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The Stakes of Globalization in the Field of Health: The Tolerance in Self-Regulatory Ethics Perspective, a Solution for Health Professionals for the Management of All Differences

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1. Introduction

Cultural background builds a specific context in which individuals experiment life and learn the meaning of disease, suffering and death. In health care context, the way in which sick individuals, families and health professionals take decisions is widely influenced by culture. Also, what is considered as good or bad within a care relationship depends on the culture of involved partners (Chattopadhyay & Simon, 2008). In this way, what seems obvious is the position that bioethical speech holds in the management of real facts. The big challenge for bioethicists is then to find a probity denominator, common to all cultures and which recognize and comply with cultural diversity (Chattopadhyay & Simon, 2008).

When we look at the notion of common morality or of appliance of the universal principles deriving from the western philosophic reference, this may contain the risk of striking complex realities of the intercultural health which we have to take into account in the ethical process of decision-making (Turner, 2004). Accordingly, it is unsuitable to use and enforce, consciously or unintentionally, constructed ideas or western theories and ethical methods to other societies (Chattopadhyay & Simon, 2008). Indeed, although ethnocultural groups share many similar values, it however exists between them some differences that can be a source of conflicts if the health professional is not aware of it or if he is little inclined to work within a framework which takes into account cultural, historic and structural influences (MacDonald, 1998), which have an impact on the process of decision-making relative to care (Thomas, 2001). According to Klessig (1992), it is not the ethnic membership in itself but social experiences of various groups that help a particular cultural organization and a values system to take shape. This system undergoes constantly, although sometimes slowly, changes as social experiences of the groups alter. Furthermore, since all the cultures are made up of individuals, intracultural variation can be huge, sometimes bigger than the intercultural variation.

With reference to the growth of the cultural diversity in the American society, Wray (1992) asserted that former policies initially conceived for a homogeneous population were outdated, and that it was compulsory to consider certain factors able to overcome obstacles, which prevent minority groups from getting adequate and suitable healthcare. According to

this author, effects of race bias or of ethnicity on the status and health behavior must be separated from those of the biological, environmental, socioeconomic, cultural and temporal factors. Data collection and analysis methods must be improved; also methods of planning, of implementation and of programs evaluation must be revised in order to effectively meet healthcare needs.

With globalization, homogenization of health practices increases (Solomons, 2002). This situation puts a new challenge on health acitivities whose practices were always guided by ethical principles, which reflect the cultural frame in which they were created. Then, it becomes important to keep a balance when it comes to apply these principles in a global context, known as culturally diversified. If they are too wide or too vague, they can have few practical applications. On the other hand, if they are too specific or too concrete, they can be difficult to implement and to convince the all community concerned (Kastrup, 2010). Indeed, in this globalization era where religious, linguistic, and cultural pluralism has given way to a diverse society, values, standards, traditions and faiths system of involved partners (sick individual, family, health professional) play a more and more significant role when it comes to take decisions in context of care (Chattopadhyay & Simon, 2008). Therefore, a patient should be healed as an individual first, then as member of a cultural group and even as member of a second cultural group (Klessig, 1992).

All this cannot be done without raising ethical questions, which generally appear because of the innate variety, which exists between populations because some individuals gain while others suffer from the same exposures. For the health professional, the challenge in the pursuit of the ethical plea in a globalized environment is: 1) to learn foundations of ethical principles and to keep in mind that he has to respect differences and differentiations which exist and which will continue to exist between individuals and between societies (Solomons, 2002); 2) to learn how to recognize what is of the culture which influences insight of the patient and the response of the health professional to difficulties which threaten health of the patient in his desire to offer culturally congruent quality care (Chattopadhyay & Simon, 2008). It is important to indicate that there are at least two distinct ways in which cross-cultural differences may become striking: 1) a health professional may come from a majority cultural group to interact with a patient who comes from a minority group; 2) a health professional himself may be from a minority group and his patient may be a member of a majority group (Jecker & al., 1995).

Besides, the unprecedented medical technological evolutions of the last decades as well as change of the socioeconomic climate in medicine have raised ethical and legal questions (Meleis & Jonsen, 1983). These issues appear as well in the private ground of patients, families, clinicians, in the semi-private ground of healthcare organizations and traditional communities, as in the public field of judicial, legal and of regulation authorities (Iltis, 2004). These issues are not only patients concerns and their families; health professionals, who are usually under stress by conflicts and ethical dilemmas, need to know that their organization understands the pressure under which they work and that by the means of an effective ethical structure and other mechanisms, it offers to them opportunities to explore ingenious technics in a supporting environment (Hofmann, 2001).

In daily practice, ethical dilemmas are unavoidable (Peer & Rakich, 1999). For health care managers for example, they are the ones appearing regularly; nature of healthcare being

such that decisions having ethical implications are daily taken for diverse situations such as accessibility to organized services, employees' behavior, clinical practices, allowance of restricted resources (Nelson, 2005). For health care managers, they appear particularly in the management of care systems where there are two allegiances (responsibility to a third party and responsibility to the patient) and where a set of responsibilities cannot be carried out without violating another one (Rakich & al., 1992, as cited in Peer & Rakich, 1999). These dilemmas appear at three overlap levels: 1) the macro level which includes the social and community concerns reflecting governmental measures or social policies, and which has a typically cultural base; 2) the meso level which focuses on professional or organizational concerns; and 3) the micro level interested in personal or individual concerns, and which can include interpersonal communication or relationship between the manager and another individual (Hiller, 1986). According to this author, an ethical dilemma has two components: 1) a real choice must be between the possible current actions; 2) every possible action or its consequences wears a significantly different value. The manager is therefore asked to develop a certain capacity to differentiate ethics and values, and to know the value, which often affects decisions.

Hunt (2008) has written about ethical concerns experimented by health professionals who are involved in humanitarian assistance organizations and in development projects around the world. Results of his phenomenological study realized among a ten persons sample (a director of a non governmental organization focused in healthcare projects and nine health professionals that is six nurses, a therapist physician, a doctor, a social worker) with at least seven years of experience in this type of missions and who have dedicated at least eight months to supply clinical services, indicate that several professionals involved in this category of mission have no training in international health and have to struggle in order to adjust themselves to new cultural and clinical realities. Hunt asserts that complex ethical concerns can have a substantial impact on the clinicians and can also be a source of anxiety, moral uncertainty and angst. The main sources of the ethical issues identified by participants to this study are: difficulty to choose between the respect of local customs and the imposition of values mostly when these customs get into conflict with their own moral convictions; obstacles (restricted resources) to the delivery of satisfactory care; difference in the understanding of health, of disease and of death between humanitarian workers and the local populations; confidence matters and of distrust between both groups; identity concern for humanitarian workers in the sense where humanitarian ethical dimension turn to a source of reflection and self-assessment.

Study conducted by Grönlund and al. (2011) among a group of doctors working in hemodialysis, shows that a doctor is morally disturbed when he feels torn by conflicting requests and trapped by indecisiveness due to ethical dilemmas when he is compelled to take key decisions regarding life or death, or when he is forced to prioritize between time constraints and professional or personal requests. When these ethical dilemmas occur, the doctor avoids waking conflicts, is afraid of using his authority, rots under the weight of the moral responsibility, feels devalued and questioned as for the way he treats these situations, by being allowed guide by his consciousness.

According to Gabel (2011), even when he simply witnesses that his colleagues or his organization have a practice which breaks certain ethical principles, a doctor or another health professional can live a conflict or a confusion with regard to values and to ethical

principles, a situation which can lead to stress, to depression and to a burnout. O'Donnell and al. (2008) also support that values conflicts can be a source of stress during health care delivery, a stress which, if not properly managed through an effective ethical conflicts management structure, can generate job displeasure and urge professionals to leave their position.

2. Ethics and its principles

Globally, ethics is all the values, which individuals interiorize in a more or less aware and interactive way so as to reach internal coherence and to get closer to the hoped social cohesion (Dionne-Proulx & Jean, 2007). Ethics can thus be defined as the assertion of individual convictions and as the expression of its sense of responsibility, because before committing an action and making a decision, an individual analyzes among other things the consequences of these on himself and on the others. Ethics so underlies the worry of greater welfare (peace of mind and personal coherence) and that to live better together (social cohesion) which the worker has to have as actor involved in an organizational environment (Ntetu & al., 2010). The term "ethics" thus means behavioral basic rules intended for interactions in the society and with the physical environment; these rules are based on recognized principles which application allows resolving ethical dilemmas which appear when different interests are at stake (Solomons, 2002).

Recognized ethical principles are: autonomy, charity, justice and usefulness. With regard to the autonomy for example, when someone is free to exercise its independence concerning its own health and the treatment of its environment, this can compromise the health of the others (Solomons, 2002). So, although ethical statements focus generally on the individual, on the assumption that the relationship established between the patient and the health professional on a base of trust, confidence and mutual respect, has to be in the center of any intervention, it remains that the health professional does not have to only look at interests of the patient, he also has to consider interests of the other involved partners such the family or the society in general (Sartorius, 2000, as cited in Okasha & al., 2002). As Nelson underlines (2005), because of their impact on the quality of care, decisions taken in response to ethical questions are very crucial so that every health care organization is called to set up an effective ethical infrastructure which includes a structured process to resolve ethical conflicts.

3. Resolution of ethical dilemmas

According to Nelson (2005), the principle of procedural justice is the foundation of ethical decision took at the organizational level. It implies to understand values, which are at stake in the answer to a particular ethical conflict and to investigate various options. From this principle, Nelson suggests an approach which takes into account rights, values and interests of a rather wide range of individuals and groups which are concerned by an ethical conflict and which will be by the fact either harmed by or benefit from the decision which will have been taken. This approach has several stages: clarify the conflict; identify all the involved individuals/groups and their values; understand circumstances surrounding the conflict; identify the ethical perspectives connected with the conflict; identify the various possible options for the action to be undertaken; choose an option to be privileged among the possible options; share and implement the decision; estimate the results. Furthermore, Nelson (2007) thinks that instead of waiting that ethical conflicts occur and then try to

resolve them, organizations should rather adopt a proactive approach of prevention of ethical conflicts which would contain five stages: 1) identify persistent ethical issues that generates conflicts and uncertainty; 2) study the ethical concerns in a system-oriented manner; 3) develop and disseminate protocols to guide partners and managers in the case of a conflict reappearance; 4) register these protocols into organization's culture; 5) review protocols in terms of process and results.

The purpose of preventive ethics is to improve the quality of health care by identifying, prioritizing and raising ethical questions at the level of the systems. Thus, the role of preventive ethics must be well integrated with the other constituents of the organization. Its most specific domain is to bring assessable improvements on ethical health practices of the organization, by setting up at the systems level, changes which reduce distances between current practices and best practices which follow ethical principles (National Center for Ethics in Health Care/NCEHC, 2005). Its responsibility is to identify and to set right situations involving the processes and the organizational systems which create ethical issues (NCEHC, 2005).

As for Grönlund and al. (2011), they emphasize on the usefulness to increase "the level of communication within and among various professional groups - to transform being burdened by a troubled conscience into using conscience as a guide, the dishearten - in situations where no way of solving the problem seems to be good." In this kind of situations where health professionals and organization are involved as a whole, Gabel (2011) recommends that clinical and not clinical leaders receive an education and training in health care ethics, in resolution of conflicts and in negotiation. He also suggests seven different approaches that health professionals can use when they consider that their values are not congruent with those of their organization. Those approaches are:

1. Organize seminars, discussion groups, workshops on ethical issues and values recognized in medicine;
2. Integrate ethical issues and values as themes to be examined by medical staff during board of directors meetings;
3. Paying special attention to specific situations which cause moral strain, to think about it so as to know what are its meanings for us, patients, families and others, and if other perspectives can be envisaged with regard to these situations or issues;
4. Discuss these situations with trusted colleagues, families and friends; do not assume to be too sensitive, to be the only one who cares this kind of situations or issues, or you should not be concerned;
5. Discuss these situations or particular concerns with the medical staff and\or the committee of ethics, with the ombudsman if the organization has one, to know which perspective this person brings to the situation or issue;
6. Depending on the situation, address it with executive, administrative and\or clinical staff, directly or through the appropriate channels of communication; try to have allies and to be inclined to go beyond the disciplinary borders to contact colleagues of the other professional categories which share the same perceptions; discussions with organizational leaders are likely more to succeed if a group, or more than a person, is involved;
7. During discussions with organizational leaders, emphasize on ethical and values orientation as well as on the practical and administrative implications of moral strain or incongruence of values (burnout, demoralization, staff turnover).

To manage the cultural conflits which raise in cross-cultural, Jecker and al. (1995) propose an ethical approach consisting of three distinct steps. The first, identifying goal, asks the health professional to identify the central alms that him and his patient bring together to the medical encounter in order to clarify their respective purposes; this requires the health professional to inquire information about the patient' ethical values and cultural orientation. The second, identifying mutually agreeable strategies, implies that the health professionnal to take the initiative in identifying alternative mutually agreeable strategies to meet these goals.The third step, meeting ethical constraints, engages the health professional in ethical deliberation about the acceptability of alternative means of realizing goals. From their part, Björn and Björn (2004) emphasize on the importance of discussions and ethical reflections in the clinical practice. They also believe that by analyzing in a repetitive and structured manner his decisions, the health professional increases his capacity to make decisions suited for the profits of the patient and of its surrounding families. The study of Sorta-Bilajac and al. (2011) conducted among a group of nurses and doctors of a Croatian hospital points out that clarifying ethical questions, having the literature suited on the situation, having a more complete information about the patient, speak to him on ethical questions are the most appreciated types of help by those professionals. They even assert that those types of help were highly appreciated by American and European health professionals.

According to Hofmann (2001), adressing significant differences between the patient, the members of his family and the health professional, is rarely easy. Some individual characteristics will always be very important to solve conflict. These characteristics are: have an outline of its own values; accept values and faiths which can be diametrically set against those of the nursing; be sensitive to irregular needs and to the hope of the involved actors who try to reach an agreement, while facing the consequences of a disease or a wound; have the patience to give the patient and/or his family time to think about advantages and inconveniences of the adoption of a given option; show some perseverance by working for a suitable conclusion.

On the other hand, Murray (2010) urges health professional to keep morally courageous when he encounters an ethical dilemma. According to him, it is the sole way for health professional to handle ethical matters and to act because acting properly is not often an easy thing. For a professional who has encountered an ethical dilemma, being in good spirits means investigating a possibility of action based on his ethical values and keeps right up to the end, in spite of consequences which he can incur (Aultman, 2008; Kidder, 2005). This requires a continuous commitment and a reflection on personal values and moral behavior, which influence ethical decision-making (Clancy, 2003; Kidder, 2005).

4. Perspectives

In consideration to the above facts, incorporation of an ethical dynamics within the organizational life constitutes a keystone to arouse a bigger harmonization between personal, professional and organizational projects. Ethical dynamics here mean an interactive and continuous process during which authors and actors of an organizational environment combine daily by their efforts, values, principles and standards, their aspirations, practices and objectives, in a way that personal coherence and social cohesion spread more inside the person.

Regardful to take up the challenge to articulate the personal, professional and organizational ethics between them on one side, and between these ethics and the performance as a value on the other side, many authors advocate to firstly take an active interest in tacling ethical diagnoses and secondly in elaborating ethical devices mainly based on codes. Very often, they talk of integration of an ethical approach. It also appears that the health professional tends to guarantee as well the personal ethics as the professional ethics, even the organizational ethics according to the ethical dilemmas, which he encounters.

Ideally, no matter the problem to be treated, the health professional would not be anxious to choose the type of ethics if there was harmonization and stowage of these three levels in his organization. To support and encourage individually the worker to stay sensitive and mobilized compared to this balance which it is called to look for, managers' team can choose to make explicit an ethical organizational initiative as constituent of the process of co-construction of an ethical organizational. When articulating an ethical dynamics, this type of initiative consists to start from expectations and views of the actors of an organization, from their values and practices to be inspired by it, so that tools which will stand out from it can carry the seal of those who develop it.

While encouraging this way of making, we firmly believe that to improve the sharing of the common values by all in an organization, oneself blossoming, that of everyone, of the organization, build codes on one hand or try on the other hand to make so that an organizational environment gives itself the other convincing tools for its development constitutes stages in the articulation of an ethical dynamics. For us, it is also important that every health professional comes there, by a joint representation, to appropriate values, which are carriers of sense for him and for his organization in a perspective of great coherence and ample cohesion. That is why, throughout the process of articulation of an ethical dynamics within organizational life, we encourage insertion of an ethical approach centred on the integration of values (self-regulatory ethics), as vector of harmonization and conciliation between the various forms of ethics (Ntetu & al., 2010).

Besides, to get committed in a proficient practice, the health professional needs to understand and to know himself as actor, to regulate himself in an ethical perspective, to build a robust interpersonal and collective relation with the patient and family, to recognize the uniqueness and to use working strategies of nearness to join the members and professionals of diverse groups (Thomas, 2000). The solving of ethical dilemmas requires a detailed examination of the impact that it will have in concerned districts because the real dilemma appears when a resolution has conflicting effects on diverse districts (Price, 1992). As Peer and Rakich (1999) underline, an efficient manager has to take into account not only the importance of the decision which he must take but also the impact that this decision will have on all partners (community, organization, individual).

For that purpose, the proposition to choose an ethical approach centred on the incorporation of values is original because it aims at reaching a human balance between values such as performance, profitability or productivity and values like recognition of the other one, self-esteem, success. The purpose, instead of being centred on construction of tools, aims essentially at the harmonious development of individuals and communities within the organizational environments. In short, are taken into account decisions expressed by human beings, value systems that define all sorts of memberships, the desires and dreams that everyone carries (Dionne-Proulx & Jean, 2007).

The ethical dynamics which we propose through an approach centred on integration of values takes into account the authenticity of every health care organization and becomes integrated within the framework of management of this one by considering its view and its strategic and operational orientations. Such a problem rehabilitates the organization as a premise of collective learning and valuation of the individual, the person. The valuation of the individual is all the more important in this process since the actor is personally called to get involved in the approach in a way that his personal and professional values influence directly or indirectly the organizational perspective that we wish to implement. By involving the health professional in the strategic planning process where are discussed views, mission, orientations, values of his organization, the way to follow, increases its chances to support and to facilitate implementation of an organizational ethics co-built around common and shared values. Identification of common and shared values is not enough to say that there is an organizational ethics in a health environment. Actors (staff members, decision makers, employees' representatives, health professionals, etc.) have also to interiorize these values (Ntetu & al., 2010).

Since their purpose is to find solutions to moral and ethical problems, and because to do that, partners need to understand diverse perspectives and learn some of the others, the dialogical approach can support their initiative. Anyway, Widdershoven (2005) privileges dialogue as the best means to communicate in health care ethics because, according to him, dialogue allows partners to submit and fully discuss various possible options; this explicitly or implicitly includes a discussion about the values, the standards and the virtues to make good choices. A dialogical approach must be concrete and contextual because a dialogue is an interaction between people involved in real problems. Indeed, dialogue presupposes that participants already have certain interests and an outline of the subject, which they can elaborate and know their interests through an exchange of perspectives (Widdershoven & al., 2009). A dialogue opened to systems and ethical principles is moreover one of strategies used to develop bravery to health professional (Aultman, 2008; Kidder, 2005), to identify risk factors, to defuse potential conflicts, to diminish patient and family suffering and the health care professional's moral distress (Pavlish & al., 2011).

5. Conclusion

In short, within health care organizations, there are individuals and communities who are about to initiate an integration process of an ethical dynamics. While looking for a framework through a professional ethic or by specifying organizational parameters, it appears that the research for an integration process of personal, professional and organizational values in the numerous daily challenges constitutes a keystone for the complete integration of an ethical dynamics. Since health care organization partners are choosing to invest themselves so as to change their behaviors and manners, since everyone agrees to get acquainted with common working tools in ethics, it may happen that life of an organization comes to experiment structural changes.

At the end of this discussion, it is effectively clear that a health care organization can still evolve normally without necessarily making use of the integration of such a process of ethical reflection. When an organization chooses this process, it opts for a life dynamics, which goes beyong formal agreements and beyong standards and principles. It looks for the best. With and for those who are members of the working group, it appoints the sense of

which it is a carrier in terms of welfare and to live better together. Through its mission, aims and objectives, one recognizes its actual ethical nature.

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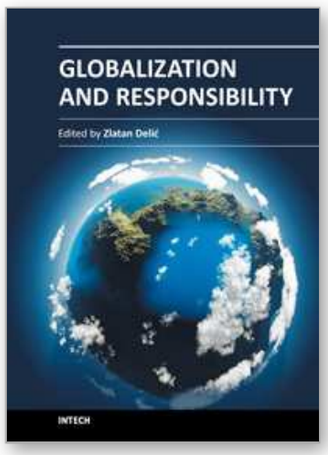

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The book "Globalization and Responsibility" consists of 8 chapters. The chapters in the book offer a decentered and dynamic terminology. They show that globalization consists of not only an objective process, but also of a lot of statements that define, describe and analyze the different experiences of the process. The chapters are written by authors and researchers from different academic disciplines, cultures and social contexts, therefore different experiences and scientific analyses on the consequences of globalization have been unified, starting from the multicultural and social epistemology to ethics of responsibility. Each chapter can be read separately, but in a complex, interconnected global universe of intertextuality of our world.

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