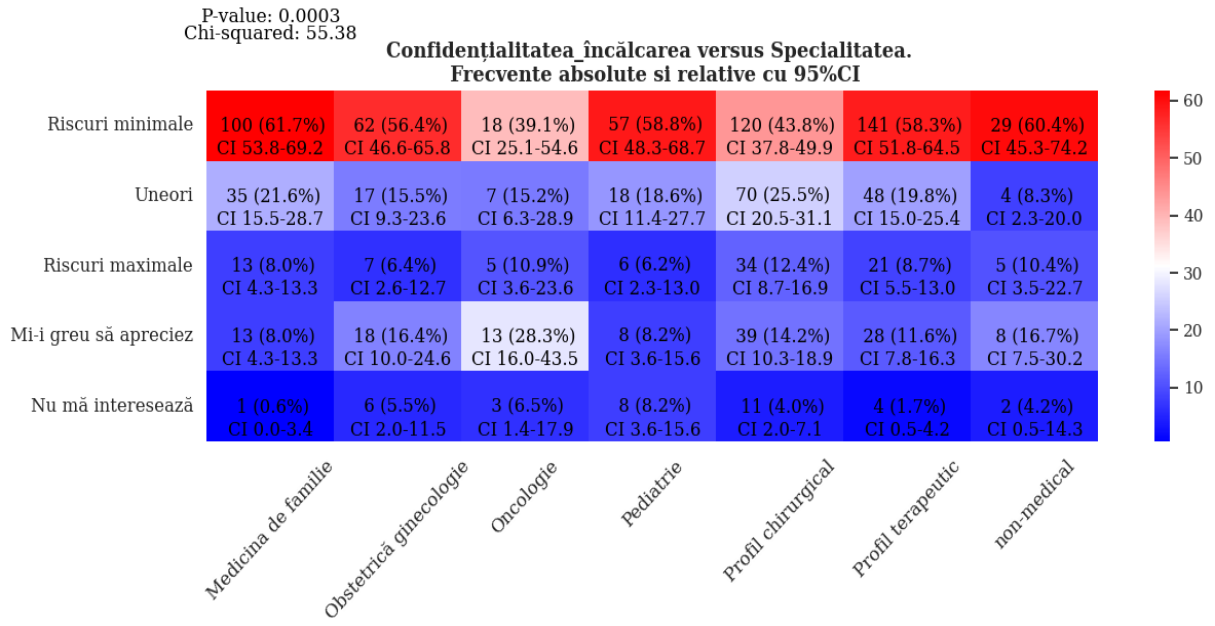

Figure 36. Assessment of risks of breach of confidentiality, by specialties, %, abs.fig.

8. ETHICAL EVALUATION OF HEALTHCARE INSTITUTIONS – ETHICAL AUDIT

Ethical auditing is increasingly being approached as a proactive tool for the development of integrity organizations. This is an assessment activity, the purpose of which is to determine whether it is necessary to make any changes in the climate, environment, code of the organization and to strengthen its ethical policies [14, p.120]. It is a process for the external evaluation and diagnosis and internal coherence of the values of an organization and their congruence with the real behavior of those who represent it [271].

In the research, the author studied in detail the international practices of ethical auditing, including those applied in medical and health institutions, the stages of evaluation and the correct conduct of an audit, through all possible forms of this process. As a result, the researcher developed her own ethical audit grid, which consists of 9 standards of compliance with ethical principles and fundamental human rights, namely:

1. The medical and healthcare institution demonstrates responsibility in organizing processes and procedures that support the promotion of an ethical culture and respect for patients' rights during the provision of medical services.
2. The institution respects the dignity, individuality and values of patients, reduces barriers (physical, linguistic, cultural, etc.) for access to medical services and information.
3. The institution supports the application of a process of correct communication with beneficiaries, respects the right of patients to participate in the decision-making process on treatment and the right to consent.
4. The institution respects the patient's right to privacy, intimacy and confidentiality.
5. The institution respects the patient's right to file a complaint and to be compensated for damages received as a result of the medical act.
6. The institution supports the right of patients to be treated with respect and not to be subjected to unjustified pain and suffering.

7. The institution organizes the activity based on respect for the patient's time and ensures urgent intervention.
8. The institution organizes adequate conditions for respecting patients' right to quality and safety standards.
9. The institution ensures a friendly working environment and an ethical climate for employees.

Each standard is proposed a set of criteria through which it is proposed to evaluate the existing conditions in the institution to assess the level of institutionalization of ethics and respect for fundamental human rights values. To facilitate the audit process, the author proposes a set of questions for verification intended for each criterion. Thus, the audit grid proposed by the author can become easily applicable even for personnel without specialized studies in the field of ethics, representatives of the quality management department or the managerial body of healthcare institutions interested in determining the gaps and non-conformities from the perspective of ethics management, in order to propose and implement resolution or improvement measures.

The grid was applied to conduct an ethical audit within a hospital institution (IMSP Clinical Municipal Hospital "Holy Trinity") with the establishment of gaps and the development of a set of recommendations for the management of the institution, which are described in the paper in the form of a Case Study. The implementation of the respective recommendations and of the proposed changes was a stage in the institution's preparation for accreditation, which was subsequently (in 2025) successfully passed, being awarded the qualification of an *Institution of Excellence* by the National Council for Health Evaluation and Accreditation.

GENERAL CONCLUSIONS

The research determined, through a multidimensional approach, the level of implementation of the process of institutionalizing ethics in healthcare institutions in the country, as well as of ensuring respect for human rights in the process of organizing and providing health services. Based on the extensive analysis of the reasearch results, it was possible to draw the following conclusions:

1. ***The obvious need for the process of institutionalizing ethics.*** In the managerial approach of healthcare institutions, it is necessary to apply contemporary theories of institutional ethics management, with a broad process of institutionalizing ethics, proposed by international experience and practices. Through the conducted research, we have demonstrated that ethics, from the theoretical field, is transferred to an applied form, and the organization of a healthcare institution is approached as a business, where the satisfaction of the beneficiary (patient) directly influences the material aspect of the institution and even its survival, in the conditions of competition and increasingly high standards imposed by the medical services market. Failure to comply with ethical values and unethical behavior within the medical institution will increase the risk of litigation and financial losses for the institution. Therefore, the implementation of ethics management programs in healthcare institutions, with the implementation of ethical tools, must become an indispensable part of the management strategies and development plans of institutions. The research identified that in healthcare institutions in the Republic of Moldova there is a low level of implementation of ethics management tools, and the process of institutionalizing ethics is, for the most part, insufficiently approached by managers. (Objective 1, paragraphs 1.1, 1.2, 1.3, 3.2.1).

2. ***The unethical climate and employee dissatisfaction lead to the violation of patients' rights.*** The research identified the close interconnection between the values and principles of medical ethics and those promoted by fundamental human rights, many of which are practically identical. Approaching

them from a common perspective becomes logical and even indispensable. Respecting ethical values in the institution inevitably leads to respecting human rights principles. At the same time, we determined the presence of many negative values and a high degree of dissatisfaction on the part of employees. A third of respondents without managerial positions (33.3%) and 28.1% of those with managerial positions believe that insufficient models of morality management are applied in the institutions in which they work (the immorality and reactive models). At the level of institutions, the presence of negative values such as indifference (22.4%), personal profit (18%), fear (14.2%), envy (13.3%), and unhealthy competition (12.1%) were reported. The research established a low level of ethical safety and trust on the part of some employees. Every third doctor (33.7%) will hesitate, for various reasons, to raise an ethical issue in their practice; every fifth respondent (20.5%) is convinced that no one will help them in solving ethical problems in practice; 17.6% of respondents stated that in the institutions where they work, no measures are taken to assess employee satisfaction; in many institutions, penalization (29.8%) of employees prevails in case a non-conformity is found. It is necessary to implement measures to increase employee satisfaction, which will lead to maintaining an ethical climate and, in a unique way, to respecting fundamental human rights, both from the perspective of employees and beneficiaries of medical services *(Objective 2, paragraph 1.2.3, paragraph 3.2, 3.3, chapter 7).*

3. ***Insufficient measures to reduce the risk of harm, both for employees and patients, respectively, induce the risk of violation of the rights of these persons.*** Guaranteeing safe working conditions is the employer's obligation to ensure respect for the social rights of employees. In turn, a satisfied employee, who works in an appropriate environment, will be much more responsible in his behavior. However, one in five doctors participating in the study (20.1%) and 15.6% of nurses are dissatisfied because the manager is not interested in employee satisfaction. Many employees believe that their sacrifices and efforts are not fully appreciated by managers, while managers believe that they offer many benefits to employees, which are not appreciated at their fair value. Ethical safety of the work environment involves ensuring employee autonomy, respect and trust. The manager must always demonstrate his willingness to listen to employees' opinions and understand their problems. The research identified a low level of trust in the management body. Only 42.9% of doctors consider the manager's behavior worthy of following and only 37.2% give this rating to deputy directors. Some respondents negatively assessed the image of the institution in which they work. The lack of possibilities to identify and reduce burnout states, the lack of a well-organized system for reporting errors without fear of penalty, inadequate supervision of the process of using medicines in institutions – are the conditions that significantly reduce employee satisfaction but, at the same time, increase the risk of violation of fundamental patient rights such as: the right to safety and security, the right not to be harmed, the right to quality – essential parts of the right to health. (*Objective 2, chapter 4*).

4. ***Value conflicts, ethical dilemmas and dual loyalty of employees influence the moral decision-making process.*** Decisions that influence the behavior of managers and employees of medical and healthcare institutions are significantly influenced by the appreciation and values of each one, but also by the established institutional context. Value contradictions within organizations can contribute to the emergence of conflicts. The research identified the most frequent conflicts faced by medical personnel as those with the patient's family (31.5%), with the administration (29.4%), with colleagues (28.8%). Many employees (68.4%) confirm the presence of inappropriate influences, 74.4% note conflicts of interest and favoritism (33%) in the institution. One in four respondents (25.4%) report reduced transparency in their institution. The conflict of values may require the healthcare worker to choose between two competing interests, developing the phenomenon of dual loyalty, which could cause harm to the patient, but also moral discomfort to the employee. Respondents admitted that they have faced ethical dilemmas between the patient's well-being and the economic interests of the institution

(26.1%), the interest of the insurance company (23.3%) or the interest of a colleague (13.9%) over the interests of a patient. It becomes indisputable that making decisions based on values is a mandatory measure for an organization that tries to demonstrate integrity, this being the basic condition of a good image and the satisfaction of beneficiaries. Management strategies are needed through which conditions should be created for employees to comply with common values, which would determine ethical decision-making behavior, managers themselves being, at the same time, a role model (*Objective 3, paragraph 4.1, 4.2)*.

5. ***Healthcare institutions have gaps in the process of organizing conditions for respecting the patient's fundamental rights.*** Many respondents (61.1%) mentioned problems related to patient decision-making, information and collection of informed consent. Every fifth respondent (20.5%) considers the time dedicated to communication with a patient to be insufficient or very little. A third (30.9%) of respondents frequently encountered difficulties in situations of communication of a serious diagnosis. Many gaps were found in the implementation of the standardized informed consent and the refusal form. The research also identified problems in realizing the right to confidentiality, 44.2% of respondents reported problems in maintaining confidentiality, only 53.8% positively assessed the organization of conditions for respecting confidentiality in the institutions where they work. Extensive managerial involvement is necessary to create adequate conditions for the provision of medical services while respecting the autonomy and dignity of the patient. The need for strategic actions at the management level of medical and healthcare institutions is evident to promote a positive culture in the organization, in which relations with beneficiaries are organized appropriately, in conditions of confidentiality, respecting the autonomy and dignity of the person – ethical values of the medical profession, but also fundamental rights of the patient (*Objective 4, paragraphs 6.1, 6.2, 6.3, 7.4*).

6. ***Institutional ethics/bioethics committees are not sufficiently effective as instruments of ethics management.*** The research found that in all medical and healthcare institutions in the country, there are bioethics committees, but their activity determines certain gaps. Some respondents (16.2%) consider them irrelevant and useless, others did not even know about their existence (18.9%). 63.7% of respondents have never sought the assistance of the committee, and a fifth (20.8%) did not know that they could appeal. The committee's decisions are known only in 55.4% of institutions. For the most part, the role of the committees is reduced to resolving disciplinary issues, analyzing cases of conflicts with patients (81.3%), colleagues (66.3%), and relatives of the patient (57.5%). Cases related to the violation/protection of patient rights are discussed much less frequently (18.8%), and issues related to clinical ethics or bioethics are discussed in a very small number (6-8%). Serious gaps in the competences of committee members are identified. One in five members (20.8%) has no training in the field of ethics, 40.3% of members mention that, in the field of ethics, they only have university training. The need for training and the lack of opportunities for this training were recognized. The majority of committee members (72.4%) would like training through periodic on-the-job training, about a quarter of respondents (26.9%) indicated the need for thematic materials. Committees must be an essential support for the administration. It is necessary to transform ethics committees from formal structures into effective tools for organizing institutional ethics, which provide essential support to employees in their clinical work (*Objective 5, paragraph 1.3, 5.1, 5.2*).

7. ***Employees recognize the insufficiency of ethical knowledge and the need for ongoing training in the field of ethics.*** The decision-making process in ethical dilemma situations is strongly influenced by the level of knowledge, skills and practices of each employee. The study identified that every third respondent (33.7%) believes that employees in the institution where they work need additional training and negatively assessed their ability to recognize and resolve moral dilemmas. 43.2%

of respondents admitted that they have insufficient knowledge and would like additional training, and 10.1% admit that they even need extensive training. It is alarming that many respondents believe that they have not received any training in the field of ethics, both at the university level (30.8%), during residency training (50.2%), in continuing education courses (29.1%), and at the workplace (21.2%). Continuous employee training programs are one of the important tools of ethics management and must be a priority on the managers' agenda, while at the same time identifying the needs and expectations of employees (*Objective 5, paragraph 1.3, 3.1.2*).

8. ***The ethical audit of medical and healthcare institutions is an effective tool for organizing ethics in institutions, reducing ethical non-conformities, and ensuring high standards of quality of medical services*****.** The ethical audit is put forward as a proactive tool for ethics management in healthcare institutions through which facts and real contexts existing in the institution can be ascertained, which are or may lead to immoral behaviors and negative events. The audit grid developed and proposed by the researcher represents an innovative method for assessing the level of compliance of the conditions existing in medical and healthcare institutions with the requirements imposed by the respect for human rights in the performance of the medical act, but also those recommended for creating an environment of ethical behavior of employees. The application of the grid by the managers of healthcare institutions, individually, provides the opportunity to identify existing gaps and non-conformities, in order to implement preventive measures, to improve conditions, to develop a friendly environment for employees and beneficiaries, to respect their fundamental rights and to promote essential moral values in the institution. The independent assessment of the institution through the criteria included in the Grid is useful for preparing the evaluation and accreditation process of medical and healthcare institutions (*Objectives 5, 6, paragraph 1.3., 8.1, 8.2*).

PRACTICAL RECOMMENDATIONS

National Council for Health Assessment and Accreditation

1. Taking over the criteria from the ethical audit grid developed by the author of the research to be implemented in the evaluation standards applied in the evaluation and accreditation process of medical and healthcare institutions.

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2. Development of a certified course for advanced training of a longer duration (e.g. web-based learning) for members of ethics/bioethics committees of healthcare institutions.
3. Development of a continuing education course on the subject of Ethics Management in Institutions for managers of healthcare institutions.
4. Development of dedicated information materials/guides for institutional ethics/bioethics committees to facilitate understanding of the ethical analysis process of the clinical case and guide the activity of ethics/bioethics committees in healthcare institutions.
5. Development of a master's degree program in clinical ethics/bioethics for ethicists/bioethics counselors who should be employed in hospital medical and healthcare institutions in the country.

Managers of medical and healthcare institutions

6. Nominating the person responsible for ethics and human rights in the institution, including providing for the possibility of hiring consultants/specialists who will provide support in developing the

ethical environment in the institution – ethicist/bioethicist, psychologist dedicated to the issue of burnout, human resources specialist who will deal with policies and measures aimed at the permanent evaluation and increase of employee satisfaction;

7. Periodically conducting an ethical audit within the institution under management and eliminating identified non-conformities (elaboration of strategic documents, development and implementation of procedures and instructions), including nominating the person responsible for periodically conducting the process of evaluating and monitoring ethical aspects and with reference to the rights of patients and employees.

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Adnotare

Rodica Gramma

Managementul eticii instituțiilor medico-sanitare pentru respectarea drepturilor omului în prestarea serviciilor de sănătate

Teză de doctor habilitat în științe medicale, Chișinău, 2024

Structura tezei: introducere, 8 capitole, concluzii și recomandări, bibliografie (275 surse), 11 anexe, 259 pagini text de bază, 143 figuri, 7 tabele. Rezultatele sunt publicate în 82 de lucrări științifice.

Cuvinte-cheie: cultură etica, siguranță etica, climat etic, etica organizațională, instituționalizarea eticii, programe etice, leadership etic, etica afacerilor, decizii etice, managementul eticii, comitete de etică, audit etic, drepturile pacientului, dreptului omului, loialitate dublă, responsabilitate morală**.**

Scopul lucrării: Evaluarea pluridimensională a managementului eticii instituțiilor medico-sanitare din sistemul sănătății al Republicii Moldova pentru a determina nivelul de asigurare a condițiilor care duc la respectarea drepturilor omului în procesul de organizare și prestare a serviciilor de sănătate.

Obiectivele cercetării: (1) Studierea teoriilor managementului eticii în organizații și a experienței internaționale în instituționalizarea eticii. (2) Evaluarea contextului etic al instituțiilor medico-sanitare prin prisma valorilor drepturilor omului. (3) Analiza factorilor care influențează procesul de luare a deciziilor în instituții (4) Identificarea nivelului de respectare a drepturilor omului în organizarea serviciilor în instituțiilor medico-sanitare. (5) Identificarea instrumentelor etice pentru organizarea procesului de instituționalizare a eticii. (6) Elaborarea recomandărilor pentru aplicarea instrumentelor managementului eticii în instituțiile medico-sanitare ce ar reduce riscul de violare a drepturilor omului în organizarea și prestarea serviciilor de sănătate.

Noutatea și originalitatea științifică: 1. Formularea inovativă a conceptului de management al eticii aplicat pentru instituțiile medico-sanitare. 2. Propunerea instrumentelor pentru instituționalizarea eticii în instituțiile medico-sanitare. 3. Propunerea valorilor drepturilor fundamentale ale omului ca reper pentru analiza contextului etic organizațional al instituțiilor medico-sanitare din țară. 4. Diferențierea conceptului de drepturi ale pacientului de cel al drepturilor omului aplicate în îngrijirea medicală. 5. Identificarea factorilor care influențează procesul de decizie etică a lucrătorilor medicali și a riscului loialității duble în instituțiile medico-sanitare. 6. Propunerea conceptului de audit etic aplicat în instituțiile medico-sanitare.

Problema științifică soluționată în teză: Studiul prezintă o direcție nouă, fundamentată științific, în analiza mediului etic al instituțiilor medico-sanitare din Republica Moldova ca precondiție pentru respectarea drepturilor omului. Instrumentele propuse pentru instituționalizarea eticii în managementul instituțiilor medico-sanitare sunt soluții inovative pentru reducerea riscului de violare a drepturilor pacienților și angajaților în prestarea serviciilor și creșterea calității actului medical.

Semnificația teoretică: Teza reprezintă un studiu comprehensiv a procesului de administrare a instituțiilor medico-sanitare din perspectiva dimensiunii etice, care este promovată ca context necesar a fi asigurat pentru respectarea drepturilor omului în cadrul prestării serviciilor medicale, concentrându-se pe instrumentele eficiente care trebuie aplicate pentru instituționalizarea eticii.

Valoarea aplicativă: Rezultatele acestui studiu pot constitui bază pentru implementarea unui set nou de criterii de calitate pentru a fi aplicate în procesul de evaluare și acreditare a instituțiilor medico-sanitare, din țară. Instrumentele etice propuse în teză pot servi ca suport metodologic pentru managerii instituțiilor medico-sanitare interesați de creșterea calității serviciilor medicale și reducerea riscului de violare a drepturilor omului în instituțiile care le gestionează.

Implementarea rezultatelor științifice: Rezultatele cercetării au fost integrate în procesul didactic din cadrul USMF ”Nicolae Testemițanu” și în activitatea practică managerială a IMSP Spitalul Clinic Municipal ”Sfânta Treime”.

Аннотация

Родика Грамма

Управление этикой медицинских учреждений для соблюдения прав человека при оказании медицинских услуг

Диссертация доктор хабилитат медицинских наук, Кишинев, 2024 г.

Структура диссертации: диссертация состоит из введения, 8 глав, выводов и рекомендаций, библиографии (275 источников), 11 приложений, 259 страниц основного текста, 143 фигур, 7 таблиц. Результаты опубликованы в 82 научных работ.

Ключевые слова: этическая культура и безопасность, этический климат, организационная этика, институционализация этики, этические программы, этическое лидерство, деловая этика, этические решения, управление этикой, комитеты по этике, этический аудит, права пациента, права человека, двойная лояльность, моральная ответственность.

Цель исследования: Многомерная оценка управления этикой медико-санитарных учреждений системы здравоохранения Республики Молдова для определения уровня обеспечения условий, ведущих к соблюдению прав человека в процессе предоставления медицинских услуг.

Задачи исследования: (1) Изучить теории управления этикой в организациях и международный опыт институционализации этики. (2) Оценка этического контекста медико-санитарных учреждений через призму ценностей прав человека. (3) Анализ факторов, влияющих на процесс принятия решений (4) Определение уровня соблюдения прав человека при организации медицинских услуг. (5) Выявление инструментов для организации процесса институционализации этики. (6)Разработка рекомендаций по применению инструментов управления этикой, которые снизят риск нарушений прав человека при оказании медицинских услуг.

Новизна и научная оригинальность: 1. Инновационная формулировка концепции управления этикой применительно к медико-санитарным учреждениям. 2. Предложение инструментов институционализации этики в медико-санитарных учреждениях. 3. Предложение ценностей фундаментальных прав человека в качестве ориентира для анализа организационного контекста медико-санитарных учреждений страны. 4. Разграничение концепции прав пациента от концепции прав человека, применяемых в медицинской помощи. 5. Выявление факторов, влияющих на этический процесс принятия решений медицинскими работниками и риск двойной лояльности. 6. Предложение концепции этического аудита медицинских учреждений.

Научная проблема, решаемая в диссертации: Исследование представляет новое научно обоснованное направление в анализе этической среды медико-санитарных учреждений Республики Молдова как предпосылку для соблюдения прав человека. Предлагаемые инструменты для институционализации этики в управлении учреждений являются инновационными решениями для снижения риска нарушения прав и повышения качества услуг.

Теоретическая значимость: Диссертация представляет собой комплексное исследование процесса управления медико-санитарными учреждениями с точки зрения этического измерения, которое предлагается как необходимый контекст для обеспечения прав человека при предоставлении медицинских услуг, с акцентом на эффективные инструменты и механизмы, которые необходимо применять для институционализации этики.

Прикладное значение: Результаты данного исследования могут быть использованы для внедрения нового набора критериев качества, которые будут применяться в процессе ккредитации медико-санитарных учреждений страны. Этический инструментарий, предложенный в диссертации, может служить методической поддержкой для руководителей учреждений, заинтересованных в повышении качества услуг и снижении риска нарушений прав человека.

Внедрение научных результатов: Результаты исследования были интегрированы в процесс обучения в ГУМФ «Николае Тестемицану» и в практическую управленческую деятельность Муниципальной Больницы «Sfânta Treime».

SUMMARY
Rodica Gramma

Ethics management of medical institutions for the respect of human rights in the provision of health services
Thesis of doctor habilitat in medical sciences, Chisinau, 2024

Structure of the thesis: the thesis consists of introduction, 8 chapters, conclusions and recommendations, bibliography (275 sources), 11 annexes, 259 pages of basic text, 143 figures, 7 tables. The results are published in 82 scientific papers.

Keywords: ethical culture, ethical safety, ethical climate, organizational ethics, institutionalization of ethics, ethics programs, ethical leadership, business ethics, ethical decisions, ethics management, ethics committees, ethical audit, patient rights, human rights, dual loyalty, moral responsibility.

The goal of the study: Multidimensional evaluation of the ethics management of healthcare facilities in the health system of the Republic of Moldova to determine the level of ensuring the conditions that lead to the respect of human rights in the process of organizing and providing health services.

Research`s objectives: (1) To study the ethics management theories and the international experience in the institutionalization of ethics. (2) Evaluating the ethical context of healthcare facilities through the lens of human rights values. (3) Analysis of factors that influence the decision-making process in institutions (4) Identification of the level of respect for human rights in the organization of healthcare services. (5) Identification of ethical tools for organizing the process of institutionalization of ethics. (6) Elaboration of recommendations for the application of ethics management tools in healthcare facilities that would reduce the risk of human rights violations in the organization and provision of health services.

Scientific novelty and originality: 1. Innovative formulation of the ethics management concept applied to healthcare facilities. 2. Proposing the specific tools for the institutionalization of ethics in healthcare facilities. 3. Proposing the values of fundamental human rights as a benchmark for the analysis of the organizational ethical context in the healthcare facilities of the country. 4. Differentiating the concept of patient rights from that of human rights applied in patient care. 5. Identifying the factors that influence the ethical decision-making process of medical workers and the risk of double loyalty. 6. Proposing the ethical audit concept for healthcare facilities.

The scientific problem solved in the thesis: The study presents a new direction, scientifically based, on the analysis of the ethical environment of healthcare facilities in the Republic of Moldova as a precondition for the respect of human rights. The tools proposed for the institutionalization of ethics in the management of medical institutions are innovative solutions for increasing quality and reducing the risk of violating the patients' rights and employees in provision of medical services.

Theoretical significance: The thesis represents a comprehensive study of the management process of healthcare facilities from the perspective of the ethical dimension, which is promoted as a necessary context to ensure respect for human rights in the provision of medical services, focusing on the effective tools and mechanisms that should be applied for the institutionalization of ethics.

Applicative value: The results of this study can form the basis for the implementation of a new set of quality criteria to be applied in the process of evaluation and accreditation of healthcare facilities in the country. The ethical tools proposed in the thesis can serve as methodological support for managers of healthcare facilities interested in increasing the quality of medical services and reducing the risk of human rights violations in the institutions that manage them.

Implementation of the scientific results: The research results were integrated into the didactic process within the USMF "Nicolae Testemițanu" and into the practical managerial activity of the IMSP Municipal Hospital "Sfânta Treime".