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SOCIAL MEDIA AS A COMMUNITY INCUBATOR

Gabriel STOICIU[1]

Abstract: *The emergence of the Internet and, consequently, of social media brought into the area of human interaction a set of transformations with a historical dimension. In the last ten years, the information society has become an expanding reality. There are countless possibilities for communication and exchanges of ideas, including among scientists, such as: forums, blogs, social media platforms (Facebook, Twitter, Instagram, etc.), text, audio and video conferencing applications (WhatsApp, Windows Live, Skype, etc.). The main objective of this study is to highlight, through the ethnographic method (observation and interviews), the study of the initiation and organization of virtual communities that manifest in the public space through protest movements. It aims also to point out the role that socialization platforms have in forming spontaneous solidarities and in shaping the civic engagement.*

Keywords: *social media, virtual communities, protest movements, Facebook, #REZIST*

1. Introduction

The emergence of the Internet and, consequently, of social media brought into the area of human interaction a set of transformations with a *historical* dimension. This label, while it may seem exaggerated, is reinforced by the remark often encountered in different types of conversation, namely: *How did I manage to solve things before I had a smartphone or a tablet?* The Internet represents, in advanced societies, ubiquitous and all-knowing instrument, gradually appearing to become also all-mighty.

In the last ten years, the information society has become an expanding reality. There are countless possibilities for communication and exchanges of ideas, including among scientists, such as: forums, blogs, social media platforms (Facebook, Twitter, Instagram, etc.), text, audio and video conferencing applications (WhatsApp, Windows Live, Skype, etc.). Today, virtual space is the one which seems to play an increasingly important role in responding to the need for territoriality. Having a website, blog or

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video channel (individually or hosted by YouTube, Vimeo, etc.) is now, in some cases, more important than owning a real estate, because this type of virtual territory can be much more lucrative rather than an agricultural land or a residential or hotel complex.

The use of the computer as the main means of communication has led to the growing within the virtual space of a "*public sphere" - a virtual or imaginary community that does not necessarily exist in an identifiable space.* "(J. Habermas, 1962). However, there are situations in which such "virtual communities" develop spontaneously - in response to an event of great interest, in most cases a catastrophe. This was the case of *Colectiv nightclub fire* in Bucharest which had a civic response on a Facebook platform called *#CorupțiaUcide Virtual communities* is a term introduced by Howard Rheingold (1993, p.3) consisting of: "*social aggregations that emerge from the Net when enough people carry on public discussions long enough, with sufficient human feeling, to form webs of personal relationships in cyberspace."*

The urban environment represents, *par excellence*, the germinating space for the development of modern civilization. This is where the most intense and profitable economic relations are established, but also where the decisions and policies through which different institutions coordinate public life are made. Here, too, most conflicts arise spontaneously or organized by citizens, when their political, economic or social interests are harmed. In the national states - more centralized, inherently, than the federations - the capital cities represent the "privileged" stage of social movements, hosting genuine "territorial behavior" displays. In ethology, the term territorial refers to a sociographic space that an animal of one species dominates over other individuals of the same species and sometimes of different species. The behavior of conquering, marking/claiming and defending such a space was named by Peter H Klopfer (1969), territorial behavior. Edward T. Hall (1966) also used this concept of territory as opposed to personal space regarding areas of interaction with *the other*.

In the computer age, virtual space offers human individuals a new substrate to manifest their territorial behavior, but this time more strongly impregnated with the symbolic dimension, being closely linked to the ability of projecting a popular image, bringing with it notoriety and credibility. Clearly marked by territorial behaviors, the protest movements represent events that animated urban spaces, in the last seven decades, with the utmost intensity in times of peace. New information and communication technologies have also made their mark on these events and, in some cases, even they generated them. The most widespread form of E-democracy is the expression of opinions on online platforms.

2. Objectives and methods

The main objective of this study is to highlight, through the ethnographic method (observation and interviews), the study of the initiation and organization of virtual communities that manifest in public space through protest movements. It aims also to point out the role that socialization platforms have in forming spontaneous solidarities and in shaping the civic engagement. To better illustrate the different aspects of such a topic, a qualitative approach turns out to be the most suitable one. Participatory observation provides important data on public events in Bucharest since the first half of 2017.

Through semi-structured individual interviews and group interviews I managed to gather a number of relevant opinions regarding the impact of "new technologies" on social engagement and also to obtain important recollections on the events of the University Square 1990 (on this topic I interviewed some of the participants at those events - now also in Victoriei Square). The group interviews have the advantage of a strong engagement in the discussions but at the same time they are harder to moderate. Individual interviews helped to deepen issues and motivate opinions. I also used photo-video techniques that enriched the information of this research. Visual ethnography has the advantage of inducing a state of empathy between the viewer and the author. Field research that involves participating in protest movements involves certain risks and difficulties that may impede, hinder or contaminate data collection. The psychology of crowds is inherently affected by a state of suspicion towards possible "infiltrators". And if they also have photo-video equipment (as is the case in visual anthropology) the "civilian" agent label is applied almost automatically. This can also pose a potential threat to personal physical integrity or equipment. The same risks can occur in case of a bust. On the other hand, the sympathy for the supported cause can affect the attitude of maintaining objectivity and axiological neutrality. *In situ* research implies a significant risk of informational intoxication; however, the online environment also presents such a phenomenon and is called "trolling".

3. Field research of the protest movement #REZIST

3.1. A short history of #REZIST movement

- October, 30th2015 – a violent fire burns down 'Colectiv' nightclub during a metal-core concert, killing 64 people (26 on site, 38 in hospitals) and injuring 147. The investigation's conclusions point to criminal negligence and corruption deeds in local and central administration;
- Popular reaction against Government incompetence and corruption is ignited – a Facebook initiative "#CorupţiaUcide" (Corruption Kills) and several protests are organized from 1st to 3rdof November 2015.
- Government formed after 2016 elections - intention to modify the penal legislation on corruption - which would free from indictment some of the political leaders;
- "#CorupţiaUcide"initiative evolves (identical followers) in several FB initiatives: "#REZIST" and "Geeks for democracy" and a first protest against Government is organized on January, 18th, 2017 in Bucharest;
- January 31st, 2017, at 23.00, the Government issues the infamous Ordinance 13 dis-incriminating some corruption deeds. A spontaneous reaction brings about 15.000 people in Victoria Square;
- A large protest (~300. 000) took place next day (February 1st) in Bucharest (~150.000) and other major cities in Romania. An order for the police to clear Victoria Square was issued and enforced. Next morning, an ongoing protest is initiated with few thousands permanently occupying Victoria Square in Bucharest and several hundred in other squares in major cities of Romania;
- February4th - Children's protest;

- On February 5th a record number of 600.000 people participated in protests. Government withdrew the Ordinance 13 without really abandoning this project;
- February 12th a huge flag of Romania is formed by the protesters using mobile phone lanterns and colored paper;
- February 27th an EU flag is formed in the same manner;
- by the end of spring the number of protesters permanently occupying Victoria Square decreased to less than 100, slightly increasing only through a Facebook mobilization for a few weekends;
- the Autumn saw a resuscitation of protests as the Government submitted to Parliament the former Ordinance 13 as legislative project;
- January 20th, 2018 – one-year anniversary meeting of #REZIST movement titled as „All roads lead to Bucharest. The revolution of our generation"-reuniting in Victoria Square people coming from all over the country.
- August 10th,2018 – 100.000 people consisting of Romanians coming from all over Europe, USA, Canada and Israel, alongside indigenous, protested in Bucharest against corruption of central administration and asked for Government resignation and snap elections. Among protesters, several "diversionist individuals**"** provoked the police agents throwing urine and feces bags and by pushing the separation fences. Police responded with tear gas. An order to evacuate the square was issued and police charged using batons, water-cannons and tear-gas;
- August 11th and 12th several thousand people occupied for several hours Victoria Square – no violent act was committed.

3.2. Deeds of group awareness

Besides the social and political agenda, the civic engagement manifested also as community spirit through several deeds of group awareness (photo credit of the author):

- intense communication among followers, initiatives for different activities, photo uploads, banner ideas, various announcements, etc.;
- non-violence and cleaning the waste after each event;
- tea preparation and distribution, banner creation, video-mapping (photos by author);

#We are watching you!

Resist!

3.3. Main findings after on-line and in situ research

After a year and a half (January 2017 - August 2018) of constant participatory observation of the online and *in situ* activity of the Facebook platforms entitled #CorupţiaUcide, #REZIST, and #GeeksforDemocracy and short semi-structured interviews with the participants in the protests in Victoriei Square, it is important to highlight the following aspects:

- intense communication takes place between the followers, initiatives for different activities, uploads of photos and clips, banner ideas, various announcements, etc.;
- there is a high civic commitment: concern to maintain cleanliness in the public space, the preparation and distribution of hot tea (temperature in the evenings of January 2017 dropping to -15C), civic education (February 4th "Children's protest");
- the involvement of a grand-dramatic aspect of the protests (the flag of Romania and the EU and light carpets formed with mobile phones);
- there is a constant concern for the external image: the creation of banners in English and the transmission of messages addressed to the EU institutions and foreign embassies through the platforms #CorupţiaUcide, #REZIST or #GeeksForDemocracy;
- a mixture of ideas and political values between the participants: from libertarianism to communism (a more heterogeneous group than the one from the University Square '90)
- not a common voice, not a single-oriented crowd, but a multi-polar one (shown even by people disposition in small crowds / circles rather than a "classic" compact mass);
- political agenda without leaders – nobody should be a speaker for the crowd;
- it is not a movement against the establishment - support for the rule of law and fundamental institutions.

3.4. Discussion

A movement can quickly build up within an interactive group when people begin to see a problem that comes not from flawed individuals, but from flawed public policies. Micro-mobilization contexts act as a launching pad for social movements. Three resources influence the creation of a movement: members, leaders and an existing communication network. New members often appear through informal interaction channels, through existing personal connections, and the more a person is integrated into an activist community, the more willing he / she will be to participate in protest

activities. The model, speed and extent of a movement depend on the communication networks available. In general, the greater the number and diversity of people participating in a network, the greater the willing to make an effort to mobilize. Activists can even use viral marketing techniques.

As social movements can spread like other innovations, the embracing of ideas and behaviors by members follows the mechanism of cultural diffusion. Social platforms have created the possibility to easily join initiative groups, but also to instantly express positive or negative feelings about various topics, ideas or opinions advanced by the members of a group. Having a strong social impact, the topics and events discussed within the groups #CorupţiaUcide, #REZIST and #GeeksForDemocracy have rapidly generated an increase in the number of members, outlining some means of collective action.

The extension of the framework takes place when the organization of a social movement seeks to encompass interests and points of view that are very important for potential adherents. In fact, the movement is trying to expand its membership base by designing its goals and activities as being congruent with the values and interests of potential members. In 1990, the disclosure of photo and video images of the violent repressions on the young people on the streets in downtown Bucharest prompted the coagulation of a large number of politically unregulated persons on behalf of the citizens' rights, culminating with the creation of the Alianţa Civică. In 2015, images from the scene of the tragedy at 'Colectiv' club generated a solidarity in revolt that far exceeded the number of people who had a direct or indirect connection with the victims and allowed the construction of the #CorupţiaUcide platform.

Micro-mobilization stimulates collective action, but groups of friends, or even larger associations of activists are not enough to develop or maintain a movement. This requires organization, and people in charge. Usually these command posts of the movements have an office, volunteers and a board of directors. Even a spontaneous uprising such as that of May 1990 brought some leaders forward and found resources to promote themselves: there were groups producing banners, others procuring/ composing poems and mobilizing songs, others composing press releases, etc. On-going rallies of the present have less spontaneity, but they can benefit from a much better organization: an increase in creativity in the forms of protest and an impressive dominance of the audio-visual and online media. However, as with other recent social movements abroad generated by the online environment (Occupy, Indignados, etc.), the lack of leaders is the fundamental feature that differentiates #REZIST from the University Square '90.

As social movements can spread on the model of promoting innovations, the embracing of ideas and behaviors by members follows the mechanism of cultural diffusion. If in 1990 access to high-impact media (the audiovisual ones exclusively subordinated to the state) was quite limited to independent newspapers and radio stations, in 2017 the Internet and private radio and TV stations allowed a broader reflection of the actions of protest and thus the popular reaction grew steadily over time.

The inherent appearance of spontaneous or opportunist extremist groups often contributes to the maintenance of social movements. This fact, by contrast effect, leads to greater support for the moderate groups. To reinforce their message, moderates must delineate the slogans and actions of the extremists. In 1990, in the University Square but also in 2017 in the Victoriei Square, individuals evoking the memory and the "heroic" facts of Vlad Ţepeş and Zelea-Codreanu appeared. Without resorting to violence, most of the protesters have taken care of these tendencies even now. On the other hand, as Dykstra & Rivera (2016, p.66) pointed out: "*collaborating within cyber communities […] while shunning outsiders and internal resistance can hinder collective abilities to actualize organizational goal, creating isolated 'cyberbalkans' that do not interact effectively with other social movements and political actors."*

Often, protest movements which go beyond the specific and assumed actions of some unions have their origins in the university environment, which serve as incubators for progressive and even revolutionary mobilizations. Unfortunately, these are often abandoned by students who have graduated and who no longer identify themselves in the causes of the initiatives of their younger colleagues or who begin to face the pressures generated by entering the professional environment. In addition to these individual pressures, there are some collectives generated by the state. The authorities seek to restore peace in the social milieu either through intimidation measures or through "incentives" addressed to the group or to the more active individuals. In the short term, a systematic, sustained use of moderate force can be effective. But if it lasts too long or becomes extreme, the use of force can generate a reaction against the authorities and sympathy from the media and the general public for the social movement. Unfortunately, in Romania, the authorities did not know how to handle the protests of 1990 and those of 2017, resorting to actions of repression with a force disproportionate to the resistance and the means of manifestation of the protesters. This attitude resulted in an immediate effect of victimizing the protesters and engagement of a large number of "indifferent citizens". An essential contribution to this, of course, was the media. What the public often assumes as their own opinions for or against a social movement is actually built news. This was ignored to some extent in 1990 by the movement's leaders (with initially mixed image consequences - protesters accused by the official press of being "drugged" or "paid"). However, the phenomenon was well understood by the participants in the protests of 2017, seeking to be as present on audio-visual or online information channels as possible, generating positive news of the type of national flag or of the European Union.

The diversity of messages and ways of expression in public demonstrations (allegorical chars, street dramatization, video-mapping) - a product of lucid creativity and not an impulsive act of rebellion - nevertheless, confirms the working hypothesis.

4. Conclusions

Protest movements have a key place in social sciences research. Protests in post-democracy (Occupy, Indignados, Arab Spring, #REZIST, Gilets Jaunes) are fundamentally different from the classical ones through several features:

- disregard of the political class in general;
- no movement leaders or spokespersons;
- crowds are not topographically unidirectional (oriented towards a platform or scene) but multipolar (network) - a gathering of circles;
- participants employ more creative forms of expression;
- protests are ongoing for extended periods;
- participants can have different interests and values, even opposite.

The groups that are currently manifesting themselves in the civic area through various initiatives have been called by Rheingold (2002, p.8) 'smart mobs' namely "a recent off-shoot of interaction online, are planned events created by those *who are able to act in concert even if they don't know each other* by using networked devices such as cell phones, PDAs and laptops and Internet." An increased activity on social media such as Facebook and Twitter helped the initiation and further organization of the protests, though it failed to promote an authentic leader. Protesters generally support the rule of law while demanding reforms of the fundamental institutions. There is no political orientation or platform. As Loader & Mercea (2011, p.21) pointed out: "*Early conception of digital democracy as a virtual public sphere or civic commons have been replaced by a new technological optimism for democratic renewal based upon and collaborative networking characteristics of social media."*

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THE DIFFICULTIES OF ROMANIAN FAMILIES WITH ELDERLY PEOPLE IN CARE (A DIAGNOSIS OF THE ROMANIAN ELDERLY WHO ARE AT RISK)

Sebastian FITZEK[1]

***Abstract**: The difficulties of families in Romania that have elderly people in care are the main subject of this analysis. The research is part of the exploratory and diagnosis area of a specific social work theme with multidisciplinary implications. The Romanian society nowadays faces an unprecedented aging process. The need for a diagnosis and for proper questions contributes to the understanding of a complex phenomenon that, in many situations, goes beyond a simple picture of the figures. The main statistical data was extracted from the PHC (Population and Housing Censuses), Eurostat, NSI (the National Statistical Institute of Romania, for demographic, social, and economic indicators), while Eurobarometers and secondary studies relevant for the diagnosis of the quality of life in the case of the elderly have been used for subjective data. Besides the descriptive and explanatory approach of social phenomena related to the elderly groups in Romania, I have chosen an approach of the statistical indicators relevant to this topic that I introduced in the analysis.*

***Keywords:** elderly, aging, family, vulnerabilities, risks, violence, aggression*

Introduction

Senectute is often associated with wisdom that elderly people have acquired in their life experience. For many people, senectute is considered a resource, a treasure for younger generations. There are many meanings for the saying "*Ill luck is good for something*" (in Romanian, literally as "*Who doesn't have elders [as part of their lives], should buy themselves*

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some"), but these are not really taken into consideration in our country, unlike in most developed nations such as the United States of America, Japan, China, South Korea, Germany, the Nordic countries etc., where the elderly are an important and active resource in the process of economic development. In Japan, elderly people represent a distinct social category which never gets retired, a class also called the "viewers at the window". Such people are maintained by large businesses in expert positions, providing valuable advice in decision-making processes. In Romania, there are elderly people who die in solitude, lacking affection and medical care. Unfortunately, the specific shortcomings and risks of this age are not just financial or medical. The opportunity of retirement has turned into multiple vulnerabilities, contributing to rising poverty rates. Although elders have worked for a lifetime, most of them have become sick, and are poor and lonely. Three decades after the Romanian Revolution, the country is still represented by a weak sovereign state, unprepared to manage its own resources. The are multiple answers to this inability, but in this research I will concentrate on the situation of the elderly people in Romania from a risk perspective. The research efforts are directed towards obtaining a larger understanding of a complex phenomenon, that should go beyond the mere image provided by statistical figures.

It is known that the current ratio of the elderly population to the youth population is in a worrying imbalance, a fact that can have negative effects for the future. Is Romania prepared to face the new challenges? In the first phase, we conducted a general socio-economic diagnosis of the elderly groups by subindicators used by NSI (Eurostat), adding an analysis of secondary data from specific research and reports. The study was part of the theoretical lines defined by the volume "*Asistența socială în România după 25 de ani: răspuns la problemele tranziției*" ("*Social Assistance in Romania after 25 years: an answer to the problems of transition*") (Zamfir et al., 2015), which focuses on the new tendencies of analysis and measurement of the quality of life used in the system of social assistance in recent years. Scientific literature rather addresses the topic in an institutional and legislative manner, from the perspective of the social assistance system, and less from the perspective of the families who have elderly people in care. Rarity of data in this regard is a limit of the study, but this does not diminish the need for an empirical analysis to show the typical advantages or difficulties for the subject.

The title of this article has the role of highlighting the challenges a family faces when choosing to share the household with an elderly person, especially when financial, psycho-emotional or housing difficulties occur. In the question of this research I have sought to unravel which are the most important risk factors when an elderly person is in the care of a family with different limitations: financial or other types of limitation, beyond moral responsibility. Another inquiry regards to what extent would the family be regarded legally, as a private-space/off limits subject, an argument for non-interference by state authorities in conflict situations? The two inquiries will not necessarily meet the proper answer in this study, but they will be regarded on a wider scale, discovering where Romania currently finds itself in this phenomenon.

The socio-demographic context of the elderly groups in Romania in recent years

According to Article 1(4) of Law 17/2000, the elderly are the persons who have reached the retirement age established by law. According to the National Institute of Statistics, the average number of pensioners in Romania slightly declined in 2018, reaching 5.2 million in the first three months, with only 6000 fewer than last semester. However, it is estimated that the share of the population aged 65 or more will double from 15% to 30% by 2060, with the possibility to exert a strong pressure on the costs of pensions, medical services and long-term care services (National Strategy for Promotion of Active Aging and Protection of the Elderly 2015-2020: 3). The average monthly pension did not exceed 1,122 lei (about 240 euros), which cannot provide a decent living standard. Some of the Romanian pensioners cannot pay their usual medicines, nor their daily debts to the government. A major objective of the National Strategy on Social Inclusion and Poverty Reduction (2015-2020) is to increase the self-sufficiency for the elderly through actions that will lead to their appreciation and respect as active citizens with living conditions closer to the European level.

In fact, the poverty rates offered by the NSI showed that, in 2016, 25.3% of the population was considered poor, so almost five million people. In other words, one in four people owns a household with a lower income than the threshold set by the median of the 60% of adult-equivalent income[1]. In rural areas poverty is three times more prevalent than in the urban environment.

According to the National Strategy on Social Inclusion and Poverty Reduction (2014-2020) there was a decrease in poverty among the elderly between 2008 and 2012; nevertheless, at national level, one in five pensioners is at risk of severe poverty. Increasing life expectancy due to medical technology and medicines is another important factor worth considering. The question therefore arises as to what extent the increase in life expectancy corresponds to an improvement in the quality of life? The consequences can go in two directions, assuming two scenarios:

a. Increased pressure on the pension and social assistance system;

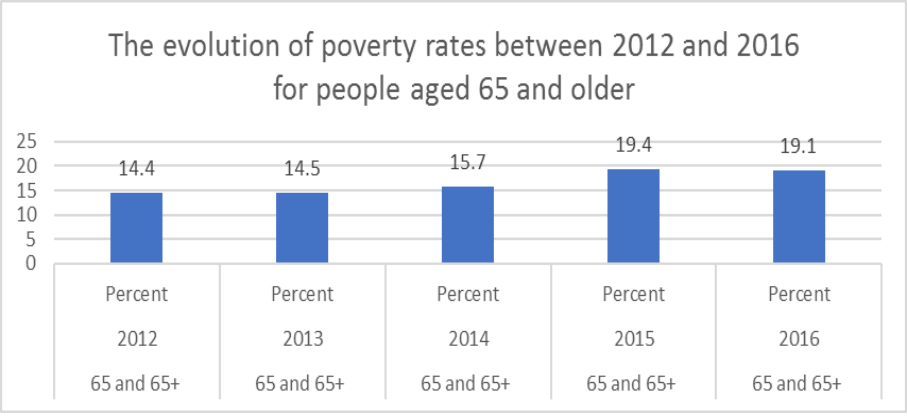
b. the construction of intelligent public policies that involve and encourage the elderly to live an active and productive life.

Neither scenario depends on a simple choice. The orientation towards one direction or another is rather an effort for the future that we are currently building. The choice of the second scenario starts from a single condition: combating the poverty rate. The 2016 distribution of poverty among the population remained uneven: 36.1% in the North-East region of the country, 34.2% in South-West Oltenia, 32.1% in South-East,

[1] The relative poverty rate represents the share of poor people (by the relative estimation method) of the total population. People in households with disposable income per adult equivalent (including or exclusively the consumption of own resources) are considered beneath the poverty line. Currently, this indicator is determined for the threshold of 60% of the median income available per adult-equivalent. The indicator is sometimes referred to as the 'poverty risk rate' (NSI, SAR102B - Relative poverty rate, by age groups).

while the lowest figures were registered in Ilfov (10.2%). The evolution of poverty rates at national level (between 2012 and 2016) for persons aged 65 and older is displayed in Figure 1.

Figure 1. Evolution of poverty rates between 2012 and 2016 for persons 65 and older



Source: © 1998 - 2018 INC

Figure 1 lets understand that the evolution of the poverty rate for the elderly in the total population worryingly increased from 14.4% in 2012 to 19.1% in 2016. In terms of gender differences, there is an important gap in the group of 65 years and over: in 2016, women registered a score 11.5% higher compared to men (NSI, 2018). This gap could be explained through the earlier retirement of women. Romania is trying today to recover several gaps that separate it from the European standard. One of the major goals of the anti-poverty strategy is to reach 70% of the working population employed in active labor by 2020. Another objective is to reduce the number of people at risk of poverty or social exclusion by 580,000 compared to the number reported in the reference year 2008. This objective includes the whole population, with two segments hihgly exposed to vulnerabilities: children and elderly. The objectives have already been assumed by Romania in the framework of the Europe 2020 Strategy and the National Reform Program (PNR), being assisted by the financing of some European projects that have come to support the concept of active aging.

An interesting demographic forecast was made by the National Institute of Statistics on employment and unofficial employment in terms of the numerical evolution of the elderly in relation to their pensions, by simulating a program created by the World Bank for the period 2012-2020. The simulation shows how Romania will undergo a major change in terms of population structure (as shown in Table 1). The total population in 2020 will be lower with approximately 177,000 people.

Table 1: Demographic changes obtained from the simulation for the period 2014-2020 (in thousands of people)

Age groups	Year							Modified 2014-2020
	2014	2015	2016	2017	2018	2019	2020	
0-14	3.133	3.127	3.117	3.116	3.117	3.113	3.110	-24
15-19	1.093	1.088	1.092	1.090	1.081	1.071	1.061	-32
20-64	12.464	12.368	12.270	12.174	12.083	12.002	11.907	-557
65+	3.297	3.381	3.457	3.524	3.592	3.656	3.733	+436
Total	19.987	19.964	19.935	19.904	19.873	19.842	19.810	-177

Source: PROST model of the World Bank for Romania

The increase in the number of those 65 and over will exceed 436,000 people in 2020 compared to 2014, while the working age group (20 - 64 years) decreases in this interval with 557,000 people. The group of children between 0 and 14 years decreases with 23,000 and young people between 15 and 19 years decrease with 32,000. In conclusion, the active population decreases as the older population increases. In this situation, the pressure on the Government to manage the pension system, the medical care and the elderly care will increase. Subsequently, the Government will most probably have to raise taxation levels.

Some of the most important reasons that could explain the demographic aging in Romania are:

a. migration of young people and of the active population;

b. the gradual decrease of the birth rate, especially in the last 25 years;

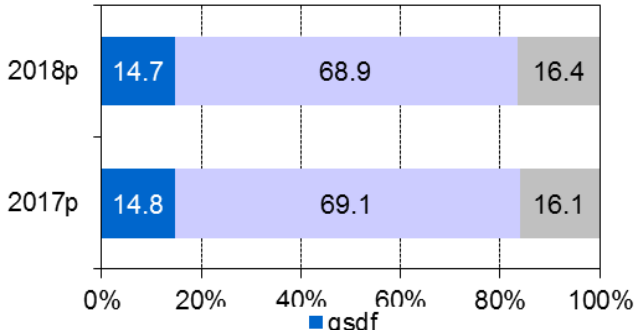
c. increased adult mortality (stress, economic insecurity, unemployment, increased violence and homicides, economic and psychosocial insecurity, deterioration of the environment and health conditions);

d. increase of life expectancy among the elderly (phenomenon explained by technical-medical progress).

The forecast made by the World Bank was already confirmed in 2018 by the figures presented in the press release of the NIS (no. 225/29 October 2018: 1). The release shows that the phenomenon of demographic aging has increased, the population aged 65 and over has surpassed by almost 395 thousand people the young population of 0-14 years (3647 thousand compared to 3252 thousand people). In the same press release, we find that the index of demographic aging has increased from 109.2 (as of July 1, 2017) to 112.1 elderly people per 100 young people (as of July 1, 2018). In the same graphs, it was observed that the average age of the population increased from 41.2 years (July 1, 2017) to 41.4 years (July 1, 2018) with a difference of 0.2 years. The growth of the elderly population will create pressure on the pension system. As shown in Figure 2, the government needs to find other solutions to avoid a possible increase in taxation,

especially on the account of the working population. Romania needs to increase investments in preventing some situations in which the demand for free medicines and treatments for different chronic diseases will increase. This requires a better management of the pharmaceutical system in terms of providing adequate and specific medicines and care for the elderly population.

Figure 2. Population structure by domicile by age groups, on July 1, 2018



Source: NSI (nr. 275/29th of october 2018)

Public medical services need to pay specialized attention to geriatrics and family medicine to prevent certain diseases and to better manage human resources. The lack of doctors and the precarious conditions of hospitalization show a turn back, which is unfortunately reflected in the quality of life of the entire population. Prevention and early treatment of cardiovascular disease, diabetes, Alzheimer's dementia and depression have become desirable for a medical system weakened by human and material resources.

Risks and opportunities for elders under family-care

In the population of Romania, the elders occupy the second place as a measure of the poverty rate by children. However, according to a study conducted by the World Bank in 2012, the presence of elder members in families leads to a decrease in poverty. The incidence of poverty among families with an elder member was 21.2%, so 1.6 percentage points lower than the incidence of poverty in families without older members. Also, the incidence of poverty among families with two elder members in 2012 was only 6.9%. It is important to note that, in 2008, the situation of families with an elderly member was actually worse than for families with no older members. Similarly, families with two or more elder members had a slightly lower incidence of poverty in 2008 than families with no older members. However, the situation of families with an elder member has improved considerably in 2008 and 2009 due to the significant improvement in the real value of pensions (The World Bank, Poverty Strategy 2014-2020: 24). The same was confirmed by the report in the "National

Strategy on Social Inclusion and Poverty Reduction 2015-2020", where the situation of the elderly living in poverty registered a slight improvement.

Table 2 shows that the largest difference between the sexes appears in the group of 65 years and older, in which situation women are at a significantly higher risk than men by 11.5 points. The only reversal occurs in the 50-64 age group with a difference of 3.1 points in favor of women. In conclusion, women in the group of elderly people in Romania are more likely to be at risk of poverty than men. The phenomenon of gender differences appears more frequently in rural areas.

Table 2: Poverty rate by total, sex and age groups in 2016 (%)

Age	0-17	18-24	25-49	50-64	65 and over
Female	38,1%	32,1%	23,6%	17,4%	23,7%
Male	36,4%	32,3%	24,0%	20,5%	12,2%
Total	37,2%	32.2%	23,8%	18,9%	19,1%

Source: NIS, Dimensions of social inclusion in Romania: 14

Lonely elder people have a higher risk of poverty than those living in families, and, according to the report prepared by the Ministry of Family Labor, Social Protection and the Elderly, about 1.2 million people aged 65 and older live alone (three-quarters of whom are women). While 25.8% of the lonely elders live in poverty, only 5.8% of the elderly couples are in this situation. The poverty rate closest to that of the lonely elders is that of households without elderly members (22.7%), with a large gap between single women and single men (30.2%, compared to only 13.8 %) (National Strategy for Social Inclusion and Poverty Reduction 2015-2020: 25). The statistics presented by Eurostat at EU level provide an overview on each country of the lonely elder by gender. They live in their own household without any other family members. Romania is in the European average in terms of the number of elderly single people by sex and does not represent an exception; however, in relation to the evolution over the past ten years, there is a constant increase, which coincides with the further evolution of the number of pensioners in the total population. According to Eurostat, Romania had 205.4 thousand single elderly men in 2010, and 255.7 thousand in 2017. The same happened in 2010 with 672.2 thousand women, raised in 2017 to 763.3 thousand (Eurostat, Number of persons by sex, age groups, household composition and working status, 1000).

The vulnerable group is described in the Social Assistance Law no. 292 of December 20, 2011 as those persons or families who are at risk of losing their ability to meet daily living needs due to illness, disability, poverty, drug addiction, alcohol or other situations. Vulnerability among elderly is not only the physiological or fragile limit, but also includes the social, financial or moral limits. The "loneliness" of those who have lost their spouse or who have been abandoned by their families becomes a psycho-emotional vulnerability. Older people who do not enjoy the presence of a family are more exposed to depression due to isolation, lack of affection and communication. Compared to its Western counterparts, it seems that the Romanian government does not have viable solutions to deal with this phenomenon. A best practice example would be the German "*Senioren-Dorf und Wohnparks*" (villages and parks for the elderly), a project which aims to qualitatively improve the psycho-emotional life of those who choose to spend the rest of their lives in these 'villages', in a community with other elders. The main objective is to maintain a collective individuality and at the same time independence for the elderly in houses that benefit (at the level of each apartment) of a small garden, offering an infrastructure that helps and facilitates aging. The same kind of project was developed in countries such as Austria, the Czech Republic, Slovakia and Hungary.

In Romania, the alternative for an elderly person to live outside the family is to stay in a geriatric nursing home. In the provisions of the Law no. 17/2000 on the social assistance of the elderly, the access to the homes for the elderly is granted for the person who *does not have a family or who is not in the care of a person or persons obliged to it, according to the legal provisions in force, it has no housing and neither the possibility of securing her living conditions on the basis of the own resources, does not make its own income or this is not sufficient to provide the necessary care, cannot be housed alone or requires specialized care, is unable to get the own socio-medical needs*. The fulfillment of any single condition of those presented is sufficient in order to be received in a geriatric nursing home, although in the case of those who have a family, but do not want to live together with the family, the situation becomes complicated. The notion of obligation is relative and does not include the concept of abandonment encountered in many situations in Romania. There is also a vulnerable category of elderly people who were left without a home, falling prey to scams[1]. There are also homes that provide home medical services in accordance with Art. 15 of Law no. 17/2000, at the request of non-governmental organizations, pensioners' organizations or recognized religious units in Romania. The homes can provide some home care services for the elderly: household help; legal and administrative advice; prevention of social marginalization and social reintegration in relation to psycho-affective capacity; aid for the maintenance or rehabilitation of physical or intellectual capacities; providing some occupational therapy programs; support for body hygiene; consultations and treatments at the medical office in medical institutions or at the person's bed, if she is immobilized; nursing-care services;

[1] According to Art. 8 of the instructions of the Law no. 1/507 of 2003, point d): The social workers have the obligation to carry out the necessary investigations in cases of abandonment in order to identify the belongings of the abandoned persons, afterwards to prepare the reintegration into their own family or preparing the admission to geriatric nursing homes or care and assistance centers.

insurance of medicines; providing medical devices; dental consultations and care. In addition to these measures, the system of granting the assistive devices (walking frames, wheelchairs, crutches etc.) necessary to increase personal independence (National Strategy for the promotion of active aging and the protection of the elderly 2015) can be reanalyzed.

In the case of the elderly under the care of families there are risks, but also opportunities according to several criteria listed here without necessarily including all the particular situations:

- diseases that require specialized medical care;
- disabilities that require adequate medical care;
- dependencies such as drug, alcohol, or other situations that lead to economic and social vulnerability;
- social exclusion and marginalization;
- abuse caused by aggression and violence by family members;
- lack of space opportunities;
- ensuring adequate living conditions;
- financial situation sufficient to ensure daily living needs;
- support and collaboration;
- psycho-emotional support from the family.

By ensuring adequate living conditions for the elderly, Ruginã (1986: 355) refers to maintaining elder people in their own environment, with or close to the family of children and not in isolation. The family plays an important role in maintaining the self-esteem for the elderly, ensuring them an important role in the lives of others and a sense of usefulness and appreciation. In most cases it can be stated that the material and moral support is reflected in the health of the elderly and that, in general, the persons under the care of a family extend their life expectancy. The strongest psycho-emotional support for the elderly comes from within a family, especially in the relationships between them and their children.

Care needs are established based on a national grid to assess the needs of the elderly, which has been thought of in three distinct categories: physical dependence, mental dependence, psychic dependence. Unlike other European countries, Romania is facing an acute lack of funding for social services and especially for the care of the population in dependency situations. On the other hand, the human resources are insufficient, and the low salaries demotivate social workers to get involved in establishing a performing system. In the conditions of the future growth of long-term care services, the problems now are even more pronounced. As a result, the current prevention services are debatable, and the policies of encouraging and supporting older people to stay in the family are weak. The care and social assistance system may soon be overcome challenges. From a systemic perspective, underfunding of social assistance in Romania is the main cause of the performance deficit, which, together with the lack of personnel, will make its mission increasingly difficult to manage.

An analysis of the strategy for promoting active aging and policies for the protection of the elderly

In the strategy sheet on active aging, the Ministry of Labor, Family, Social Protection and Older People together with the World Bank have set out to carry an inter-sectoral analysis of the current situation. However, the diagnostic results are worrying. Unemployment of people between 57 and 65 years is increasing, and the employment rate of people beyond 65 years remains low. Considering an increase in the number of elderly people by 2020, the objective of encouraging older people to extend their active labor years seems to be a suitable solution to ease the pressure on the pension system. In fact, according to the data provided by the NSI, the employment rate of persons 65 and beyond shows an involution in this regard.

Table 3: Evolution of the employment rate of the population aged 15 and older, by age groups

	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
15-24 years	24.3	23.4	23.7	22.9	22.5	24.5	22.3	24.5
25-54 years	76.8	75.8	76.6	76.3	77.1	77.4	77.6	79.9
55-64 years	40.7	39.9	41.6	41.8	43.1	41.1	42.8	44.5
65+ years	**12.4**	**11.9**	**11.8**	**11.3**	**10.8**	**8.9**	**8.2**	**8.8**

Note: The data only includes figures from the resident population.

Source NSI Press release no.99 / April 18, 2018

It is difficult to believe, based on the figures presented in Table 3, that the employment rate of persons 65 years and older would increase significantly until 2020. The data indicate a visible regress, an objective that in this case becomes increasingly difficult to reach. The results of the strategy, however, depend on the achievement of complex results, which, in turn, are evaluated through a series of specific indicators:

a. To extend and improve the quality of active life of the elderly:
   - % increase in the number of elderly people active in the labor market who are not affected by occupational diseases;
   - % decrease in the number of persons receiving early invalidity pensions, compared to the previous year, as a result of applying the provisions of Law no. 263/2010 on the unitary system of public pensions, with subsequent amendments and completions;
   - number of jobs favorable to the elderly existing on the labor market;
   - number of senior citizens trained, counselled, mediated;
   - introducing regulations regarding the granting of tax facilities for the elderly exposed to the risk of working in the informal sector in order to access the formal labor market;

- number of support, mediation, support and assistance services for the elderly, in the community.

b. To promote the active and dignified social participation of the elderly:

- number of elderly people actively involved in community life;
- number of organizations representing the interests of the elderly, active at national level;
- number of positive evaluations from the elderly in the community;
- number of public infrastructures accessible to meet the needs of the elderly;
- % decrease in cases of abuse reported by elderly people.

c. To achieve greater independence and security for the elderly with long-term care needs:

- number of elderly beneficiaries of the long-term care system;
- the regulation of a coherent system for the realization of the long-term care system in both public and private system;
- resources allocated for the development of the long-term care system;
- Increasing the number of home care units that provide social services to the elderly.

d. Cross-cutting goals for a longer and healthier life. Delay of physical aging and the appearance of chronic conditions:

- % decrease in the number of elderly people with serious illnesses;
- % of health services provided to the elderly.

At point a) the indicator regarding the increase of the number of the elderly active in the labor market who are not affected by occupational diseases, as it has been shown, does not seem to be achievable.

Table 4: The average number of pensioners and the monthly pension

	The average number - thousands of individuals -			**Average pension - monthly lei -**		
	Trim.II 2017	**Trim.I 2018**	**Trim.II 2018**	**Trim.II 2017**	**Trim.I 2018**	**Trim.II 2018**
TOTAL	5225	5223	5207	1022	1122	1122
of which, according to the level of retirement:						
Social Security	5222	5220	5204	1022	1122	1122
of which, state social insurance	4673	4686	4680	982	1072	1073
of which, social insurance by categories of pensions:						
A) Age limit	3965	3991	3989	1154	1266	1264
B) Early retirement	**22**	**22**	**21**	**1165**	**1280**	**1283**
C) Partial Early retirement	77	86	88	808	924	971
D) Invalidity	**595**	**565**	**554**	**591**	**623**	**616**
E) Heir	563	556	552	570	620	624

Source: NSI Press release no.235 / September 12, 2018

It is worth noting in Table 4 that the number of anticipated pensions has increased, which, again, raises a gradual pressure on the pension system. The other indicators in point a) do not have real support pillars in terms of increasing the number of jobs favorable to the elderly existing on the labor market, given that the employment rate of the population 65 and over is decreasing, according to Table 3. The last three sub-paragraphs of a) have no relevance in the support and financial protection of the elderly, but they can be taken into account in the evaluation of the quality of life, although their support also implies a financial effort from the social protection system.

At point b) the most important indicator in the subject of vulnerabilities is the one related to the decrease of the cases reported by abuses on the elderly. According to the National Council of Older Persons, Romania faces a worrying increase in this phenomenon, the main problem being the lack of abuse reporting. As a consequence, the real number of abuses does not become known.

For point c), the long-term care system is underfunded and under-represented and therefore unable to respond to the growing number of applications. Developing the private system could be a solution to help the public system, given that its target could also include the poor population that does not allow high maintenance costs. The resources allocated to the long-term care system depend on both financing, public and private, but the European resources remain the most important sources that support smart projects for improving the quality of life at this time. The increase of the number of home care units that provide social services to the elderly remains a dilemma objective beyond the financing of this sector, its main problem being generated by the lack of qualified personnel and especially by the lack of human resources.

Point d) has a cross-sectional objective that aims to achieve a longer and healthier life. This involves delaying physical aging and diminishing the occurrence of chronic diseases. Evolutions can be noticed here, confirmed by the data regarding the increase of life expectancy due to the development of medical techniques and medicines.

The last point is the only objective already confirmed, the others remaining in an area of probabilistic uncertainty that did not belong to the natural range of the desired things. In other words, extending and improving the quality of active life of older people is far from being achieved as long as the number of pensioners is increasing and the pension system is under pressure.

Abuse and violence in the life of elderly people in the care of a family

Three theories exist in scientific literature about family violence and abuse. In the caregiver stress theory, it is claimed that abuse occurs when a family member caring for a dependent old person is not able to perform his duties due to obstacles he cannot overcome. The theory was accepted, but also criticized because it would legitimize the abuse by blaming the victims. The psychoanalytic perspective created the theory of social learning which stipulates that those children who grew up in a violent environment reach maturity and adopt a behavior just as violent as the one in which they grew up. The manifestation of abuse in these cases is a reaction of authority to the

punitive model in which they grew up. The third perspective belongs to the theory of reciprocity of social exchange that explains the interaction between the victim and the abuser manifested in a transfer of material goods that the victim does in the power-domination-submission relationship. The caregiver takes advantage of the vulnerability of the victim, who most of the times cannot defend herself, and pays for her non-violence, buying her peace through various prizes or gifts. The game of attitudes is defined by the contexts in which the abuser is interested in certain advantages that he can obtain by exercising a punitive and authoritative power. In these relationships, the victim seeks to maximize the rewards and minimize the penalties. The theory validates the situation in which the caregiver takes advantage of the vulnerability of the elderly dependent on it by the exchange of cost/benefit in an unequal, unbalanced and abusive relationship.

In the case of the family, violence can be considered a form of negative and destructive behavior that one or more members exercise to maintain a dominant and abusive control over other persons through forms of psychic or physical abuse. Usually, behaviors that target different forms of punishment or revenge turn a family partner into a victim. The categories of abuse mentioned by NCOP are:

1. attacks (physical violence),
2. insufficient nutrition (food deprivation),
3. improper administration of medicines (non-administration of prescribed drugs),
4. emotional, mental and verbal abuse,
5. sexual abuse,
6. financial abuse,
7. voluntary isolation (or keeping the elderly in captivity),
8. failure to provide assistance in daily care activities.

In Romania, the NCOP registered the following types of abuses, which it considers to still be ignored by the protection system for the elderly:

1. Moral abuse, characterized by the non-respect of the dignity of the elderly person, marginalization and social exclusion, ignorance of his rights and freedoms, discrimination on the grounds of age; moreover, moral abuse is found in all other types of abuse;

2. Negligence (disguised abuse) as abuse in the family, at home, but also in the institutionalized framework (nursing home or recovery center) is a disguised abuse, hardly noticeable, ignored in its real dimensions and with serious repercussions on the existence of the elderly. Abuse by negligence can be: involuntary (the elder can be left alone, isolated, forgotten, without help); intentional (the elder is deprived of intent on nutrition, hydration, care, body hygiene and living space);

3. Behavioral (psychological) abuse is a type of abuse commonly encountered, it slowly grinds the resistance (and so weak) of the elderly, intimidates him causing

him to be dominated in the interest of the abuser; psychological abuse is like a slow destruction without traces and manifests itself as a lack of patience in listening to the old man, and through intolerance. Violence against the elderly in relation to the negative notes of the aging process, lack of communication, insults, verbal violence, psychological terror;

4. Physical abuse (violence), is becoming more and more frequent and appears in various forms, from robberies, to beatings or crimes. It is common within the family, the abusers being the close relatives (children, kindergartens, grandchildren), followed by the other more distant relatives and persons outside the family;

5. Sexual abuse is becoming more frequent in the case of older women, subjected to rape by young men or adults, with complex, perverted sexual behavior disorders, in association with the crime of robbery;

6. The financial abuse, also called the hijacking of the assets of the elderly, as the elderly are considered easy targets for the criminals, in relation to the reduced possibilities to defend themselves, both physically and on the possibilities of noticing the abusive intentions of the abuser, falsifying acts, detaining pension under the pretext of shopping etc.

7. The abuse of institutionalization, that is, the admission to a home for the elderly or a recovery center, against the will of the elder, even if there are conditions to stay in the family, at his home (NCOP: 5-6).

Unfortunately, in Romania, the exact information in figures regarding the reporting of abuses on the elderly in the care of a family is missing. The only governmental body responsible for combating this phenomenon is the National Institute for Crime Research and Prevention within the General Police Inspectorate. At the research level there are some data that confirm the presence and the increase of the number of abuses in this segment, but the data do not reflect the situation at national level. Another problem is the well-known principle of outside intervention in internal conflicts because the family is considered a subject of private law. The legal regulations prevent the authority to intervene in the family life, while the victims of the acts of violence are protected by a set of different norms applied in the context. At this time, domestic violence is defined and punished by law, but the legal norms in Romania place more emphasis on defending the rights of the aggressor and less on the protection of the victim.

The national strategy on promoting equal opportunities between women and men and preventing and combating domestic violence for the period 2018-2021 can make a change of the legislative framework in favor of institutions fighting against violence in the Romanian family. The strategy established a set of measures designed to reduce the frequency of acts of domestic violence, to reduce the feeling of insecurity of the victim and to reduce the risk of recidivism through the policies of social reintegration of persons who have committed abuses and crimes of domestic violence. The three general objectives of the strategy are:

1. Prevention of domestic violence in order to reduce the phenomenon;

2. Protection of victims of domestic violence and empowering the aggressors by establishing an integrated institutional framework and adopting specific policies and measures;
3. Promoting cross-sectoral cooperation and supporting partnership with civil society and public-private partnership in the implementation of policies in the field.

The Ministry of Labor, Family, Social Protection and Older Persons, in accordance with the three objectives of the strategy, has proposed the following set of actions:

1. Developing the capacity of local public administration authorities to intervene in the prevention and combating of domestic violence;
2. Implementation at national level of the integrated information system for recording, reporting and managing cases of domestic violence;
3. Increasing the efficiency in combating crimes of domestic violence;
4. Carrying out actions to prevent the phenomenon of domestic violence, in collaboration with partner institutions;
5. Continuous professional training of specialists working in the field of domestic violence (e.g., for social worker, police officer, forensic doctor, psychologist, prosecutor, judge);
6. Recovery of the victim and/or of the family aggressor through integrated and complementary medical, information, counseling, psychotherapy and other therapies, carried out in an integrated manner in order to increase the autonomy and individual social value, to develop responsibility and regain social ability;
7. Continue the financing process for setting up new units for preventing and combating domestic violence.

In conclusion, there is no precise rate to measure the number and frequency of abuses on this subject, although there is no doubt about the extent of this scourge in the Romanian space. In this sense, a series of complex researches are needed to radiograph the image at national level.

Conclusions

The present study was part of the exploratory area of a complex subject that involved a multidisciplinary and structural vision regarding the situation of the elderly in Romania. The study revealed that the difficulties of the families who support the elderly are not only financial, most of the times the psycho-emotional factor is the most important index that establishes consensus or abuse in the relationship between elder people and their caregivers. Education, the environment and the emotional transaction of communication make up the set of causes and conditions that define one situation or another. The context remains an indefinite invariable, but the education and the environment are crucial in the quality of the relationship between an elder and the other members of the family. Domestic violence is a sensitive topic in Romania, which at this time could not yet be measured in statistical figures, but can be framed, in an empirical

analysis based on secondary data. To the first question of the present research I answered - by listing and analyzing specific risk factors - why an elderly person in the care of a family depends more on the psycho-emotional relationship with the other members and less on the financial situation of the family. Most of the times, except in cases of alcohol and drugs, abuses occur, according to the psychoanalytic theory of frustration, in situations where the abuser has grown up in a violent family. The increased frequency of these cases shows that there is a causal relationship with the past. Uncertainty remains a common feature of the second research question. The legal situation in Romania regarding prevention and intervention is uncertain. In the letter of the law, the family is the main subject of the private space, and this argument has generally favored an attitude of non-involvement and non-intervention by the public authorities, with some exceptions that are not well defined. A revision of the legislation at the moment is more than necessary, and this is happening through the proposals made in the Strategy on the prevention and combating of domestic violence in accordance with the provisions of Law no. 217/2003. The Ministry of Labor, Family, Social Protection and Older Persons has proposed a series of measures to improve and mediate an effective legislative framework. It remains to be seen and analyzed in another research to what extent the legal environment has improved its position towards the most painful and sensitive subject and to what extent these actions will reach their final goals.

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WHAT MATTERS FOR THE EFFECTIVENESS OF A TRAINING ORGANIZATION? EVIDENCE FROM BPATC

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Abstract: *Organizational effectiveness is the concept of how successful is an organization to achieve its goals in what the organization intends to serve or produce for its customers. Organizational effectiveness is more important for non-profit organizations or service providing organizations that primarily depends on their performance. The objectives of this study are to identify factors and their influence on organizational effectiveness. A structured questionnaire survey was conducted to get information and valid data. The study has nine independent variables and each variable was measured at least by three items. The consistency of the items has measured the reliability of the variables through Cronbach Alpha and found most of the variable items were very consistent. This study has also developed nine hypotheses. A multiple regression equation was performed for testing relations. Among the nine independent variables along with 'organizational effectiveness' as the dependent variable, it is found that three hypotheses were accepted according to standardized beta values with a considerable level of significance. Accepted hypotheses are related to 'motivation', 'integrity', and 'empowerment'. The ANOVA results highlights a significant relationship and explains as 79.50% ($p<.05$) of the total variance. Thus, the results of this analysis indicate that variables can explain about 80% of the organizational effectiveness. However, the small size of the population and quantitative results are some limitations of this study. Besides, this study was limited within faculty, who were engaged in training activities and very limited staff who were engaged with training programs.*

Keywords: *organizational performance; leadership; motivation; integrity; BPATC*

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1. Introduction

Bangladesh Public Administration Training Centre (BPATC) is the hub of the public sector training organization. It has the mandate to develop the capacity of a civil officer who works at the different organizations in the central and provincial levels. The training itself has the role to build individual capacity and change a mindset towards job performance (Yamoah, 2014). Here the role of training organizations has given more importance to improve the morale of civil servants, who are responsible to discharge their duties towards service delivery to the citizen. Merely training picks up work efficiency and productivity or performance of employees. Therefore, well-trained employees can produce quantity and quality performance at their respective workplaces. On the other hand, for organizational effectiveness or success the development of training programs is a must.

In a competitive changing world, every organization, either private or public, for-profit or not-for-profit, has to be responsive to its client's and to be creative and innovative in delivering a product or service that satisfies client's needs in a distinctive way to achieve the highest level of organizational effectiveness. Organizational effectiveness refers to the ability of an organization to account successfully for its outputs and operations to its various internal and external constituencies (Gaertner and Ramnarayan, 1983). More precisely, organizational effectiveness is the concept of how efficient an organization is, and achieving the goal, what an organization intends to serve or produce. According to Richard et al. (2009), organizational effectiveness captures organizational performance and the myriad internal performance normally associated with more efficient or effective operations. Ondoro (2015) argues that the organization's performance is one of the indicators of organizational effectiveness. Successful organizations sustain their performance over time irrespective of a conducive or volatile environment.

Training organizational effectiveness depends on its performance that is the fulfillment of the needs of the various stakeholders (Lusthaus, Anderson, & Adrien. 1997). The effectiveness of the training organization successfully addresses the ever-changing demands of the client's. Training organizational performances of the public agencies, whose actions are regulated by the government, are not necessarily measurable in terms of financial quantities. Although government investments in research and training institutes are substantial, efficiency and effectiveness in the output of training and research by public organizations have seldom been investigated. This is true for Bangladesh Public Administration Training Centre (BPATC), an apex non-profit public sector training institution in Bangladesh as imparts training to the government officials at different levels. A prime mandate of BPATC is organizing training courses for human resources development of civil servants to foster goods and services towards the citizen of the country.

Islam, Arifzzaman, and Fatema (2010); Islam et al. (2014) carried out study on BPATC Foundation Training Course Curriculum and Senior Staff Training Curriculum; Islam, Haque, and Hasan (2011) carried out a study on 'Training and Job Satisfaction at BPAT; Islam (2010) carried out a study on Training Method on Training Effectiveness,

those study have given focuses on training methods, training curriculum and trainees satisfaction, did not focus on organizational perspectives.

An effective organization requires both a focus on organizational strategy and its progressive culture. Such an organization has a clear strategy that is well known and understood by all members of the organization as well as a culture that not only gives members the freedom to use their intelligence, skill and expertise in pursuit of strategy, but also ensures employees' engagement and commitment which are very much essential for organizational success. Further, the structure of the organization is flexible with an emphasis on development through a team rather than preserving the status quo through rigid hierarchies (Elsaid et at. 2013).

A study on organizational effectiveness (OE) is a neglected area of training institutes both in public and private sectors perhaps because of its technicalities or lack of expertise of trainers of training institutes. Bangladesh Public Administration Training Centre is considered an apex training institute in the country. Public service delivery is getting soaring impetus in new dimensions across the globe. Bangladesh's government is also on a consistent way to meet the citizens' needs by ensuring their service demand. But institutes need organizational preparedness. So measurement of organizational effectiveness is a must to ensure preparation to meet the newly emerged demand. But without conducting a study on its organizational effectiveness, it is simply impossible to make it an innovative and effective organization in order to satisfy the needs of its client's. Despite the difficulties in conducting a study on organizational effectiveness, BPATC needs to show evidence through a comprehensive study in support of its claim as an apex training institution. The study objectives are to identify factors (organizational strategic direction, communications, long term orientation, competencies, client satisfaction, employee empowerment, integrity, leadership, and motivation) that have an influence on training organizational (BPATC) effectiveness; and to identify the relationship among the variables.

2. Literature and hypotheses

BPATC is playing a key role to provide training with new knowledge and skills for the public sector official of Bangladesh. For providing and maintaining quality training and accomplishment of other activities such as research managers are identified as an asset for the organization. Therefore, Total Quality Management and Continuous Improvement are regarded as the best means for organizational effectiveness. BPATC upgrading training modules regular basis and methods are also updated with trainees' need base. Faculties are gone under training at home and abroad for sharpening their knowledge and skill. BPATC became effectiveness with introducing ERP to simplifying its activities such as administrative, trainees' evaluation, faculty evaluation, store management, all sorts of an online material requisition. BPATC has written a strategic plan and vision & mission statement.

Organizational effectiveness

In the rapidly changing environment, organizations are being downsized and adopted with new technology, business process to render goods or services in a simplification manner according to created demands. Thus, organizational effectiveness refers to its

strength in terms of human resources and physical resources to obtain organizational goals by using minimum resources. Therefore, it is noted that efficient Human Resource (HR) has an obvious impact on organizational effectiveness which has got the attention of scholars that results in drawing some models. Different authors have given different models of organizational effectiveness in their various kinds of literature. These are as follows:

First model measures 'organizational effectiveness' in terms of 'production', 'commitment', 'leadership' and 'interpersonal conflict'. Those concepts can be understood as *production* means the amount of output i.e. related to BPATC activity this is all about a number of training courses are offered and numbers of trainees are trained through BPATC, a number of seminars and workshops are arranged and international academic seminar or workshop are organized. *Commitment* refers to the degree of attachment to organizational activities. BPATC organizes training courses and research works, it is found that without failure training courses are successful, in terms of research work, found not much good work has been published in the international community. Thus, in terms of a training commitment, HR attachment is at the highest degree. *Leadership* can be understood as a degree of influence and personal ability. Here, in BPATC leadership matters on the work culture and ability to do more work in terms of number and quality. It is mentioned that from its (BPATC) inception in 1984, BPATC received 31 Rector (Secretary to Government of Bangladesh) as a Top and experience Executive. Executives were blended with practical and academic knowledge, which brought a uniqueness for developing the organization. *Interpersonal conflict* refers to a degree of perceived misunderstanding between supervisors and subordinates. In BPATC industrial relationship is harmonious. Mostly, the organization follows a chain of command, which is the main motto of public administration. In BPATC Civil Servants come from the field and work with a permanent trainer who is called own faculty recruited for BPATC only. Together they are working with a congenial atmosphere, no reported conflict is found.

On the other hand, Albrecht (1983) has developed organizational effectiveness with four interconnecting systems. These are namely:

A technical system, referring to the relationship among different activities for making organizational effectiveness. This technical system basically dealt with the physical facility, training aid, equipment, computer, internet, classroom, library, work process, work methods and so on. BPATC has a number of classroom sessions facility, updated computer equipment, very well equipped physical infrastructure, etc. but the training work process in written form (standard operative procedure) was not seen.

The social system, this system referred to people associated with an organization and their activities in which they are engaged. Also, it dealt with organizational values, norms, organizational communication styles like power hierarchy, HR system, reward, and punishment system. BPATC practiced Max Weberian hierarchical administrative style, training norms and values followed and practiced by its customers like trainees.

The administrative system, this system is referred to as policies, procedures, instructions, reports, etc., those are required to function the organization. Training institute has two

parts of administration one is an administrative unit, this part helped for organized training and academic activities. Another part is called the training and academic part. In BPATC it is found that there is a positive relationship among training and administrative units. Effective training programs depend on pro-active and competent administrative and logistics support.

The strategic system is called the steering function of the organization. Components of the strategic system included a management team from the top executives to the lowest level of support staff.

Strategic direction and organizational effectiveness of BPATC

Strategic planning or direction of an organization, profit-oriented or non-profit oriented is a pertinent phenomenon for its long term destination. Thus, a strategy can be understood with a long-term orientation that an organization should aim, with action for achieving its goals (Johnson, Scholes, and Whittington, 2008). In any organization strategic plan is a direction of organizational objectives, policies, and actions upon which organization creates sustained competitive advance (Almani and Esfaghansary, 2011). Without strategic direction, organizational performance cannot be achieved, thus determinates to be set for directing to obtaining organizational effectiveness (Kitonga et al. 2016). For the non-profit organization, strategic direction is a must that requires proper leadership. Therefore, organizational effectiveness and strategic direction have a positive relationship. BPATC is also a non-profit organization; it has a mission and vision stated statement as well along with a written format of a strategic plan. Therefore, we hypothesized:

H1: Strategic direction has a positive and significant relationship with the organizational effectiveness of BPATC.

External communication and organizational effectiveness of BPATC

In particular, training organizations need to contact with other external communication to seek trainees or trainers for organizing training courses. Through communication, the organization lets them all external and internal such as its members, customers, suppliers, distributors, alliance partners, and a host of outsiders, provides information for the organization. Communication is a process, by which information shifts and exchanged throughout an organization (Schermerhorn et al. 2005). External communication focuses on audiences outside the organization such as partner organization, customers, regulatory bodies, and so on. For example, organizations do communicate through factsheets, press kits, seminars, workshops, conferences, flyers, magazines, publications, journals, newsletters release and annual reports as well (Shonubi & Akintaro 2016). Several studies emphasize that effective communication has a positive impact on organizational performance (Shonubi & Akintaro 2016; Garnett, Marlowe, & Pandey 2008). Therefore, external communication in an organizational environment has the objective of facilitating collaboration and cooperation with various stakeholders that are outside the formal structure of the organization. The collaboration and cooperation of these stakeholders are viewed as being an essential organizational success. Thus, we hypothesize that:

H2: External communication has an impact on organizational effectiveness.

Long-term orientation and organizational effectiveness of BPATC

In term of a cost-effective organization has put emphasis on its future direction. According to Hofstede (1988), long or short orientation refers to future direction rather than short term view. Thus, organization exhibit on its own culture both in financially and psychologically in the future, and tends to be sustained in the long run with long term commitment towards organizations and career. The organization has its own strategic action plan, which indicates organizational effectiveness, the only requirement is that to measure and follow its performance yearly. However, long-term orientation referred to organizational policy, procedure, action plan, strategic direction, employee motivational approaches, customer-oriented and so on. Therefore, we hypothesized that:

H3: Long-term orientation has a positive relationship with the organizational effectiveness of BPATC.

Competencies and organizational effectiveness of BPATC

It is pertinent to have the core competencies of an organization. Many authors have given their thought that organizational effectiveness depends on common values, common culture, legitimacy, shared vision, integrity, innovation (Kotter & Heskeet 1992; Collins & Porras 1996). For the long-term performance of an organization to develop areas of expertise are essential. Besle and Sezerel (2012); Jabbouri and Zahari (2014) study revealed that core competencies play an important role in business strategies and performance. Jabbouri and Zahari (2014) have shown their study that there is a positive and significant relationship between core competency and organization performance (Page, C., et al. 2003). Prahalad and Hamel (1990) defined 'core competency' as a management concept, which basically the relationship between harmonization of multiple resources and skill for organizational performance. Moreover, others also described core competencies as a specialized skill, qualities, and characteristics of knowledge which enable the organization to perform and to achieve the highest degree of client satisfaction (Macmillan & Tompo, 2000). Thus, we hypothesized that:

H4: Competencies have a positive impact on the organizational effectiveness of BPATC.

Client orientation and organizational effectiveness

Notably, it is said that organizational performance not dealt with only core competencies, or its processor culture, but also with the performance of financial, goods-services performance and client satisfaction. Shaohan Cai (2009) found that client satisfaction influences organizational performance. Public or private both organizations have their own customers, organizations rendering goods or services for their client's. As per the strategic direction of BPATC, it is clearly mentioned that this organization committed to providing quality training and education for its client's (BPATC, 2013). For doing customer-oriented services, BPATC has a circle that is responsible for training curriculum development and given direction for updating training delivery methods. In the same vein, top executives of BPATC monitored and give suggestions for improvement of training contents as well as training methods for organizational performance due to client satisfaction. Islam et al. (2012) study measured training institution client satisfaction with training facilities such as classroom,

library, and different service windows, the study result found that the model is significant and service windows have an impact on client satisfaction. Particularly, internal customers defined as organizational employees and measurements of their satisfactions are working environment; job satisfaction; benefits financial or non-financial; career planning at work; retirement benefits and so on. Therefore, we hypothesized that:

H5: The more organization is focused on its internal or external client satisfaction, the organization shown more effectiveness in BPATC.

Empowerment and organizational effectiveness

According to Schermerhorn et al. (2011), organizational culture is a system of shared actions, values, and beliefs that develops within its organization and guides the behavior of its members. Management scholars do believe that organizational cultural differences have an impact on organizational performance. In particular, literally empowerment can be understood with a given degree of responsibility, authority and power to an employee or a team for discharged his or her duties at organizations. Employment is the act of identifying the tasks on which employee is trusted to act independently. In the organization, every job has a description and specification, according to those jobs that are managed by the competent authority. For high performing jobs, individuals are given authority and power to the respective individuals. But, employment requires open discussion among managers and employees. In the organization, once information shares, rewards, power with employees for taking initiative and making decisions for organizational actions are called empowerment. Therefore, we hypothesized:

H6: Empowering organizational staff has a significant and positive impact on organizational effectiveness in BPATC.

Organizational integrity and organizational effectiveness

One of the major inputs or components to measure organizational effectiveness is integrity. In general terms, integrity is defined with a set of values and beliefs. Very precisely this is a system of work and practices required to obtain organizational goals. Thus, refer to organizational effectiveness, means that effective organizations must have well-defined values, beliefs, systems, and actions in the practice of that system at the organization. Therefore, integrity is a hallmark of a person who has sound moral and working principles with demonstrates at the office. Integrity is required to increase business communication with trust and confidence between people at the workplace. On the other hand, Weber defined organizational integrity is a formal bureaucratic and management rules and regulations for effective organizations (Jose, et al. 2012). Bowie (2009) argued that organizational integrity is basically a mechanism for individual responsibility. Integrity as a predictor study report found that it has a link with job behavior, job performance, decision making, creating a high performance team environment, a significant correlation among employees (Luther, 2000; Murphy & Luther, 1997). Therefore, we hypothesized:

H7: Organization integrity is associated with organizational effectiveness in BPATC.

Involvement in leadership and organizational effectiveness

In an organization, it is found that management and leadership both are important. Needless to say that organizational success even the whole country depends on the effectiveness of a leader (Rawhmanwati et al, 2016). It is revealed that effective management to be a leader too (Daft, 2018). Leaders' qualities are associated with management that provides organizational strength. To some extent top-level managers are mostly leaders, they focused on a vision for the future and sustainability of the organization. Besides, leadership influences people to obtain organizational goals. Leadership is dynamic and uses the power of people, an organization is also having people. Thus the role of leadership is to influence people to achieve their goals. Achieved organizational goal is a measurement of organizational effectiveness. More precisely, Kotter (1996; House, 1995; Semin & Fiedler, 1996; Rahmawati, A., et al. 2016) have argued that leadership behavior is the ability to influence others to do actions by motivating people given authority or power. In public sector organizations, things are changing fast, thus the orthodox working environment is replaced with transformational leadership (Bass et al. 2003). Therefore, according to the idea of transformational leadership, within organization people are inspired, motivated to obtain their vision and also manages delivery for vision. Thus, in the changing work process, the proper direction is required for obtaining organizational goals. Finally, we can say that effective leadership is more important for organizational effectiveness. Thus, we hypothesized:

H8: Leadership has a significant relationship with organizational effectiveness in BPATC.

Motivation and organizational effectiveness

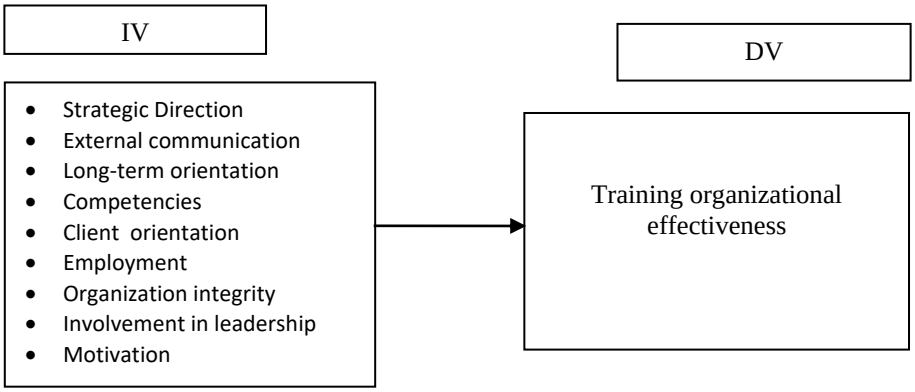
K.P. Sing (2015) study argues that there is a positive relationship between employee motivation and organizational effectiveness. This study identified some of employee motivation factors those factors are recognition, empowerment is a direct positive relationship with organizational effectiveness. Employee motivation is an approach to get things done by people. Organizational people are motivated through recognition, reward, organizational policy, financial and non-financial packages as well. Manzoor (2012) study found that a sample of 103 respondents was taken and Pearson correlation was performed, shown there is a significant positive correlation between employee motivation and organizational effectiveness. In Human Resource Management motivation is a core function of Human Resource Management, there staff or employees are an asset. Employees are motivated through their needs, wants, and benefits. But, organizational performance depends on their ability and motivation. It is said that organizational performance increased through motivation if ability and knowledge are remained constant (Nishii, et al 2008). Therefore, we hypothesized:

H9: Motivation has a positive relationship with organizational effectiveness in BPATC.

Conceptual framework

The following figure (conceptual framework) illustrates the relationship between Independent variables related to 'Faculty Perspective' with dependent variable 'effectiveness of training organizational', that is determining factors for organizational (BPATC) effectiveness (Figure 1).

Figure 1. Conceptual framework



Source: authors

3. Research methods

At this stage of the article describes the sample design, questionnaire design, variables measurement with reliability result, data collection, data analysis, and results.

Participants and procedures

This study administered a survey to proven the theoretical framework and apply it to identify the factors which are influenced by training organizational (BPATC) effectiveness. Participants in this study were from the Bangladesh Public Administration Training Centre, who worked with training programs. Participants were categorized as worked on deputation, in house faculty (direct recruited) and training staff, who were closely engaged with training programs. Respondents were selected randomly from BPATC. A total of 120 structured questionnaires were sent to them and received 73 valid filled in questionnaires. The study was given approval for the financial year 2016-2017. But due to some administrative formalities study extended time up to 2018 December. The data collection period was done from September 2016 to March 2017. The following table shows the distribution of the respondent demographic profile.

Table 1. Distribution of Respondent Faculty Members of BPATC

Particulars	Frequency	Percent	Cumulative Percent
Gender			
Male	64	87.7	87.7
Female	9	12.3	100.0
Total	73	100.0	

Particulars	Frequency	Percent	Cumulative Percent
Service grade			
Grade 1-9 (Faculty)	38	52.1	52.1
Grade 10 (Training officer)	4	5.5	57.5
Grade 11-16 (Training staff)	12	16.4	74.0
Grade 17-20 (Support staff of training programmes)	19	26.0	100.0
Total	73	100.0	
Length of service			
less than 3 yrs	20	27.4	27.4
3-5 yrs	7	9.6	37.0
6--10 yrs.	4	5.5	42.5
11-15 yrs	8	11.0	53.4
16-20 yrs	10	13.7	67.1
21-25 yrs	5	6.8	74.0
26-30 yrs	11	15.1	89.0
31 + yrs.	8	11.0	100.0
Total	73	100.0	
Mode of requirement			
On Deputation	9	12.3	12.3
On Direct recruitment	64	87.7	100.0
Total	73	100.0	

Source: authors

We have used a structured questionnaire for this study. For this study, a set of questionnaire dealt with faculty and training support staff, who are working at BPATC. Survey structured questionnaire was administered to measure training organizational effectiveness and some related independent variables, which are related to measuring organizational effectiveness, especially of BPATC. A questionnaire was in English version and respondents were confident to understand. Constructs are measured with a 7-point Liker scale.

Variables measurement and their reliability

A reliability test is performed for this study. As this study used variables items and measured with a scale, the measurement of the overall consistency of the items is verified with Cronbach's Alpha. Variables items, internal consistency, and coefficient identification are the most important results for social research or business research. Cronbach's alpha result is recommended (0.70) by Hair et al. (2006) and (0.50 or more) recommended by Nunnally (1978). The range of Cronbach's Alpha value is 0.00 to 1.00. Reliability 0.50 is fair and 0.70 is good, more than 0.70 is excellent. Alpha coefficients above 0.70 are considered acceptable (George & Mallery, 2003).

Strategic Planning & Direction: The strategic direction variable is measured with eight items. These are: 'BPATC strategic aims are clear and communicated to all'; 'few people contribute to formulation strategy'; 'strategic plan operates by timetable'; 'faculty members know their contribution toward strategic plan of BPATC', 'BPATC training activities different from other institution', 'BPATC is recognized to everyone', and

'BPATC has a system for monitoring'. The response format was measured with a seven-point Liker Scale, ranging from '1' completely untrue to '7' completely true, in developing a scale for this variable, this study used a statement from (Steiner 1979; Wood and Laforge 1981; Ugboro 1991; Miller and Cardinal, 1994). The Cronbach alpha value is .839.

External communications: The external communication variable is measured with five items. These are: 'BPATC has a close touch with its customer'; 'Faculty have good working contacts with client organization', 'Contact with other training organization and exchange information'; 'BPATC has regular contacts with research institution & universities'; and 'BPATC updating client information'. The response format was measured with seven-point Likert Scale, ranging from '1' completely untrue to '7' completely true. Communication scale is developed by Barkman and Machtmes (2002); Kumar (2017). The Cronbach alpha value is 0.875.

Long-term orientation: Long-term orientation variable is measured with three items. These are: 'Top management emphasis on long-term issues'; 'BPATC emphasizes heavily in research & development'; and 'BPATC is continually improving the quality of training program'. The response format was measured with seven-point Likert Scale, ranging from '1' completely untrue to '7' completely true. The Cronbach alpha value is 0.853.

Competencies: Core competencies variable is measured with four items. These are: 'BPATC aware of latest global development aspects'; 'BPATC pursue international collaborations '; 'Use of research fund'; and 'Pursuing new training technology'. The response format was measured with a seven-point Liker Scale, ranging from '1' completely untrue to '7' completely true. The Cronbach alpha value is 0.693.

Client orientation: Client orientation variable is measured with six items. These are: 'BPATC invests time & money for satisfying customer'; 'client value of training'; 'efficient in order to satisfy BPAT's clients; 'regularly conducts TNA'; 'regularly conducts PTU'; and 'BPATC management responsibility for ensuring client value'. The response format was measured with a seven-point Likert Scale, ranging from '1' completely untrue to '7' completely true. The Cronbach alpha value is 0.527.

Empowerment: The empowerment variable was measured with seven items. These are: 'BPATC management regards its employees'; 'work as a team'; 'employee training & development'; 'strong communication with employees'; 'top management control over employees work performance'; 'uses of faculty potential'; and 'BPATC maintain inter-departmental coordination'. The response format was measured with a seven-point Likert Scale, ranging from '1' completely untrue to '7' completely true. The Cronbach alpha value is 0.887.

Organizational integrity: The organizational integrity variable was measured with eight items. These are: 'equal opportunity, no favoritism'; 'honest & fair with customer'; 'best training course in the public sector'; 'best research & consultancy'; 'good & fair recruitment'; 'formal arrangement'; 'quality training'; and 'ethical behavior'. The response format was measured with a seven-point Likert Scale, ranging from '1' completely untrue to '7' completely true. The Cronbach alpha value is 0.865.

Involvement in leadership: This involvement in the leadership variable is measured with six items. These are: 'employees have role to influence decisions'; 'management is responsible for staff development'; 'faculty are encouraged to use their own initiative'; 'faculty are with taking important decision making'; 'faculty and support staff are directly sharing their view to top management for improving training'; and 'faculty are often talked with top management informally'. The response format was measured with a seven-point Liker Scale, ranging from '1' completely untrue to '7' completely true. The Cronbach alpha value is 0.871.

Motivation: This variable is measured with six items. These are: 'recognized employees' achievements'; 'work self-satisfaction'; 'merit & performance-based promotion'; 'good salaries & other remunerations'; 'employees are aware of their performance'; and 'helping & supporting management at BPATC'. The response format was measured with a seven-point Likert Scale, ranging from '1' completely untrue to '7' completely true. The Cronbach's alpha value is 0.479.

Organizational effectiveness: This organizational effectiveness variable is a dependent variable for this study, and measured with six items. These are: 'clear strategic mission & vision'; 'competent academic, training management & support staff'; 'all level staff development program'; 'work innovation'; 'strong work culture'; and 'Client is highly valued'. The response format was measured with a seven-point Liker Scale, ranging from '1'completely untrue to '7'completely true. The Cronbach alpha value is 0.908.

Analytical tools for data analysis

For this study, we performed a linear regression model to find out the relationship between the dependent and independent variables. Therefore, nine variables are considered to be the explanatory variable, and the other is considered to be the dependent variable. More precisely, here, dependent variable is 'Organizational Effectiveness'. On the other hand, independent variables are: strategic direction, communication, orientation, competencies, customer, empowerment, integrity, leadership and motivation.

This study tried to fit a linear model to observed data, a modeler shout fist determines whether or not there is a relationship between the variable of interest. It is needless to say that this does not necessarily imply that one variable *causes* the other, but that there is some significant association between the two variables. A valuable numerical measure of association between two variables is called a correlation coefficient. This correlation coefficient value is laid within minus 1 to plus 1, which indicates the strength of the association of the observed data for the two variables.

A linear regression line has an equation of the form $\boldsymbol{Y = a + bX}$, where $\boldsymbol{X}$ is the explanatory variable and $\boldsymbol{Y}$ is the dependent variable. The slope of the line is $\boldsymbol{b}$, and $\boldsymbol{a}$ is the intercept (the value of $\boldsymbol{y}$ when $\boldsymbol{x} = 0$).

This study is exploratory in nature in which data are collected through a questionnaire survey. A number of questionnaire items were used. Therefore, Principal Component Analysis/factor analysis is used by using the SPSS statistical tool. From PCA, a set of factors received. With these factors, descriptive statistical analyses have been done.

Finally, regression analysis is also done for this study to get impact factors and its variance explained on organizational effectiveness correspondence with dependent and independent variables. Moreover, to find out regression, analysis is used for this study to draw inter-causal relationships between the independent and dependent variables. Model specification of this study is as follows:

$$Y=\beta 0+\beta 1X1+\beta 2X2+\beta 3X3+\beta 4X4+\beta 5X5+\beta 6X6+\beta 7X7+\beta 8X8+\beta 9X9+e_i \ldots\ldots\ldots\ldots\ldots \text{(i)}$$

X1: Strategic Direction

X2: External communications

X3: Long-term orientation

X4: Competencies

X5: Client orientation

X6: Empowerment

X7: Organizational integrity

X8: Involvement in leadership

X9: Motivation

Y: Organizational effectiveness (dependent variable)

4. Data analysis and discussions

In regard to strategic profile and organizational culture profile, the study has computed variables with their measurement of respective items. And compute variables with descriptive statistical results are presented in the following table and found some variables have a mean value of more than 5 and some of more than 4. Results reveal that all independent variables and dependent variables mean score is satisfactory levels on organizational effectiveness (Table 2).

Table 2. Descriptive Statistics on Compute Variables

Compute Variables	Mean	Std. Deviation
Strategic Direction	5.30	.965
Communication	5.05	1.156
Orientation	4.92	1.33
Competencies	5.07	.94
Client	5.01	1.12
Empowerment	4.89	1.13
Integrity	5.22	.99
Leadership	4.68	1.21
Motivation	4.73	1.17
*Organizational effectiveness	5.02	1.25

Source: authors

Regression model and ANOVA

This regression model is composed of nine independent variables such as strategic direction, communication, orientation, competencies, client orientation, empowerment, integrity, leadership, and motivation. The regression model is found significant in this study. Analysis of variance (ANOVA) indicates that strategic profile variables and culture profile variables of BPATC have a significant relationship with organizational effectiveness. The correlation coefficient between independent and dependent variables is very high (0.892) and have a positive significant relationship. The independent variables together significantly related to the overall organizational effectiveness of BPATC. The R-square is (0.795), where the adjusted R-square about 76.4% explained the total variance (Table 3). This indicates that this is a good model that covered about 80% of organizational effectiveness.

Table 3. Regression Model and ANOVA

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
1	0.892[a]	0.795	0.764	.60937	25.848	.000

Source: authors

a. Predictors: constant strategic direction, communication, orientation, competencies, client orientation, empowerment, integrity, leadership and motivation
b. Dependent variable: organizational effectiveness

The coefficients are shown in Table 4 which reveals that the organizational effectiveness has a highly positive and significant relationship with empowerment, integrity and motivation factors. Empowerment has explained 26.00%, integrity explained 28.60% and motivation explained 31.00% of the total variance. Except for those three independent variables, the rest of the variables have a relationship, but not significant. The collinearity test is also performed for this study to verify multiple-correlations and variance inflation factors. A tolerance of less than 0.2 or 0.1 and VIF (Variance Inflation Factor) of larger than 4.0 are regarded as the potential indicators of multicollinearity (Park, 2010). Thus, the result of this study shows that multicollinearity was not a problem.

Table 4. Coefficients Result and Collinearity Test

Model/Factors	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
	B	Std. Error	Beta			Tolerance	VIF
(Constant)	-.838	.505		-1.658	.102		
Strategic Direction	.087	.125	.068	.692	.492	.358	2.795

Model/Factors	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
	B	Std. Error	Beta			Tolerance	VIF
Communication	-.068	.110	-.063	-.619	.538	.324	3.083
Orientation	.017	.115	.018	.152	.880	.235	4.256
Competencies	.158	.152	.118	1.041	.302	.267	3.749
Client value	.062	.135	.056	.460	.647	.229	4.361
Empowerment	*.329*	*.135*	*.260*	*2.440*	*.018*	*.300*	*3.329*
Integrity	*.295*	*.115*	*.286*	*2.565*	*.013*	*.274*	*3.645*
Leadership	-.027	.124	-.024	-.219	.827	.277	3.615
Motivation	*.334*	*.100*	*.310*	*3.349*	*.001*	*.400*	*2.501*

Source: authors

Hypotheses test summary

For this study, the formulated hypotheses are nine. Hypotheses testing results (H6, H7 & H9) suggest that empowering organizational staff, organizational integrity and motivation have a significant impact on organizational effectiveness (Table 5). Thus, the organization (BPATC) should execute those practices for the higher performance of an organization.

Table 5. Summary Results of Hypotheses H1 to H9

Ho	Hypotheses	Beta	t	Sig.	Result
H_1	H_1: Strategic direction has a positive and significant relationship on organizational effectiveness.	.068	.692	.492	Rejected
H_2	H_2: External communication has an impact on organizational effectiveness.	-.063	-.619	.538	Rejected
H_3	H_3: Long-term orientation has positive relationship with organizational effectiveness.	.018	.152	.880	Rejected
H_4	H_4: Competencies have a positive impact on organizational effectiveness.	.118	1.041	.302	Rejected
H_5	H_5: The more organization is focused on its internal or external Client satisfaction, the organization shown more effectiveness.	.056	.460	.647	Rejected
H_6	H_6: Empowering organizational staff has a significant and positive impact on organizational effectiveness.	*.260*	*2.440*	***.018***	***Accepted***
H_7	H_7: Organization integrity is associated with organizational effectiveness.	*.286*	*2.565*	***.013***	***Accepted***
H_8	H_8: Leadership has a significant relationship with organizational effectiveness.	-.024	-.219	.827	Rejected
H_9	H_9: Motivation has a significant relationship with organizational effectiveness.	*.310*	*3.349*	***.001***	***Accepted***

Source: authors

5. Conclusions

The principal purpose of this study was to identify factors and its influence on training organizational effectiveness, and to examine the relationship of the factors with organizational effectiveness. Identified factors are strategic direction, communication, orientation, competencies, client satisfaction, employee empowerment, integrity, leadership, and motivation. Past literature confirmed that those factors have an impact on organizational performance. The study model composed of nine independent variables, analysis of variances showed that the model is significant and explained 76.4% of total variance with organizational effectiveness. The study model correlation result showed that among the variables, there a highly significant correlation. The study result also shows that motivation has a positive and significant impact on organization effectiveness in BPATC. Integrity is the image of the organization, this study result confirmed that organizational integrity has a positive and significant impact on BPATC effectiveness. Delegation of power matter on performance, this study result shows that empowering organizational staff has a positive and significant impact on BPATC effectiveness. It has been also seen that strategic direction, external communication, orientation, competencies, client satisfaction, and leadership do have a significant relationship with the overall impact on BAPTC effectiveness. The reason might be BPATC is a unique and apex training institute of public sector training organization, like other public offices in Bangladesh. Here every job function is well defined, operative procedure is communicated to all, it has strategic direction with vision and mission; organizational values are also communicated to all even its client's as well. The head of the institute is always found talented and experienced once.

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THE APPROACH OF MEDICAL MALPRACTICE PHENOMENON WITHIN THEORETICAL FRAMEWORK OF MEDICAL SOCIOLOGY

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Abstract: *The medical malpractice represents a phenomenon which is more and more debated in the Romanian society; its connection with a series of other phenomena as those of the migration of physicians or decrease of physicians' credibility in the eyes of the public opinion can represent individual research subjects. The medical care has become a more complex process both by the social and economic developments (digitalization, technological development, demographic changes) and by the awareness at social level concerning the weak points and lacks the care systems. The higher costs of the medical care, the change of the physician - patient relationship, the ease access to online information, the unequal distribution of resources for health, the social inequity concerning the cares for health represent subjects from the area of medical sociology. The sociological approach of processes and phenomenon related to the medical treatments represent a useful systematic approach for their understanding or for the development of some adequate social policies. The objective of this paper is the identification of the ways in which the phenomenon of medical malpractice is represented in the theoretical field of sociology.*

Key words: *medical malpractice, sociological theories, sociology of medicine, content analysis*

Necessity of studying the concept of medical malpractice

In 2000, *the American Institute of Medicine* has published a report which starts from a basis which cannot be doubted; the error is human and only starting from this point we can develop a safer medical system (Kohn, Corrigan 2000). The reconceptualization of medical care is necessary from the perspective of a system which makes possible the transformation of this *cultural trend of guiltiness*, which forced the individuals take defence measure and try to grant the liability for error - especially by the fact that no side events have been reported, in a *trend of safety*. The mentioned report brings information

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concerning the huge economic and human costs caused by the deviations from the patient's safety. The report *To Err is Human: Building a Safer Health System* has continued to have consequences in the discussions about the future of medical care both in the USA and abroad. The report has especially followed the side events. Two major studies performed in Colorado / Utah and in New York have found that the side events have occurred in 2,9 and, respectively, 3,7% of the hospitalizations. In the first study, 6,6% of these events have led to a death, while in the study of New York the figure has been of 13.6%. The extrapolation of these studies have led the authors to conclude that *"at least 44.000 Americans die each year as consequence of a medical error"* (Kohn, Corrigan, 2000). These numbers have not been accepted without representing a challenge for various involved parties. However, it has reached a large acceptance that hospitals, contrary to some primary perceptions, are extremely risky places.

The tests performed by this report are not immediately relevant for the health policies; it is necessary a "translation" of this information. An important phenomenon is the one of looping between the research performed by social sciences and the immediate concerns of policies performed in the field of health (Jensen, 2008).

Introduction

The sociological theories guide us rarely concerning the interventions of public health at community level or at the health system level as assembly. The reasons for which these are not clear contain difficulties in finding, understanding or operating theories. Starting from the fundamental methodological idea according to which it is essential to understand the theoretical framework to be able to propose a practical one, we have performed a study to explore the sociological theories in a certain public health field: medical malpractice, generally, as well as, if there are, references on a wider perspective, institutional, of the system one.

The search for a theory using electronic methods is problematic because many of them are published in books which are rarely well indexed in computerized databases. There are studies which have acknowledged that the sociological models and theories have been lost within some electronic searches, mostly if these have been developed more than 25 years (Kelly et al., 2010). The sociological theory could also be embedded in an empirical paper, being more difficult to be identified. Some theories are written in a denser and complicated way, making them difficult to be understood. There are also some opinions that the theories are not easy to operate; for example, Rogers perceives the sociology of medicine as one which generates complex explanations, but unable to be reduced in accurate, isolated elements (Rogers, 1968). This issue indicates, probably, the necessity of choosing a "middle range" theory and less some grand/general ones or, again, it could mean, simply, that the sociologists must present and explain clearly the proposed theories (Merton, 2007).

We consider these theories as important concerning their potential to inform, to modulate interactions between physician and patient and to orientate the interventions in the field of public health. The objectives of this article have been the identification of some sociological theories in a certain field of interest, in this case the medical malpractice. The purpose is not to perform a comprehensive search of all relevant

sociological theories but, simply, to test the easiness with which the sociological theories can be accessed in a certain field and can be taken into consideration by their potential of practical use.

The search strategies for sociological theories concerning malpractice

We have assumed that the performance of a search on the terminology of *medical malpractice* could tend more towards a medical literature than towards a sociological literature, as we have initiated a manual search beginning with a search engine of an online library (Wiley Online Library) (recognizing that this objective drew my attention towards an extended view in the field of health, separated on certain medical sub-specialties and towards areas of the world). Because the electronic searches are considered inaccurate for the identification of theoretical literature (Kelly et al., 2010) and because we have anticipated that the theories could be enclosed in a variety of methods and could use an unexpected terminology, we have performed a manual search. Since this has been an exploratory study, we have limited to the first 200 results offered by the library mentioned above; the search has been done using the key word "*medical malpractice*". Upon the interrogation of the database of 65 magazines have been identified in which between 1 and 27 articles which have had in their title or in their corpus the searched key word has been discovered. Subsequently, the search has headed towards the -sociological journals motivated that it would be mostly probable to find sociological theories in these magazines than in the general medical journals or in ones dedicated to a certain sub-specialty. By the analysis of articles only in one journal we have lost, without doubt, some relevant publications; however, my purpose has not been of performing an exhaustive search of all the relevant theories, but the orientation in a theoretical field relevant for a subsequent search.

Finally, 27 articles published in the magazine *Sociology of Health and Illness* have been analysed from content point of view of. We have performed an encoding of the content of these articles, and the identified themes have been reunited in the sub-chapter *Content analysis*.

The approach taken into consideration for the identification of sociological theories or perspectives in which light it is analysed the phenomenon of medical malpractice has had as starting point a study published in the magazine *Sociology of Health and Illness* (Seale, 2008)[1].; it has emphasized the tendencies of sub-specialty identified as *medical sociology*. One of the exposed starting points is the translation from a sociology *in medicine* to a sociology of *medicine* by adopting a more analytical and more critical methodology (Straus, 1957).

Another acknowledged matter and which we have considered important is the one referring to the approach method of various subjects in the specialty magazines; the tendency of authors has been towards an approach depending on the particularities of

[1] *Mapping the field of medical sociology: a comparative analysis of journals, Sociology of Health & Illness, 30: 677–695*

health systems from their origin countries contrasting with more extended, compared perspectives, observed at other disciplines from social sciences. The research mentioned above reveals the fact that the magazine *Sociology of Health and Illness* is an exception from this point of view, publishing articles with a wider vision (Seale, 2008). From the point of view of approaches based on sociological theories, the authors consider that the British researchers from the field of medical sociology are somehow "a-theoreticians" in comparison with those who publish in general sociology journals. In the magazines of the USA, the researchers from the medical sub-field seem, somehow, "apolitical" in comparison with those who publish in the magazines with general sociological approach. The latter have an approach which tends towards the quantitative researches (Seale, 2008).

Another important difference has been offered by Turner in 1995; he declares that there are three analysis levels. At the level of individual, it is emphasized the perception and experience concerning the health condition or disease. The second level is a social one which concerns the social constructions of various categories of diseases, as well as the causality with various social structural factors. The widest level of approach is a "societal" one which embeds the analysis of health systems at national and global level; this perspective is one which has as basis the political economy (Turner, 1995).

Content analysis

The articles from the journals dedicated to medical sociology bring definitions of malpractice similar with the legal approach which is maintained nowadays. To be constituted as case of malpractice it is necessary to meet various conditions: a plaintiff must prove that there has been the negligence, this negligence has lead or contributed to damages or injuries (generally damages) which can be objectified (Roger & Joanne, 1985). Another approach which seems to remain current is the one in which the negligence or malpractice involve the failure to respect by the physician of the professional standards.

In theory, it is considered that the possibility that a patient address to the court, can be the result of two situations: (1) if there has been or not a *damage by negligence* and (2) if the patient (or the patient's lawyer) is *aware of the negligence* (in which situation, if decides and if it has resources); if one of these is met, the patient can choose to open a trial or another legal or administrative action. There have been comments as "*the claims and complaints cannot offer the real image of the efficiency of medical practice; these are more a measure of the care degree as it is evaluated by the patient"* (. Murray, 1984). These approaches have led to the opinions which state that the negligence is irrelevant in the case of malpractice. However, there is the suggestion that, the physician - patient relationships is used to adjust the patient's opinions, even when the physician feels that a complaint can become a solution to the problems caused by the typical positioning: the physician is positioned actively in the relationship while the patient adopts a passive role; it is very probably that the current realities have evolved a lot in this regard. The patient owns a certain control degree in this "alliance". The building of this type of relationship can meet difficulties from organizational point of view (even systematic), even if the will of the two parties is a real one.

Since 1963, the American Medical Association (AMA) has recognized that the physician must "*have the necessary skills to exercise the occupation which is similar to that exercised by other physicians from the same locality"; the physician must "continue to be a professional in the care for a patient as long as necessary" and "to perform any action for diagnostic or procedure for the improvement of patient's condition only with the expressed or implicitly consent*" (Committee Report AMA 1963). The phenomenon related to malpractice in medicine reached visible proportions in the USA in the middle of 1970s. The subsequent analysis has shown that it has been promoted by the disputes related to the huge increases of insurance price for physicians, by the withdrawal from the exercise of occupation of many physicians and by a series of "physicians' strikes". In some American states, there have been hospitals forced to stop the activity or reduce the volume of services which they have provided (Somers, 1977). The action upon the functioning of the health system has obliged the legislative system to intervene fast and implement a legislative framework, which consolidates the defence of physicians and hospitals against the many claims for compensation and limiting the level of indemnities. The legal norms have begun to contain and request certain assessments before the beginning of the trial, certain limitations of the indemnities' value have been imposed and witness of experts and evidence of facts have been regulated (Robinson, 1986). The situation from Romanian health system can follow a similar course; the level of granted indemnities is a higher one for the economic and salary level being able to lead to the blocking of functioning of some hospitals and, as such, entire communities can be deprived of providing medical services. Even though the examples are not various, and the length of trial is a long one, it is important to regard them as a warning signal. In the middle of 2017, the mass-media has described the situation of a province hospital which has had to pay jointly with an obstetrician the amount of half of million Euros for a case of malpractice of 2009 (Sofronie, 2017).

Within the purpose of understanding the answer of the physicians to the "crisis of malpractice", the cultural and economic effects which this phenomenon has on the medical profession must be taken into consideration. The loss of the social status by subjecting the physician to a procedure of malpractice represents a severe hit on the "pride" and professional notoriety. Annandale acknowledges two comments of some physicians as response to the threat of malpractice: *"patients have seen him as being together with God. People will never see their doctors as such (…). Physicians have never felt as a subclass of the society. We have always been the higher class of society. Now, there is a crazy schizophrenia in the medicine in which, on the one hand, you are an important group, you have obtained extraordinary quantities of skills. On the other hand, you do not want to cover yourself when walking and when you uncover yourself to see the name of a friend in a big trial and feel terrible"* (Annandale, 2008).

In the review of the book *Key Concepts in Medical Sociology* written by Gabe and collaborators, (Gabe et al., 2004), several study directions of medical sociology are identified. Even though no clear explicit theoretical approaches concerning the concept of malpractice can be identified, certain aspects are important to be mentioned. The social modelling of health can be done analyzing the social dynamics which structures the demographic and epidemiological profile of health and disease, with approaches which emphasize in the analysis elements related to the type of individual development, life events and life cycle. The human experience related to health and disease includes

discussions about the embodiment, risk and death. The economic, social and political structures contours medicine in a society which tends more towards occupations and professionalism, were we register the decline the medical autonomy. The reflections concerning the organization of system for the care of health will contain records, concerning the privatization, social movements, citizenship and medical malpractice (Chamba, 2006).

1. Individual opinions of patients regarding…?

For more than 50 years, the behaviours related with the disease have been researched empirically using mainly the quantitative methodology (Young, 2004). The inclusion of the qualitative research methods has raised new questions concerning the adequate method of each method of delimiting the complex problem represented by the humans' behaviours in front of the diseases (Norris, 2001). The modern social relationships are complex ones, include many levels of interaction: it becomes necessary to include the persons, institutions, as well as the interaction elements interests.

In the article of Winance and his collaborators, the analysis of complaints against the medical care is done from the perspective of the patients' point of view (Winance et al., 2017). Analyzing the experience of chronic diseases, Charmaz proposed the notion of "*self - loss"* to designate the transformation of identity related to the transformation of body caused by disease (Charmaz, 1995). This *"self - loss"*, which is a specific pain, is characterized by a double breakdown: first of all, between self and body, and second of all, between the personal identity (self-defining by individual) and social identity (identity formed by the relationships with the others). Charmaz analyzed then the processes which allow people to maintain this breakdown (but to keep the identity of past despite the transformation of their body) or to establish a new unit (by the transformation of the identity in accordance with the new body modification induced by disease).

The disease can determine a permanent loss (in terms of functionality, abilities, autonomy or quality of life) for the person in question and depends on the way in which the person reacts and adapts to the loss. Focusing on the identity matter, this approach underlines the cognitive dimension of people relationships with their bodies. The body is a representation which people build based on personal experience. The notion of "*loss"* becomes pertinent for the analysis of which the body lesion represents for plaintiffs. In many situations, the notion of loss exceeds the *"loss of self"* and includes losses of other type (Winance, Barbot, & Parizot, 2017). It is opened a way to repair the damage by the provisions of the civil codes.

A part of the patients has been designated and analyzed from the perspective of their litigious potential or predisposition to have such an attitude up to the level of behaviour („*suit-prone patients*"). A part of the attention given to the relationship physician - patient in association with the medical malpractice has been headed towards the change or analysis of the physician's behaviour. It is assumed that the patients send a set of hints which guide the physician towards the use of a consultative style which focuses on taking decision and liability mutually. The patient's behaviour cannot be ignored in the attempt of analyzing or even reducing the impact of medical malpractice. Considering

the importance of patients' perceptions concerning the body injury during time (negligence, mistake or otherwise), the attention of physicians focused on the recognition of patient such that he has approaches during consultations or treatments. This perspective is a common one in the medical community because the patients' stereotypes have been proved to be common in the medical practice (Wallen, Waitzkin, & Stoeckle, 1979). The features of the patients predisposed to legal actions can be divided in psychological and social demographic dimensions. The psychological features of patients, like anger, fear and rejection are some of the strongest psychologically motivating forces; other researchers have chosen the type of personality starting from the basis that it is most probably that, depending on its type, that a patient can address to the court in comparison with another. Other features taken into consideration have been the dependent attitudes and the lack of understanding of personal emotions. The social demographic dimensions specific to this type of patient are not fully described.

2. The therapeutic relationship between physician and patient

Depending on how rich and complex the meeting between the physician and patient is (at interpersonal and role level), the two parties are surrounded by rich and complex backgrounds. The claims and preoccupations of families, the values and expectations of society and some of the special matters of some social restraint, religious circles cannot be omitted. (Mount, 1990). All these are modulated in the specific setting of the hospital or clinic and are influenced by other members of the care team; today, the number of professionals involved in the process of care increased a lot compared to the moment of creating the initial Hippocrates medical model. The therapeutic relationship is influenced by intra-hospital policies, governmental regulations, requirements and documents requested by paying third parties (private or public insurance companies), legal limitations. To all these, it is added the possibility of some costs related to the occurrence of a medical malpractice. From this perspective, the patients and the physicians cannot be considered individuals who act freely against the influence of all the historical, social and institutional connections (Mount, 1990). All these influences can be considered constraint elements of an ideal, open therapeutic relationship.

Rayner brings into discussion the perspective of Parsons, taking into consideration the lack of trust in the physician manifested by mothers, as representative of their children as patients (their discourse is the basis of the ethnographic research of the article). The author emphasizes two extreme perspectives against which, he considers opportune an intermediary one. The first situation would presume the understanding of the therapeutic relationship as a "trade transaction" and the second one as a separation of the two roles: the physician would be the "professional" and the mother would take the role of "patient" as representative of the child (Rayner, 1981). This separation leads to a physician preoccupied with a discourse which contains the reasons which led to a severe evolution and with non-reparable lesions for the child and the mother will focus the "pleading" on the fact that the lesions have occurred during the period in which the child has been under the care of the physician. Even though the language and the way

in which such a dialogue can take place in such a situation can take extreme forms, it might be more important for the understanding of the situation the start from the conventional sociological roles of the physician - patient relationship. Even though the researches of Parsons in the 30s have become "classic" and time has brought many critics concerning the applicability in modern world, the central idea remains current: the problem of health is intimately involved in the "functional premises" of the social system. Consequently, the patient is dysfunctional and the sick person, by occupying the role of "patient" receives the status of deviant. For Parson's perspective, the role of "professional", on the other hand, occupied by the physician, "*combines the healing technique, in the benefit of the patient, with the responsibility of social control for the benefit of company*". Several critics claimed that in the concept of "professional role" and "patient role", the physician appears as technical expert, benignant and neutral, while the patient is passive and dependent. The current situation of the physician - patient relationship is one distanced from this division, in two roles: the patient is not a passive and "obedient" one anymore.

The article of Maseide is structured based on the opinion that the sociological literature concerning the medical practice targets mainly the therapeutic relationships physician - patient which is currently described in terms as asymmetric relationship, cognitive conflicts and dominance from the professional party of the relationship. The unwanted consequences of the physician's power towards the patient are common elements to critics brought to this biomedical model of modern medicine; consequently, alternative models as social and psychological perspective have been developed. The understanding of nature and the role of power in medicine represents an insufficient and uncompliant perspective, such that an alternative vision of designing and understanding the power becomes necessary for an adequate medical practice (Maseide, 1991).

It is introduced the term of medical adequacy for reporting the process to the context in which the medical treatment takes place. The medical activity includes the regular use of a specific language and of other documents and symbolic forms. The understanding of language within medical specialty context, together with the cultural arbitrariness concerning the medical practice and competence, lead to the necessity of existing a local production of a social order or medical adequacy. The possibility of the existence of a mismatch between the cognitive contextual plans of physicians and those of the patients create a potential and real threaten to the medical conduct (Tannen & Wallat, 1987).

The possibility of being sued for malpractice represents for the physician a strong enough impulse to comply or, in other words, to be adequate medically. This adequacy can be assured by clinical rituals and routines (called now protocols of good practice or procedures) and which will serve to obtain a normative order in the medical practice. It is important for physicians, mostly in the cases with uncertain prognostic, to be able to guide patients towards procedures which, even though are probably inefficient or even dangerous, are adequate medically. Even though a physician can be wrong, he must be secured institutionally. Pushing the medical practice to a routine or standardization will secure this medical adequacy, but it will have a minimum impact on what the physician - patient relationship means.

The theoretical approach of Maseide is represented by the analysis of physician - patient interaction models, of incongruencies types (of competence or expectations) which can affect the practice, but of constraints which can occur in the everyday practice. The control model, which presumes a control of the physician within the therapeutic relationship by the power which he has by the professional status, does not accentuate the social privileges of the physician and the directive force on the patient. The focus on the potential asymmetry of competence created and maintained by the social inequality and social contradictions will not succeed in describing correctly the role of power in the medical practice. These approaches would indicate a concept of power which, first of all, would be an abusive one. Instead, the power is thought as necessary in the clinic and, in this regard, it is benignant. Thus, the physician can act as a competent person from situational and institutional point of view. By the discursive formats of medicine, the power of physician can produce knowledge, competences and practice models and generates a medical adequacy (Foucault, 1973). The relevant problems from medical point of view are achievements of the clinical practice, with the use of personal technologies and methodologies, based on medical reasoning and knowledges, based on the medical reasoning and knowledges and performed by the relational domination of the physician and by the institutional authority during clinical examinations.

Murray's and collaborators' article identify a situation in the case of Chilean obstetricians, considered similar to the Italian ones; the physician have the "feeling" that the lower number of malpractice complaints is related to the way in which the therapeutic relationship of physician - patient is built and the ease of communication between the two parties of the therapeutic dyad. It is about a private obstetric care and of the promise of a permanent availability from the physician. The personal phone number and the professional contact data are offered. These matters reflect the literature of the USA and Great Britain, reviewed by Annandale (1989), in his study (Murray & Elston, 2005). The litigious cases are considered rare in Chile and, when these occur, they receive a large media cover. The theoretical approach concerning the malpractice is discrete; the comments are related more to the perspective of structural organization of health systems.

The trust as basic element in the improvement of the therapeutic relationship was regarded as vital matter of the relationship between the providers of medical services and patients. The choice which the consumer exercises has been credited, more and more, as a method for the improvement of quality and efficiency of medical services provision. However, it is uncertain the method in which the increase of information quantity necessary to allow the users of health services to make choices in a market of public health systems, will affect the different dimensions of trust and the way in which the change of trust relationships will have an impact on the patients and offered services. The article of Fotaki brings some clarifications using an approach based on a theory that investigate the conceptual and material relationships between choice, trust and markets for the care of health, within the context of National Health Service of Great Britain (NHS). The patient's choices will have involvements on the system, organizational and interpersonal trust. The transfer to marketing in the public health services would lead to an excessive dependence on the rational matters and related to

cost of trust in the detriment of intrinsic, relational and social matters. It is developed an alternative psycho-social conceptualization of trust which is focused on the central role of diseases. In the public British system, the choice has been or is perceived as absent from historical point of view (Fotaki, 2014).

Mulcahy (2003)[1]guides us on an important moment concerning the introduction of some subjects as "complaints" and "consumerism" in the papers intended to students from the field of social sciences. Before 2001, these subjects did not exist in the list of discussed subjects and changes occurred subsequently. The Mulcahy's book examines the social and legal dynamics of disputes between physicians and patients, based on many studies performed by the author. The complaints concerning the medical practice are an example of the consumers' activism which has received a little attention from the researchers, even though the raised problems refer to debates about the power related to the professional type of the physician, the dynamics of the physician - patient relationship, the concepts referring to rights, the trust in the physician and the impact of law on the daily human behaviour. It is the moment when the American government has declared that it will reform the approach and the laws regarding the clinical negligence and the system for the management of complaints. The analysis detailed in the second half of the book identifies the inherent tensions to the processing of complaints as a reflection of the public debate between politicians, bureaucrats and medical professional elite, concerning the role of physicians in the society (Meerabeau, 2006).

3. Multifactorial perspectives - systemic problems

The social sciences have analyzed the problem of complaints related to the medical treatment from various perspectives. Some of them focused on the way in which the physicians and their professional organizations react to the increase of the number of litigations (Barbot & Fillion, 2006). Others have analyzed the management methods of medical errors and conflicts occurred within the medical care (Bosk, 2003) or the involvement of economic costs of receivables occurred as consequence of a medical malpractice (Danzon, Pauly, & Kington, 1990). Another perspective is the one which is focused on the analysis of complaints and the way in which these would contribute to the improvement of the medical care quality and of the dialogue between physicians and patients (Allen, Creer, 2000). The quantitative researches have emphasized the low rate of judicial actions of patients concerning the harmful events and, among the plaintiffs, the sub-representation of the most vulnerable patients (Burstin, Johnson & Lipsitz, 1993). The difference between the number of harmful events and the number of cases has led to questions related to what the complaint process means for patients. Some studies focused on the difficulties which the patients face when they call for the hospitals' services and when they face the asymmetrical competences and status which can be exercised against them (Mulcahy, 2003).

[1] In the book *Disputing Doctors: the Sociolegal Dynamics of Complaints about Medical Care,* Maidenhead: Open University

The discussion about the phenomenon of medical malpractice can be centred on the explanations of the relationship between medicine and law in terms of two models: "economic" model, used first of all, but not exclusively, by the supporters of a socialized medicine and the "multifactorial" model, which can be used to express a variety of affinities, but which presumes a plurality of factors which can explain the increase of number of deviations from the practice standards.

The strict existence of a model of economic type was fought by Titmuss (1973).[1] The fact that NHS (Public Health System of the United Kingdom) is not "abused" by the unjustified requests of patients, without a market price which can regulate these requests, represent a reason. This matter, predicted by some economists, offer a support for the thesis that patients do not perceive the supply of medical services as a trade transaction (Titmuss, 1973). Since then, the author proved that there were many evidences that there was a high level of use of some useless medical procedures in the USA. Moreover, the reimbursement mechanism of fees for services leads to an excessive use of some potentially dangerous forms and often inefficiencies of drugs; however, it is not clear if there is a direct relationship between the number of useless practices or procedures and the level of litigations in a certain state. This conclusion has as basis a comparative analysis of health systems, American and British, at the crisis moment of '70s.

Most of the comments concerning the "malpractice crisis" of '70s in the USA presents multiple reasons of its occurrence contouring a multifactorial model. David Mechanic offers a comprehensive analysis, even though one is based on the sympathy towards the medical profession. For him, the problems related to malpractice are symptoms *"of some deep problems in the medicine practice, in the insurance system and in the structure of our unit"*. He lists the following factors:

- increase of specialization in medicine and increase of public expectations towards medical care.
- high chances of human error in modern medicine, more and more technologized
- ambiguity of medical standards in front of standards requested by courts
- refusal of medical insurers to appeal the complaints with small values
- fragmentation of the care process which leads to the destruction of trust in the relationship physician - patient
- the increased accessibility to the medical documents used by plaintiffs
- the increasing refinement among the medical consumers and a higher accessibility to legal services (Mechanic, 1976).

These factors are accompanied by a higher increase of the disbelief degree in the society which, concerning medicine, takes the form of a "strange ambivalence" regarding the medical care: on the one side characterized by high standards as performance and

[1] in the book *The Gift Relationship: From Human Blood to Social Policy*

technology and, on the other side, accompanied often by unreasonable expectations. There is a strong feeling of dependence, but also a quasi-permanent critical attitude. Mechanic develops the thesis about the relationship between the money offered for the service offered by the physician (FFS „*fee for service*") and litigations starting from a lecture of the Freidson's book[1] The payment of a fee for a medical service brings a modest influence to the physician - patient relationship; the competition between physicians, the transfer of payments from some immediate ones to some intermediated by insurers, as well as the direct perspective of a payment of fee affects the way in which the patient and the physician report. From the analysis of Mechanic, it seems that it is missing the observation that patients have become more "consumers". It means the clients' control represents, from consumers perspective, a reaction of the middle class which probably originates from the assumption that "health" and not only "the health care" is purchasable (Rayner, 1981).

Duane Stroman performed an analysis[2] from a systemic perspective in which the malpractice phenomenon is a process indicator and it is analyzed as an individual phenomenon. The deficiencies of the medical care system of USA are well documented in time. At general level, for a nation which is preoccupied intensely with the increase of the proportion of amounts from the national gross product spent on the medical care, the USA obtain a relatively low yield concerning the indicators of the health status, like the infantile mortality rate. More exactly, there are evidence that many medical needs are not fulfilled, especially among the poor, black people and in the rural areas; the quality of offered care is unequal (many malpractice complaints are the proofs). A dominant fact within the medical services is represented by the financing system which encourages the performance of some useless interventions and favours the appeal to the high technology for curative medicine in the detriment of primary medicine which would have a preventive, primary function. The book objectives from the perspective of social responsibility would be the examination of these deficiencies, the evaluation of the responsibility for it and the enunciation of some proposals for change (Ham, 1980).

4. Economic problems - costs of the services and the malpractice insurances

Tomes' vision is one related to the challenges brought by the technological development in medicine and to the higher economic costs. The 80s decade is eloquent, it is outlined as a marking one from this point of view. The results of the change were many and threatening: the apparent uncontrollable inflation of costs related to medical care, the surprising increase of costs as consequence of the medical malpractice processes, the public controversies concerning the use of medical technology to extend the lives of patients or of those with severe disability. A part of these controversies is still maintained and, many times, is the agenda of media institutions. Maybe the most concerning of all, at least from the physician's point of view, are the challenges brought

[1] *Profession of Medicine*

[2] Stroman D. (1976). *The Medical Establishment and Social Responsibility,* New York: Kennikat Press

to the independent traditional practice by the one which presumes the direct payment for the medical services supply (even now, the medical corporations use two large types of clients categories: FFS – Fee-for-service and PP – Pre-paid). The direct payment by the patient of a medical service causes a change in the attitude and requests of the patient for a medical document, qualitative and safe; moreover, a result conditioning may occur many times. The Reagan administration supported such practices regarded initially as "heresies", as pre-paid group medical practice and began to use the professional organizations to establish limits of federal reimbursements for the costs by Medicare and Medicaid services. At the same time, in the field of health, it was acknowledged the increasing presence of profit-oriented corporations; this aspect promotes a care both among the physicians and civil society (Tomes, 1985).

An essential matter of the crisis from the 70s - 80s, which affected directly the physicians, but which passed further to the patients by the payments for medical services, was represented by the cost of medical practice insurance for the eventual situations of malpractice, costs that became higher and higher. In some cases, the insurance premiums for malpractice increased 500% in the middle of the seventies (Morrow, 1982).

The historical perspective offers us some explanations concerning the evolution of the phenomenon in an expansion moment. Such "rate increases" were attributed to the rising will of patients to sue physicians, lawyers' practice of charging fees only in cases completed successfully (which had as affect the orientation towards profitability) and the grant of some higher and higher indemnities to courts. Between 1967 and 1975, the payments which exceeded 25.000 dollars, performed by the malpractice insurance to patients, have increased with a rate higher than 20% per year and, in a case, dr. John Nork has been made liable requesting him a record damage of 3,7 million dollars (Law & Polan, 1978). These authors argue that this increase rate has had a lot to do with the cash flow and investment problems of insurers than with the patients' claims.

However, the claims have been usually awarded to the "bad apples" from the medical occupation: certain physicians have been considered to be more "*inefficient*" than others and these would represent a higher percentage from the proportion of payments for insurances. It is an obvious relationship with the physician's incompetence. It has been argued that the insurance costs can be reduced by the identification of this "bad apples" and, for this, the reform efforts have been led; the possible option has been the rehabilitation or their interdiction to practice. A different impulse has come from another matter of the malpractice crisis. In the litigious atmosphere that encompassed the medical services in the American system knew, it has been acknowledged that the medical personnel of the hospital would be collectively responsible for the actions of their colleagues (Stimson, 1985). Under the jurisdiction of a joint commission on accreditation of hospitals („*Joint Commission on Accreditation of Hospitals*"), the body which targets the admissibility of physicians and hospitals for medical insurance, the medical personnel is mutually responsible for the periodical evaluation of professional qualifications and evaluations of colleagues' performances and the civil liability could result if this evaluation was permissive, relaxed.

The Morris' article is a response to the review of a book which analyzes a common subject for various health systems, the alarming increase of the number of C-sections. The review performed by Anna Neller (Neller, 2015) reproaches that he did not see the focus on the malpractice phenomenon. It is discussed the danger that the sociologists are not trained enough to offer pertinent opinions concerning medical treatments and, especially, they cannot measure the efficiency of medical treatments or identify potential complications of alternative treatments (Morris, 2015). Even though, in this response, a theoretical direction concerning the medical malpractice cannot be precisely identified, the starting point of the comments have n economic motivations. The amounts spend in the USA for the assistance at birth are higher than those spend by any other state; however, the results are ineffective and it is proposed the reform of the compensation system for body lesions to a model based on results which reimburse all the lesions occurred with the occasion of birth separately from the investigation concerning the medical malpractice.

The important matter that was drifted from the view exchange of opinions is that the observation of a certain type of medical procedure (in this case the C-section) can be used as a lens by which various organizations can contribute to the modification or improvement of some medical practices which, until now, were conceptualized only as a choice of the clinician and of the patient. Various international bodies and professional companies (for example *The American College of Obstetricians and Gynaecologists, The Society for Maternal-Foetal Medicine, World Health Organisation*) raised the problem of the unjustified high number of this type of procedure, the rates of complications and other problems of medical and social type. "*There is no doubt that any connection with the women bodies (and mainly with the mother women bodies) is political*" (Morris, 2015).

The review of the book *Medical Malpractice: Theory, Evidence and Public Policy* published by Danzon, in 1985, declares the principles which have been its basis; these have been the economic ones which have promoted the increase of number of litigations in the middle of the 70s in the USA, known as the period of "malpractice crisis". The system by which indemnities are obtained as consequence of the negligence during the practice of medicine is seen as a system which brings a "control on the quality" of medical document. Discussions are raised about the relationship between the legal care standards and the "optimal" ones, about the type of "defensive medicine" and about the proposal of a new system which regulates and reduces the compensation level. The conclusion which completes the analysis of book declares that it could not be possible to answer to the most important questions about malpractice (Fenn, 1987).

5. Orientation towards the quality and safety of the medical treatment - monitoring and regulation

Another perspective is the one related to the quality of the medical documents within some larger processes for the monitoring of services quality. Waring and collaborators' articles follow more a historical approach, on an axis of time without offering sociological explanations circumscribed theoretically. At the beginning of 20th century, the American physician Ernest Codman asked physicians to track the progress of each

patient and, also, to analyze the causes of each of the poor therapeutic results (Codman, 1917); this method of monitoring can lead to the creation of a list concerning the error sources in medical conduct. Over time, many important progresses in the field of knowledges and medical practice have been, somehow, prohibitive by a wider policy of professional power, especially if new knowledges would question the autonomy and lawfulness of occurring medical occupations; this theme is consolidated by many contemporary studies concerning the medical regulation (Rosenthal, 1995). Starting from these initiatives, malpractice trials are begun against the physicians who have performed errors; initially, these have begun to be signalled in USA and their number has increased in time. The interest in quality and safety date since the beginning of 50s and until the 80s. It took place simultaneously with the evolutions from the modern medicine, including the explosion of advanced technologies of diagnostic and treatment, advanced procedures, new pharmaceutical products and the occurrence of some modern disciplines, like intensive care, emergency medicine and new surgical sub-specialties (Le Fanu, 2011).

An interest subject targets the exposure of the method in which the elite of professionals has tried to isolate the physicians from the managerial intervention in treating complaints. The standardization concerning the treatment of complaints at local level of a medical institution did not take place until the middle of 1960 and even then, it has been a preference for an informal approach.

The "scandals" from hospitals since the middle of 1970 have led to the occurrence of some committees which manage complaints but, the most comprehensive reviews consisted of defining the way in which the concession from the level of medical institutions succeed in preventing tougher actions. However, for many years, the process for the introduction of complaints included only physicians and not all of the initial practiced recommendations. There has been a minimum monitoring of complaints and a less use of this information to improve the medical practice. A theoretical approach includes the study of complaints reported to the medical conceptualization of lacks and patients' claims as consequence of some damages brought by negligence. Even though most of the lacks is caused by the failures of the systems, the legal structure encourages the perspective of an individualized guiltiness and the medical systems do not adapt easily to justice actions introduced by groups. The medical experts remain considerable as power in defining what is "deviant" and the lawyers are interpreted as "forbidden intruders" (Meerabeau, 2006).

The historical perspective by which it has been tracked the evolution of quality and safety of medical assistance movement identifies four phases of development. It is stated that only during the last three decades the subject has gained a political impulse on the international scene and this factor has led to researches in this field. The quality and safety in the field of health are central sociological subjects; medical sociologists face the dilemma of the necessity to advance towards a sociology of quality of safety or the development of a sociology for medical quality and safety (Waring, Allen, Braithwaite & Sandall, 2016).

The number of institutions and agencies which take care of the social control of medical profession increased progressively. Some reasons have been descried for which

the American physicians have succeeded in recognizing the problems of conduct and competence deficiencies of physicians. There have been some directions in which, new types of control on the medical occupation, could develop by the occurrence of many difference bodies which could be responsible of this control, both within and outside the profession. In comparison with their British counterparts, the American physician of the 1970s has become a professional body under the regulation power of a wide range of regulation entities (Stimson, 1985). This matter represents an attempt to exercise the control on medical activity, in a presumed free space, defined subsequently as market economy of medical care in which the influence of law becomes higher and higher. An additional matter is the importance of financial societies in the process of medical care. The phenomenon is facilitated by the fact that the majority of American physicians have begun to work in institutional or organizational settings (for example, as employees, members of the corporative institutions or beneficiaries of the indemnities performed by third parties - insurance systems) which increase the possibilities of activity supervision. Many features of the physicians' behaviour are monitored by the Medicaid and Medicare systems, as well as by insurances; the targeted companies have as primary objectives to limit the costs of medical and surgical services (Pontell, Jesilow & Geis, 1982). The organizations for the assessment of services analyze the costs of services financed federally and offered to patients to ensure that the supplied services are necessary from medical point of view, are supplied at the right prices from economic point of view and fulfil the quality standards recognized professionally.

The initial problem was the identification of the body which had to assume the responsibility for the evaluation and endorsement of physicians' competences; this role was disputed between the authorization councils of the state and those of the medical professional societies. The license becomes the responsibility of the state and the public council has received the responsibility for the disciplinary evaluation and the boards of directors are the only bodies with legal authority to revoke or limit the permission to practice medicine. In New York, the board of education has the responsibility of granting licenses for nineteen various occupations involved in the medical care. Moreover, this board is also responsible for other occupations, like accountants, social workers, professors and architects. The rules concerning the professional violations are encoded in the public rights and the offences include the limitation of occupation practice while the person is under the influence of alcohol, drugs or there are physical or psychic diseases, disabilities, among which narcotic, barbituric, amphetamine, hallucinogen addictions or other drugs which have similar effects. Also, it has been drafted a disciplinary investigation procedure for physicians.

The learning processes concerning the notions of malpractice, the recognition of potential litigious situations as well as the gathering of some skills which reduce these risks are the subject of some discussions within the medical occupation. These educational matters are part of the wide spectrum of medicine evolution from the professional's point of view. The sociologists appeal, repeatedly, to the notions of altruism, bureaucratization and personal interests in their effort to explain the changes at level of profession in the contemporary society.

Freidson defines an occupation as "a set of institutional regulations which allow the members of an occupation to build a life which they control the personal work" (Freidson, 2001). Gorman and Sandefur (2011) state that these institutional regulations refer to four central attributes: the specialty knowledges, the technical autonomy, the engagement to serve other as well as the obtained incomes and status (Gorman & Sandefur, 2011). The altruist reporting of the professional project has its roots in the papers of Durkheim and Weber, who have represented the group of physicians as occupational communities united by a vocation feeling or engagement against the service offered to clients or societies.

Pellegrino defines the altruism as "that feature which a person has to take into consideration the others' interests when they use power, privilege, position and knowledge" (Pellegrino, 1989). Barber goes further than this and he states that a "primary orientation towards the community interest, rather than to the individual self-involvement" is one of the defining features of an occupation (Barber, 1963). Wilensky agrees, suggesting that the "devotion towards the client's interests more than to the personal or commercial profit should orientate the decision when the two are in conflict" (Wilensky, 1964). From altruist perspective, the archetypal institutions of an occupation (containing long periods of education, ethical codes and supervision and discipline mechanisms) function to encourage and support the vocational engagement and to reassure the society that the medical occupation and persons which practice it are proficient and trustful.

In a study performed by the interview of 998 physicians in general medicine from the Wales, it has been identified an altruist engagement against the study and improvement of bureaucratic requests for the reporting of information concerning the incidents of medical practice, and also resentments concerning the changes from the occupational pack of the general medicine practice. The comments suggest that the bureaucratic evaluation of physicians has installed a series of formalized rules and procedures which have absorbed the resources in many ways, but which have not succeeded in identifying the malpractice or in facilitating the learning. The dysfunction, according to some comments from this study, is given by the fact that the official evaluation processes have not been really determined by the intention of improving the learning process or identification of malpractice, but rather by the will of reassuring or at least satisfying the requirements of public programs and policies. There are, as a physician has explained, "other imperatives than those purely educative". Another one explains the fact that it would be better to "exist an informal discussion without too many documents; the idea is that the Government will not bear anymore this thing". "The entire process", explains another one, "is generated by the professors from the ivory tower who try to answer to a political agenda which has nothing to do with the way in which we really learn" (Entwistle & Matthews, 2015).

The safety of patient is designed in a strong interrelationship with the one of malpractice. The current reforms concerning the safety of patients offer changes concerning the regulation of medicine. Based on the existing literature, it is stated that this political agenda represents a new border in the relationships between the medical and the managerial practice, offering the managers a disciplinary expertise within health services which provides knowledges and lawfulness to investigate and control the

medical performance by the procedures of reporting the incidents and the analysis of the causes which lead to the unwanted events. This tendency was followed in Romania by recent incorporation, in 2015, of the National Authority of Quality Management in Health (ANMCS); this structure took over the specific responsibilities by the reorganization of the National Commission on Accreditation of Hospitals, a new body within the autochthonous medical system.

As in the case of other organization, the physicians oppose to the managerial prerogatives by the attempt of undermining and "capturing" the components of reforms (including those which increase the regulations concerning the assurance of quality and safety). It is a phenomenon described as an "adaptive" one by which the physicians attempt to maintain the monopole and limit the government regulations. It is however considered that this process could signal the future "modernization" of medical professionalism within a larger context of reform from public sector in which the medical culture and practice are more and more internalized. This thing leads to self-supervision, self-management or "self-governance" forms, removing eventually the need that certain external groups manage or regulate explicitly the practice within the medical occupation (Waring, 2007).

The number of articles which analyze the regulation of the medical occupation in Europe seems a lot smaller, maybe because the process followed the American one. An example is offered by an article concerning the phenomenon suffered in Belgium. It is stated that the medical occupation suffered obviously a lack of internal coherence in the 19th century. The interests and objectives, for example, of the Royal Academy of Medicine, of the province medical councils and of the Medical Belgian Federation were not homogenous. Two general tendencies have been described: the legal unification of the occupation and its institutional development. Another tendency was focused on the impact of professional associations in the field of medical education and in the control of the medical documents from the practice point of view (Schepers, 1985).

It is possible that the Belgian physicians has not had an important role in the formulating of new policies and in the reforming of medical institutions. Few comments have been identified concerning the specific law. Various examples of quotes have occurred concerning the malpractice actions of some irresponsible physicians. The surgeons were content about their new legal status but, some physicians did not have their privileged position and would have preferred the prior hierarchical structure in medicine (Pollenuss, 1813, p. 62).[1]

6. The change of physicians' autonomy paradigm - Limitation of physician's "power"

Starr (1982)[2] analyses the past and present tendencies regarding the role played by the physician and enunciates a threatening conclusion. *"In the 20th century, medicine was the heroic exception which supported the decrease of traditionalism to independent professionalism"*. But,

[1] *Essai sur le disordre actuel en medecine et sur les moyens propres a le faire cesser*

[2] In the last chapter of the book *Social transformations of American medicine*

his analysis, suggests that *"the exception can now be brought to conformity by governmental rules"*. The special historical conditions which have allowed physicians the restraint of competition, the limitation of external regulations and the professional training according to priorities seem to give the lead to new tendencies; these are permissive for the occurrence of some strong third - party interests, the government and the company / organization which offers the service. It is heading towards a limitation of the physician's autonomy. Starr's conclusion is: *"Excepting the case in which it would be a radical change within the American economic and political conditions, during the last decades of the 20th century, it could exist of period of time marked by the diminution of resources and autonomy of many physicians, volunteers, hospitals and medicine schools*" (Starr, 1982).

Starr's book is characterized by the synthesis power and by the evaluation in due time of the crises from the American health system, observed in the '70s and continued in a certain extent now. As such, his book is obliged to have a significance and a long-term impact on history and sociology. As a synthesis, the book is remarkable, but it does not seem probably that it would become the standard reference concerning the American medical history, as some enthusiasts would have suggested. There are also some subjects which receive insufficient explanations, like medical malpractice and physicians' relationship with other occupations from the field of health. But such failures do not destroy the assembly power from the interpretation of Starr (Tomes, 1985).

The Charmaz's article presents a series of courses of Open University which approaches the field of medicine from the perspective of social sciences; it is observed the occurrence of some reference to the problematics of malpractice within one of he presented essays[1] It starts with the proposal that the resolution of current problems in the health care means to be based on an ample strategy which contains all the medical disciplines which are directed to problems specific to the health insurance. Moreover, the authors suggest that no matter of the proposed solutions, these will produce "problems".

The authors presume that the same problems re-occur despite of the social and historical diversity which the organization of the care systems enclose. The discussion abovementioned begins from the fact that the visibility of problems depends on the particularity of a care system. These authors succeed in getting closer when they say that NHS is, above all, "a national hospital". It is also a system dominated from medical point of view, as long as the members of the board of directors are selected rather than being chosen from the communities to which they belong. The relative lack of laic persons' power (not belonging to the medical community, patients) serves for the improvement of medical institution power. In comparison with the USA, the authors consider that the British physicians which work in NHS have more clinical freedom to treat patients, as they want, depending on the principles and knowledges which they have. The physicians of the USA can be somehow constraint, but not by their professional councils or by the colleagues. The endorsement from them are considered "cosmetic", without force. The constraints are imposed by regulation groups which

[1] *Caring for Health: Dilemmas and Prospects*

analyze the compliance of diagnostic and by the increase of number of malpractice processes which are more real and stressful in the current practice (Charmaz, 1986).

From a sociological perspective, the medical crises of malpractice, in the United States, can offer an opportunity to explore the response to medical occupation to the threatens on the practice autonomy. The way in which the physicians and jurists have responded in time can be seen in the content analysis of various articles from specialty journals and from the reflection from media; an increased attention is given to the development of a better report with patients, supplying many, credible information and involving the patient in taking the decisions concerning the care.

A special expression of the health "crisis" of the USA from the 70s is represented by the dramatic increase of malpractice litigations; this matter can be seen as an indicator of the threatens to professional hegemony and self - control of this occupation (Annandale, 2008). The reforms from the medical system of that date have led to changes in the physician - patient relationship, appealing so the patient receives more information and begins to have an active role in taking decisions concerning the treatment. The phenomenon of malpractice can be seen as one which promotes some of the changes which, a lot of sociologists observed to be essential for the improvement of the patients' care. The improvement of the therapeutic relationships, generally, can lead to a decrease of number of litigations, being in the centre of such a strategy. A second aspect of this situation is that any strategy used for the increase of satisfaction level of patients can be used to mask the possible errors of clinical practice.

A paradigm started from sociological theories is difficult to be identified even in larger papers which deal with the phenomenon of medical malpractice. Such an example is Merylin Rosenthal's book published in 1987[1]. The discussion is a comparative one, concerning two health systems, the one from the United Kingdom and the one from Sweden. The emphasis is on how a complaint is approached from procedural and organization point of view. The main role falls on the collegial structure of physicians, GMC - *General Medical Council,* respectively *Swedish Medical Responsibility Board.* The review published in *Sociology of Health and Illness* acknowledges the weak points of the book. The introductory presentation of sociology of occupations is somehow superficial. However, when sociological problems are resumed in the last chapter, the different methods by which the medical occupation exercises and holds the power are discussed in an attractive way. The discussions targeted the way in which the medical occupation succeeded in keeping the power and autonomy, both in Sweden and in Great Britain, despite the fact that it is a paid service from personal funds or one within a public contract (Stacey, 1988).

7. Physician - patient communication

The communication with patients represents an important matter, mostly in the situation of severe diseases or in the case of unfavourable news; the perspective of

[1] Rosenthal M (1987). *Dealing with Medical Malpractice, the British and Swedish Experience,* London: Tavistock Publications

Taylor's article is limited to the oncologic cases and especially to the situation of mammary cancer (Taylor, 1988). The central event against which it is done the analysis is the initial communication of diagnostic. It is attempted the identification and the method in which it is implemented an organized system of policies and strategies for the disclosure of diagnostic; even though this duty can fall in a work routing for physicians, it is characterized as a difficult and unpleasant one.

One of the fears recognized by physicians is the risk against the eventual potentially litigious practices for malpractice; for example, if a patient is discovered with cancer and he declares subsequently that he has not been informed about all the options of possible treatment. The study is a qualitative one, of ethnographic type, presenting discussions within the therapeutic team, between senior physicians and residents.

In comparison with many sociological studies which follow the way of transmitting bad news, the emphasis of this report was on the person who communicated the news, rather than on the patient who received the news. Three phases are identified: preamble, confrontation and spread of bad news. Four strategies are used to spread the message: evasion, dissimulation, approval of uncertainty and truth. This report suggests that the event of communicating bad news is perceived by the physician as a stressful one. As response, the physicians find complex methods to transform this duty in a routine (Taylor, 1988).

The improvement of didactic matters includes ideally the perspective of both parties. It is necessary a method in which this information can be useful for those who want to improve the communication between patient and physician. For example, the patient's education, the informed consent, the public discourses and regulations obtained a special importance in the medical care of North American in the 1980s. it is emphasized, more and more, the importance of patients' rights and the patient's involvement in taking medical decisions. If the objective is the open communication between the physician and patient, then the physician's preoccupations cannot be ignored. It can be easy and familiar for some sociologists to explain the apprehension of information by the patients only from the perspective of physician's power and it can be contoured as the result of a lack of professional responsibility. For sure, this distribution of power plays a certain role. However, this study suggests that this reason cannot be enough to explain why physicians adopt, maintain and transfer a certain communication policy.

Second, the way in which physicians have chosen a communication policy and which social systems encourage and support each philosophy needs a careful analysis. The medical education, the modelling of physician's role and the reward system from the hospitals provide valuable hints. Eventually, the communication policies of physicians should be seen and evaluated (Taylor, 1988).

The article wrote by Rayner brings forward the modification of communication between the physician and patient in a new perspective, different from the usual one until that moment; the medical perspective and the care one is quickly replaced by a legal one. One of the interesting features of the dialogues between a cardiologist and a mother is the way in which a complaint, which refers to a treatment, is transformed in

the discussion of the legal basis of the mother's claims and their viability, in her special case, in front of the court. Despite the few sociological researches about this matter of conflict, the introduction by a mother of the legal problem against the physician's action on her child cannot be considered unusual: the general problem of malpractice is one of the central matters of policies of USA in the 70s, leading, among others, to an explosion of the malpractice insurance premiums, to physicians' strikes and to a defensive attitude from the medical occupation which has reflected in a noisy lobby in various states to modify the legal process (Rayner, 1981). Other associated phenomenon would result from the vulnerability of profession to the legal action: the practice of a "defensive medicine" - by which physicians use useless diagnostic procedures only to "cover" themselves, as well as "the abandonment of patients" - the refusal of physicians to treat them in situations with potential litigious circumstances or their repeated transfer to other services or physicians (for example, under the legal or procedural "cover" of the competence levels or technical equipment). The detailed analysis of these matters can bring important information.

The Lupton's article regards only tangential the problematics of medical malpractice, but he brings into discussion the change of social position and status of medical occupation and the extent in which the consumerism has entered in the relationship of physician - patient. To approach this subject, it has been performed an empirical study using semi-structures interviews, deeply, with 20 physicians who live and work in Sydney. Three major matters are discussed: the extent in which the social position of physicians has changed, the impact of consumerism in the medical practice and the qualities of a "good" physician. The involvement of this data for the theorization of contemporary medical practice type, of power and status of professionals are explored, referring especially to the perspectives offered by the theory of Foucault.

An essential matter is represented by the understanding by physicians of what their patients want and the way in which these conceptualize an adequate medical practice; an accent is on being a "good communicator", on empathy and on the need of offering the patient the opportunity of assuming a higher "responsibility" by the spread of the uncertainty which he feels (Lupton, 2008).

8. Media impact – press and public reaction

The American medical profession has received, also, a bad publicity by the failure to discipline their members. Some cases of the 70s draw the attention of the audience to the problem of malpractice and damages brought with the occasion of practicing the occupation of physician. The first of these cases has referred to Dr. Max Jacobsen who has been the physician of the president Kennedy. The Jacobsen physician has had a lot of rich clients anchored in the "trend" of those years; the therapeutic ideas and options of the physician were unusual concerning the therapeutic benefits of amphetamine. The treatment had, in some case, terrible results (Derbyshire, 1974). He was accused of the irresponsible prescription and improper use of such drugs. He was excluded from the national medical society, but the professional organization did not have the power to prevent him to practice privately and in his case, it was directed to the public disciplinary council.

This period has seen, also, the occurrence and development of a critique audience. In comparison with Great Britain, the consumer's requirements become more explicit and more significant in the attempt of determining the quality and type of requested medical care. This critical consumerism has been developed further in the 70s. It was more and more present in the critique publications related to limitations and failures of modern medicine; these are familiar during the periods which followed. It is developed a form of strong assessment of consumers from the medical field which is emphasized by guides of patients concerning the medical care and patients' rights. The appeal to the patients' rights manifested by the support groups of patients led to an increasing interest for alternative forms of medical care and additional forms for promoting the health. The American medicine confronted, more and more, with an analysis about personal performance. As Starr says, "*For the first time, the American physicians confronted simultaneously with a serious challenge concerning their political influence, their economic power and their culture concerning authority*" (Starr, 1982).

Until relative recently, the individual choice has not been a priority in NHS (public British system) and trust has been taken a present parameter (Gilson, 2003); physicians have been obliged to observe the rules of professional conduct and it has been assumed that everybody, as a unitary professional body, are trustful. A series of public scandals which have involved the public health system have raised a series of questions concerning the quality in the field of public health and even have announced a failure of the system in England (Quick, 2006); also, questions have been raised about the utility of an unconditional trust in an occupation which is self-regulated. Moreover, "relatively isolated cases have been handled to build an exaggerate fear against the possibility of medical malpractice on a wide range within NHS" (Brown, 2008). By the transformation of patients in informed consumers, it has been assumed that it is obtained a reduction of the physicians' power and an improvement of the care quality. The rational perspective of such reasons is simple: the supply of information to patients allows them to request a certain treatment where the providers of health services will march to the disclosure of information concerning their performance or they will even attempt an improvement because, otherwise they will risk the closing of the sanitary unit. Offering to the NHS patients the free choice of the place where to be treated, when, where and how, it would have been suggested that it is obtained a more responsible care and even to reduce the importance of interpersonal trust, which this vision equates with dependence (Davies & Rundall, 2000).

The introduction of clinical governance within the National Health Service of Great Britain dates since the publications of early policy of the labour government, during 1997 - 1998. The development of these documents can be understood within the context of the increase of litigations costs, of awareness of large variations of care standards, of the basic economic problem referring to the limitation of resources and increase of request for health services. The concept presupposes the monitoring of some important parameters of medical services (including data about mortality, morbidity, nosocomial infections and other sensitive subjects); this set of indicators are reported regularly and have as purpose the increase of care services quality.

The conceptualization starting from this direction has disclosed that the most pertinent problem, according to many analysis of clinical governance formation, is the need to

restore the public trust in NHS (Alaszewski, 2002). The situation of trust both in the health systems and in the physicians as professionals continues to be a problem which needs a deep analysis. This accent concerning a "trustful" NHS has become, obviously in the legislation itself, and in the literature, which supports that the "interest for clinical governance has occurred because the individual professionals have betrayed the audience trust". The proofs of such betrayals include the series of "catastrophic failures in the diagnostic of bone tumours in Birmingham, the pediatric heart surgery in Bristol and the cervix screening in Kent and Canterbury" (Freedman, 2002) which have occurred at the end of the 1990s. The removal of the organs from the deceased patients, without the consent of the next of kin, which has taken place at the hospital Alder Hey of Liverpool, has completed this list of "dysfunctions". Especially, the Bristol case has been described as a "milestone in the development of health services and social care in the Great Britain" (Alaszewski, 2002), because its status of institution with high reputation and the similarity of findings of the subsequent public investigation with the reports concerning the heart services from Royal Brompton, Harefield and Oxford, has been considered an emblem of many endemic deficiencies, of the system, generally. The presentation method in the media of some relatively isolated cases can be considered manipulative to build an exaggerate fear concerning the possibility of medical malpractice on a wide range within NHS. The attention which must give to the media, as social mirror, whether of how manipulative or without loyalty it would be, must be adapted to the analysed situation.

The problem of trust reduction is extremely multi-rooted, more complex and spread than the simple incompetence, negligence or malpractice of some physician seen separately. Consequently, the avoidance of future dysfunctionalities in NHS could help to the slowdown of the trust decline, but not enough to blow over which represents a deeper tendency (Brown, 2008).

The review of Horowitz R.'s book, *In the Public Interest: Medical Licensing and the Disciplinary Process* (New Brunswick: Rutgers University Press) approaches themes which are current for the media from the last years. The mass-media and the legal system have begun to influence the public interest towards the organizational structures of medical profile and, also, it influences the discourses and the way in which various bodies supervise the medical activities. For example, mass-media draws attention concerning the inefficient complaint on medical management forums and the lack of disciplinary action on the physicians after the complaints enunciated against them. These matters have become a problem in the attention of the audience and, subsequently, legislative changes have been promoted (MacBride-Stewart, 2014). Within conceptual terms, Horowitz notes that there a lot of practical problems in the practical implementation of the democratic governance forms: difficulty for the involvement of audience, the fragmentation and orientation towards regional of the management bodies, the challenges brought by the principles of efficiency of medical practice and tensions related to the individual intimacy, community and scientism. A substantial critique is addressed to Elliot Freidson who says that the medical occupation needs a strong medical community; the promotion of the social closure "narrows the professionals" who act from the perspective of public good and, thus, it would work against the democratic deliberative processes, contouring the hypothesis that physicians refuse to

submit a testimony against other physicians in the name of good fellowship. For the medical sociology, the ideas of the author contribute to the continuation of debates about the regulation activities of medicine as occupation and offers a perspective on the principles which governs the public engagement and that of the patients. (MacBride-Stewart, 2014).

9. Orientation towards physician and towards particularities of the clinical practice - Results of the "malpractice crisis"

It is contoured the identification of a new social problem which becomes more and more real: physicians have problems of professional conduct and pathological ones. The question was if this problem has significant dimensions to justify the worry, action and financing. This thing proved to be difficult because the deficiency of environment tends to be secret. Many "moral guardians", mostly from the publicist area emphasized the identification in the public area of a multitude of social problems (abuse on the child, drug addiction, pregnancy at teenagers) and tries to prove that the problem, in the case of affected physicians, is quickly growing, it has to be sounded the alarm on a common problem which until then remained hidden from the public sight. The organizational response did not delay; programs was contoured for the "affected physicians". The initial conception that the physician is "affected" lead to a proliferation of public medical societies activity, has allowed the professional medical societies to establish the problem as one of internal responsibility of physician and have treated it as one similar to a disease than a social deviant one. The programs have tried to intervene to help the physician, more than to allow that some behaviours of the physicians become a disciplinary and license problem. The general organizational model for professional medical societies was to establish a committee for physicians with deficiencies, also composed of physicians. Confidentiality measures will be introduced to protect the physician's identity and the license to practice and, eventually, it is introduced a final sanction (for example, reference to the public license council) in case which exceed a certain severity.

The movement of this type, which regarded the physician as "affected" party was capable to occupy a significant area of professional deviation of physician, but also to maintain this thing far from the control of bodies which grant licenses. The medical occupation kept a high level of autonomy in the matter of self-regulation. The problem was not settled to a control exercised by the professional societies and there was also a reticence of certain public medical councils to allow the medical societies a full freedom to act: there are variable conditions concerning the societies' obligations to report the physicians with problems to the public councils. Also, the conditions for the occurrence of some satisfying requirements for a better control of consumers on the physician's performances have been met even though, at the same time, it excludes efficiently the patients from these control activities.

Another perspective is focused on the analysis of details of some litigations; which the parties hope to obtain, the way in which they express their needs and justify the

behaviour. Even when a complaint is taken seriously, generally, there is a piece of discontent and the plaintiffs feel vulnerable against the dominant role of the physician; it dominates the complaints in which it is declared that there are modified forms of patient - physician interaction. The researches of Mulcahy proved that the complaints also had a long - term effect on physicians who perceived that they were not defended by the profile organizations. In the discussions with colleagues (as professional socialization process), the physicians consider that the complaints are "normal", tent to regard them as a "normal" reaction to disease and, consequently, do not reflect really the situation and personal professional actions. The complaints are symbols of higher threaten of consumption and identification of some laic assertions which prove the difficulties of integration of medical occupation within social framework and incapacity to integrate the bureaucratic models of supplying medical services (Meerabeau, 2006).

The article of López does not bring information concerning the theoretical framework of the malpractice concept but identifies different reactions of physicians against those of the nurses, just as consequence of the felt litigious risk. It is discussed about an ethnographic study of Chambliss and it is argued concerning the advantages which such studies have when observing the medical practice. Such a study is centred on the observation and analysis of daily life flows within institutional context, it is capable to explore the power relationships, institutional routines and cultural scenarios (Lopez, 2004). Depending on the perspective of each professional group involved in the care of a patient, the therapeutic attitude as well as the emotions can be different; there are situations described as crises between physicians and nurses. For example, when we take into consideration the treatment of patients with terminal diseases, the physicians tend to prescribe some "aggressive" treatments, due to various reasons, but, most probably, due to the fear of malpractice costs (Chambliss, 1996). The faith in his medical efficiency is ignored, it is forgotten the main responsibility of saving lives or, it even seems that there is a relative ignorance towards the patient's suffering. This is opposed to the nurse's frustration (to whom it is imposed to work, administer the treatments prescribed by patients) who see that the patient makes no progresses and who even asks to be let alone.

The paper of Horobin and McIntosh does not bring information concerning the theoretical framework of malpractice concept; it is based on interviews on a sample of 50 physicians and their perceptions about the available time as resource and the duty which they to fulfil concerning their attempts to create satisfying work roles are explored. It is described a contrast between the physicians from the urban and rural environment at this moment. For the physicians from urban communities, the economy of time functioned as a rare resource and which generated a risk element by establishing quickly a routine diagnostic. For the professionals from the rural environment, time was not seen as a reduced resource, but they confronted with the risk of working without additional services to support the diagnostic. As consequence, most of the physicians confronted with the problem of activities which contained a variable mix of risky situations or some routine ones. At this moment of medical practice, the aspects followed in this paper continue to be present; the litigious risk degree for the primary medical practice and for the one of the rural environments is a more reduced one.

There is a perception in which the use of diagnostic packs or stereotypes are understood in the usual practice; the aspect is based on the grounds of the traditional clinical medicine in which the "disease" is conceptualized as an independent entity of individual person. So, while individual variations concerning the signs of disease, the reactions to diseases and the consequences of diseases must be expected, the disease itself is recognized and treated in a similar way. A finite range of diseases have a finite series of signs and symptoms which are learnt during the medical training. This method of regarding things, reported to the content of duties in the medical practice, helps us understand why the problems of "social", "psychological", "emotional" or "personality" type are often considered overwhelming for this type of practice. The solutions to various problems by the use of some routines can involve a failure risk, in unusual, severe risks, but the risks are limited for the primary medicine in the rural environment and the costs related to malpractice are reduced (Horobin & McIntosh, 1983).

Gross does not bring information concerning the theoretical framework of the malpractice concept but position this matter in a list of factors which generate stress for a certain part of physicians (cardiologists) and in a comparative analysis of two health systems (the American and British one). The malpractice is situated on the fourth position after burnout, the diminution of autonomy and the loading with responsibility; in the inferior part of the "classification" the following have been registered: lack of resources, insufficient time, role conflicts and interpersonal conflicts from the place of work. The occupational stress which the cardiologists experiment differs depending on the health system in which they perform the activity; the rationalization of medical care differs in the United States in comparison with Great Britain. From the interviews of this exploratory study we find that the American physicians complain about the increased limitation of autonomy which results from the intrusion of government and insurance companies. The 21 British cardiologists give a higher importance to the work volume and lack of resources in the National Health Service. The stress is associated with higher types of rationalization of health in the two countries. In the United States, where is an explicit rationalization, external controls are placed during the hospitalizations, paraclinical tests and medical procedures, the physicians' fees and the use of drugs enter in a normative control process. In Great Britain, the implicit reasoning is imposed by the general limitation of financing the medical care, letting the physicians free to perform clinical studies and take decisions. However, the medical care for all the members of the society is limited by limited financing and lack of facilities, achieving the creation of some long - term queue. (Gross, 1994).

The recent initiatives of the health policies of the United Kingdom promote a "no blame culture" and the learning from side events to increase the patients' safety within the public health system NHS. Similar initiatives exist in USA and Australia. The change of "blame culture" of NHS was supported in politics by investigation documents and reports for over two decades. Some of the key concepts are used in the political discourse - "blame" (errors, mistakes) and - "culture". These are examined and reconsidered in the light of scientific social literature and some of the hypothesis referring to these terms are doubted and suggest some questions and alternative perspectives (Ehrich, 2006).

It is recognized the intra- and inter-professional difficulty to report errors and violations from the doctors; an interpretation of social perspectives as an alternative to the approaches oriented towards the managerial matters of the patients' safety can focus on deeper structural matters of organizational matters, on the capacity of system or of the medical personnel to report mistakes and violations as a matter of patients' safety (Ehrich, 2006).

How do the physicians build the medical "interactions"? Berg states[1] that the perspectives developed in the sociology of science (especially the so-called laboratory studies) can be helpful in the approach of this relatively unexplored problem. At the level of clinical action, the medical sociologists separated until now, generally, the "content" of medical action from the "social" matters, the first one representing a field which is not accessible to the sociological investigation, being pure professional matter, technical from the medical practice. This asymmetrical approach of "cognitive" and "social" elements is since the historical and examination data of patients are considered "facts" which the physician must "disclose" because there are also scientific data, considered "fixed". A "laboratory study" of solving medical problems in the clinical practice shows that these hypotheses are not valid. It is argued that the physician, when transforming the problem of a patient in a resolved problem, do not combine only some "cognitive" elements together, but he also articulates actively a series of heterogeneous elements, which are in a continuous transformation. In this construction process, the elements participate and transform in a process which can be called "routine" (Berg, 2008).

The routines ease the medial action by the materialization of some professional action methods and to avoid the transformation processes and, at the same time, provides a framework which delimits the adequate actions from those which are not considered compliant. The routines do not simply dictate the use of an instrument but define the contact between the physician and laboratory (regarded as an extended instrument) and establishes what tests are relevant to establish a diagnostic.

The list of elements which compose the routines has only a heuristic basis. Multiple "contextual" elements can be added permanently, like: the need to "cover" itself taking into consideration the possibility of materializing a "malpractice complaint", the will to act or not of the patient, regulations, the physician's involvement in the scientific, research and educational field, and so on (Konner, 1988).

The sociological perspective emphasized various involvements of malpractice; it was described as a crisis of patient's care at the level of the micro-relationship physician - patient. First, there is a transfer cost under the form of higher costs or services and for third party insurances. Second of all, the economic cost for physicians can lead to a diminution of services volume (Epps, 1986). This thing was remarkable in the so-called specialties with high risk, like obstetrics where the physicians were forced to give up at practicing the occupation. In a report of 1986, the American College of Obstetrics and Gynaecology (ACOG) acknowledges that 12% of the physicians with this specialty gave

[1] In the paper *The construction of medical disposals Medical sociology and medical problem solving in clinical practice*

up to obstetrics due to the threatening with malpractice. Moreover, many physicians from primary, family medicine reduced, during that period, the obstetrics services due to the same reasons (Annandale, 2008).

A more discussed aspect of the malpractice crisis has been the practice of "defensive medicine" about which, many researchers tell that it promotes not only useless costs or the consumer, but also lesser possibilities of choosing for the patient. It is difficult to decide to what extent the decisions taken by physicians in treating the patients are influenced by the threaten of malpractice. Hershey draws the attention on the problems associated with the "*difficulty of differentiating which seems to be a good medical practice from the defensive practice of medical interventions and the need to assess subconscious aspects as the conscious influences caused by the awareness of liability"*. His study, based on unstructured interviews with 17 physicians from the private practice, suggest that the practice of a defensive medicine varies depending on certain "*personal features of physicians and patients which they consult"* (Hershey, 1982).

The response of the physician to the crisis of malpractice followed certain directions in the attempt of medicine of repairing the economic and social damages of the occupation suffered as consequence of the occurrence of this contemporary phenomenon: (1) lobby for modifications of legislation, (2) lobby for the modification of public opinion and (3) primary and secondary prevention by the "management" of physician - patient interaction (Annandale, 2008). An example was *AMA Special Task Force on Liability Action* which represented an educational campaign to "improve the public understanding" and to educate patients concerning the medical malpractice (Montgomery, 1987). The campaign involved the publishing of some leaflets for the patients, available in many medical practices. The public reaction was not only positive one, but sometimes it took comic aspects as it existed in a pamphlet distributed by Rhode Island. It said that the medical society told the patients that "medicine was a precise science; each patient is different and will react somehow different concerning the drugs and treatment. Despite the best efforts of a physician, some patients do not obtain the results which their physicians expect, after a certain treatment of medical procedure".

The third way in which the medical profession attempts to repair or prevent the damages caused by malpractice is represented by the modelling of interaction with the patient, being able to be constituted as source of litigation. The controversy doctrine of the informed consent is crucial to understand why physicians localize the source of costs of malpractice in the relationship physician - patient. In the complaint of negligence, the plaintiff must prove a causality between the failure of receiving the information considered necessary and the caused damages (Koopersmith, 1984). The roots of the informed consent is found in the recognition of the right to self-determination of the patient which could be interpreted by the fact that the "physician must give the patient enough information about the proposed treatment, such that it offers the occasion to make an "informed" or "rational" choice concerning the possibility of subjecting to a treatment" (Robertson, 1981). The capacity of informed consent to increase the self-determination of the patient can be questioned. The rhetoric concerning the informed consent offers a higher possibility for the medical paternalism. In practice, the informed consent can be more than a formality. But,

however, its central functions in practice, are to establish a physician - patient relationship to prevent some malpractice situations. Harrison and collaborators (1985) observe, for example, that *"this relationship is one from which all the obligations which fall on the physician result and without this relationship no negligence can exist or the violation of duties"* (Harisson, Worth, & Carlucci, 1985). It has been explained why physicians and lawyers cannot focus on the negligence itself, but, rather, on the failure to communicate with the patients.

Conclusions

The approaches of the medical malpractice phenomenon remain some limited to a perspective centred on a determinant as it is the communication physician - patient, therapeutic relationships, quality of medical document or costs related to the medical care. The identification of a unitary sociological theory remains a desideratum. Such a theory could offer a clearer image against the one which we can project with the current approaches.

Current research seems to be directed, separately, either to some individual determinants (such as the doctor-patient relationship or communication with the patient) or to some general or even systemic ones (such as general aspects of medical practice, related issues costs of medical care, monitoring the quality and safety of medical treatments through formal regulations or the impact of press releases). The sociological approach can bring an overall, integrative vision. Ethical aspects can also be an important element being confronted with a somewhat antagonistic analysis: ethics centred on the individual and his rights (a Hippocratic, classical ethics) and ethics centred on groups of people or populations (a functionalist ethics).

The so-called "crisis of malpractice" from the American health system had as enter the incapacity of the insurance system of supporting the avalanche of requested indemnities. The economic approach proved to be a limited one and could not explain the subsequent evolution of the phenomenon. Subsequent researches went deeply identifying a series of determinants in which the cultural factors or one which are related to the individual opinions of people proved to be important too, but the enunciation of such a unitary sociological theory delayed occurring.

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THE SIGNIFICANCE OF THE PSYCHOTHERAPEUTIC PROCESS: AN ANALYSIS OF CLIENTS' AND PSYCHOTHERAPISTS' PERSPECTIVES

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Abstract: *Studying the perceptions of the therapists and the clients on the meaning of psychotherapy is important because through them one can grasp some of the realities of therapy that cannot be studied through conventional quantitative research. Reintroducing a phenomenological perspective may further ease our understanding of psychotherapy in general. In this study, the action of giving significance to one's experience is used to describe the perceptions of the psychotherapists (N=137) and the clients (N=103). The analysis used in the study, a version of grounded theory research, revealed that when it comes to the significance given to therapy, psychotherapists and clients tend to have similar opinions. The categories found in the clients verbatim were self-knowledge, personal development, answer, help, healing and others and in therapists' responses were: self-knowledge, healing, solution, personal development, change and others. The different themes were help for the clients and change for therapists. The difference in the analysed categories is a conceptual one, psychotherapists tending to be more idealistic in their meaning giving process than clients.*

Keywords: *psychotherapeutic process; clients' perspective; therapists' perspective; psychotherapy meaning.*

Introduction

In this paper, I will analyse the perceptions of the clients and the therapists regarding various elements of the therapeutic process. The complexity of the psychotherapeutic process doesn't allow the researcher to reveal the process as a whole, but rather different elements of the perspectives of clients and psychotherapists. The action of granting significance to one's experience can be considered a sum of points of view, all integrated into a single one. Understanding the act of granting significance is similar to

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the understanding of the process of analogy and metaphor, which is widely used in the humanistic approach of psychotherapy, and in this paper, it is a research method. It is important for the psychological knowledge to understand to what degree psychotherapists and clients form a similar representation of the therapeutic process and where their opinions diverge. This study doesn't intend to present an analysis regarding different schools of psychotherapy from Romania, but an understanding of the view on psychotherapy regardless of one's studies, school of knowledge or other therapeutic factors. This applies to the clients as well, their diagnostic or motive for undergoing psychotherapy was questioned but was not used in the analysis. The main goal of this research was to have a larger understanding regarding how the psychotherapists and clients understand what is happening in the psychotherapy sessions.

When studying the perspectives on psychotherapies of clients and therapists in recent research, one will stumble upon elements of the therapeutic process such as: working alliance, therapy outcomes, changes brought by therapy and so on. One such study is *A meta analytical research of the perspectives of clients and therapists on the psychotherapeutic process* by Tyron, Blackwell and Hammel. The researchers made a comparison between the perspectives of both psychotherapists and clients regarding one component of the therapeutic process: *the working alliance*. The studies included in the analysis had a series of inclusion criteria such as: defining the alliance as working alliance, helping alliance, therapeutic alliance, working relation etc.; the study had to be published in a certain timeframe, between 1985 and 2006, the researcher had to include either a correlation between the working alliance viewed by therapists and clients or a comparison of the mean score, the design had to include at least 5 participants, the therapeutic process had to be an individual one, the research was based on the same assessment instrument for therapists and clients, the publishing language, English. The Working alliance was measured from the perspective of adult clients and researches which used particular instruments to measure alliance were excluded. From 300 articles found via PsychInfo, Medline, Google Academics, 53 fulfilled the inclusion criteria. To better understand the gathered data, the researchers categorised clients based on their claimed causes that lead them to psychotherapy: light dysfunction 37% (clients were recruited either by colleagues and had no known official diagnosis), medium dysfunction 44% (depression/ anxiety disorders, substance abuse etc.) and severe dysfunction 19% (clients were recruited from hospitals with various psychiatric diagnosis). The psychotherapists were: 17% psychotherapists under supervision, 52% experienced, and 29% of studies used psychotherapists from both categories. Other criteria used in the analysis were: number of sessions, type of psychotherapy and instruments used in the working alliance assessment (Tyron et al., 2007). The data provided by the selected studies analysis had two stages: in the first stage, researchers did a meta-analysis to obtain a correlation between clients and therapists assessment of the working alliance. From 2 331 therapist-client dyads the mean correlation between working alliance assessment was r= 0.36, SD= 0.00.

The other analysis included the difference between the assessments means of therapist and clients. The difference between the two means was 0.63, SD=0.42. The possible mediators of these relationships were: the level of dysfunction of the client, the

therapists experience, therapy length, the assessment used and the type of treatment. They observed that the level of dysfunction the client had was a mediator for the evaluation of the working alliance: the discrepancy between the therapist and client regarding the working alliance was smaller when the client had a severe dysfunction than a moderate one (Z=6.67. p<0.001) or a lighter one (Z=7.11, p<0.001). From the perspective of the therapy length the discrepancies were larger in the short-term therapy (≤20 sessions) than in 21-39 sessions. The level of experience of the therapists had no influence on the assessments. When it comes to the types of therapies, Tyron et al. found that: behavioural therapy was a stronger mediator for the discrepancies than psychodynamic therapy (Z=2.38, p<0.05), but not than humanistic approaches (Z=1.72, p>0.05). This meta-analysis indicates that between the perceptions of clients and therapists regarding an element of the therapeutic process there can be convergence and divergence. The correlation between alliance assessments by the dyads was a moderate one, r= 0.36; this relation was not mediated by any of the factors listed above. This means that the views of clients and psychotherapists are only moderately the same when it comes to the therapeutic alliance (Tyron et al., 2007). The manner that the authors chose their studies, based on what the therapeutic alliance is, can represent a weak point of the study. Even if the instruments used in the researches are not created for a specific type of therapy, the therapeutic alliance is defined in a different way, depending on the therapy orientation, specifically what a humanistic oriented therapists may find as an indicator for a well-established working alliance, a therapist from a different approach might find it a sign of weak alliance.

A more recent research, *Deconstructing the therapeutic alliance: Reflections on the underlying dimensions of the concept* analysed this difficulty to conceptualise the therapeutic alliance. M. Krause, C. Altimir, A. Horvath (2011) described different approaches to describe alliance, their inaccuracies and difficulties. The researchers choose not to describe the therapeutic alliance as a static concept but a rather fluid, complex one that evolves in time. To explore the differences and similarities between therapists and clients a systematic exploration was used to establish how each side experiments this aspect of the therapeutic process. The examples used in the research were extracts from 5 different studies: one from Germany (Krause, 1992 apud Krause et al., 2011) and four from Chile (Altimir et al., 2010; Krause, 2005; Krause, Cornejo, 1997; Winkler, Avendaño, Krause, Soto, 1993). In all the researches above, the participants had to respond to semi-structured questionnaires with open questions which explored their experiences regarding the therapeutic relationship, the changing process etc. The therapeutic alliance was segmented in different components:

a) *Affective reciprocity and emotional expressions:* both clients and therapists considered that the emotional bond and its manifestation is a primordial ingredient for developing a therapeutic relationship. The clients expectations for the therapists were that the therapists were kind, emphatic etc. and the need to consider that the therapists can put themselves in their shoes. The therapists on the other hand emphasised the necessity of openness from their clients.
b) *Acceptance, trust and understanding*: the acceptance capacity of the therapists was one of the precursors of a well-established therapeutic alliance from both clients and therapists point of view. The therapeutic alliance in this study is viewed as an

emotional manifestation of the therapeutic process, in which the two main actors have mostly convergent perspectives.

The most difficult part in Krauss's et al. analysis is to differentiate between facts and opinions of participants and their ideals, when it comes to the way they imagine a client-therapist relationship. The perspectives on this element of the therapeutic process are projected from different stances: most of the times from positions of authority-submission/collaboration and the perspective of the therapist must include not only his own, but both of them.

An ignored aspect by most researchers is the measure in which what therapists and clients say is actually what happens in the therapist's office. M. Blanchard and B.A. Faber [1] (2016) explored the process that the clients go through when they lie to their therapists. This research includes the whole spectrum of conscious dishonesty including moments where clients lied, minimised, exaggerated events, invented stories or hidden the truth. In this exploratory study, 93% of clients declared that they had lied to their therapist with a total of 1 616 lies reported to the 547 participants. The younger clients were more prone admitting to lying that older ones ($r=-.0.16$, $p < 0.001$). One of the authors interpretations is that these lies can be a sign of weak therapeutic alliance, of lack of trust between therapist and client (Blanchard, Faber, 2016).

Blanchard and Faber's approach is one inspired from the social psychology science, where the accent is on the action and its social context, in this case on client and therapy process. I believe it is vital to include, when talking about psychotherapy, concepts as transference, countertransference and defence mechanisms. The negative reactions towards the therapist can be a manifestation of transference and the sheltering of the therapist may indicate that the roles in therapy were reversed. This distortion of the reality of therapy can be conscious or not, and the degree of consciousness of the distortion can be correlated with factors such as: diagnosis (if it exists), at what point in time the therapeutic process is, space and other aspects regarding the therapist as a person. In this research, I use the terms of sense and significance of the process because they imply a more thorough processing of psychotherapy and its effects as opposed to an open question where the therapist or client is asked to evaluated what technique and what type of therapy worked.

Convergent opinions on the same psychotherapy issue from the therapist and clients are sometimes hard to encounter, furthermore, therapists can sometime start the therapy process with a series of predetermined beliefs. Mick Cooper (2010) exposes these psychotherapist beliefs in one his studies[2]. One of these pre-established ideas that is criticised here is that the therapist know well how their client experiment psychotherapy. The author offers examples from the studies that researched this topic that reveal the divergence between clients and therapists in regards to therapy in general, but also in regard to the components of therapy (Cooper, 2008 apud Cooper 2010). He debates one study that shows that psychotherapists tend to overestimate the efficiency of the services that they offer, 90% of the questioned therapists placed their

[1] *Lying in psychotherapy: why and what clients don't tell their lying in psychotherapy*

[2] *The challenge of counselling and psychotherapy research*

expertise in the first 25% when it comes to evaluating the quality of their given services (Dew, Reimer, 2003, apud Cooper, 2010).

Some authors don't subscribe to the idea presented before, that for a well-established therapeutic alliance there has to be an overlap between the opinions of therapists and clients. Holmqvist and Philips (2016) reached the conclusion that there are other factors that predict a good collaboration between the two than an accordance in their views on the client's problems. The goal of their study was to explore to what extent the opinions of clients and therapist align when it comes to the clients' symptoms of anxiety and depression and if these concordances are related to therapy outcomes and the working alliance. The results showed that there was only a medium accordance between therapists and clients opinions regarding the symptoms and that this level of accordance was not correlated with the working alliance or therapy results. The authors conclude that one of the most notable result is that therapists identified symptoms of anxiety and depression in clients that didn't report these kind of problems; not only this, but a part of the clients had high scores in rating scales of depression and anxiety but the therapists didn't report that such problems existed. (Holmqvist et al., 2016). The results of this study are important for understanding the therapeutic process and its implications. The discordance between the perceptions of the symptoms may have a series of explanations that imply not only the complex problems that a client may face, but also the level of professionalism and experience a therapist has. It is common that a client, when commencing therapy to overestimate or underestimate his symptoms trying to protect himself. When facing such mechanisms, a therapist can only get close to the internal reality of the client, not to completely grasp it. Another aspect is represented by the level of professionalism of the therapist himself. Some of the therapists in Holmqvist and Philips's study only had some courses in psychotherapy, without following a degree in psychology and some of them had as a main profession nursing and social worker. The necessity of studying psychology, especially in a clinical practice is crucial.

Studying the perceptions of therapists and clients on the meaning of psychotherapy is important because through them one can grasp one of the realities of therapy that isn't studied anymore as a result of the grounded methods of research in this timeframe. Reintroducing a phenomenological perspective may further ease our understanding of psychotherapy in general. One study came close to this view, specifically trying to understand the relational depth in psychotherapy through recording one session of therapy. The term of relational depth was first used by Mearns in the 90' and it can be conceptualised as a "*state of profound contact and engagement between two people in which each is authentic with the other and is capable of understanding and valuing the other one's experience at e high level*" (Mearns, Cooper, 2005, apud J. Frzina, 2012, p.52). This particular conceptua–lisation is relevant for the present study as it describes the depth and the necessary contact for one to understand and to give meaning to psychotherapy. It is unclear however how one can measure depth through a simple evaluation minute by minute. One cannot achieve depth by fragmenting a relation through constant evaluation. What the study brings is the innovative idea of evaluating perceptions through the idea of depth, a rather abstract, hard to operationalize concept. Rather than depth, other

factors come into play when trying to understand how therapists or client view and give meaning to their therapeutic experience, one such factor is the socio-economic status. Dougall and Schwartz (2011) from the University of Arkon studied the influence of the socio-economic status of the client on the attribution biases of the therapist and countertransference. When talking about the attribution biases, the socio-economic status was not a mediating factor, the countertransference process however, was a different issue. Therapists who participated in the study declared that they felt that the clients were more dominant when the socio-economic status was high. This type of manifestation from therapists is not only an awareness of social attributes but an emotional reaction that can influence their answers in therapy (Dougall, Schwartz, 2011). Emotional reactions, both from the therapists and clients are at the core of the therapeutic process. Zeeck et al. (2012) studied the dimension of therapists' stress in psychotherapy. The study results indicated that there is no correlation between stress experienced in therapy and the level of severity of the clients' symptoms. What did correlate however was experienced stress and the working alliance: the ones evaluated as positive were correlated with a lower level of stress and the weaker ones were associated with a higher level of stress. Another interesting correlation was between negative emotions in sessions and experienced stress, and the most correlated emotion was` "discouragement" (Zeeck et al, 2012). Multiple experiences of perceived failure in therapy may affect the therapist's whole vision on therapy and even the meaning they attribute to therapy.

Methodology

Objectives

The two main objectives of the research were:

- To explore the significances of the psychotherapeutic process from both clients and psychotherapists perspective;
- To interpret the significances through a comparative analysis to illustrate the similarities and differences in perception.

Method

The design used in this research is a model proposed by Charmaz (2006). In the classical Grounded theory approach, Glaser and Strauss state that through the collected data one can develop new theories regarding the studied issue. Charmaz has a different view in his design, the goal of this type of analysis is to further understand reality not only as a result of an actual phenomenon, but as a sum of the interpretations and perspectives of the researcher (Charmaz, 2006). From this point of view, Charmaz's approach is closer to interpretative phenomenological analysis by its acknowledgement of the presence of the researcher in the analysis process. This approach doesn't intend to realise a portrait of the studied phenomena, but rather a translation through the researchers' interpretations (Charmaz, 1995b, 2000; Guba & Lincoln, 1994; Schwandt, 1994 apud Charmaz, 2006).

The research questions are formulated in accordance with the questions proposed by Glasser (1978), fundamental to qualitative research ("What is happening here?", Which

are the social and psychological processes underneath?") and those proposed by Charmaz (2006) "What significance do different participants give to the process?", "What do they underline and what do they leave out?" (Glasser, 1978, apud Charmaz, 2006, p. 20).

Thus, the research questions of the current research are:

- In what terms do clients represent the significance of their psychotherapeutic process?
- In what terms do psychotherapists represent the significance of the psychotherapeutic process?
- Are there any similarities between the perspectives of the clients and of the psychotherapists regarding the significance of the psychotherapeutic process?

The participants in this study are part of a larger study that intends to further understand aspects of the psychotherapeutic process from both a qualitative and quantitative stance. They were asked to answer two questions. For the therapists the question was "From my point of view the significance of the psychotherapeutic process is" and for the clients: "For me the significance of the therapeutic process is". The answers to these questions received a code and were included in categories based on their conceptual similarities. After this step, I explored the similarities and differences between them to better understand how each party views what is happening in the psychotherapeutic process. The action of coding is *"the categorisation of data segments via a short name that not only summarises but describes each information"* (Charmaz, 2006, p. 43). The codes assigned in this analysis provide an insight into the significances and perspectives given to the psychotherapeutic process.

The software used to analyse the verbatim was QDA Miner Lite. Through this program, the answers were assigned to a series of semantic categories and then analysed by their frequencies in the collected data.

Research limits

- The results should be interpreted with caution due to the low number of participants;
- The therapists and clients were not from the same group; the specialists here did not provide their service to the clients in this group;
- The degree of desirability in therapists' answers: they gave answers that may describe a rather utopic psychotherapy process not their general opinion on the process;
- The answers of the clients were referring to the last therapeutic process they had; the undefined time period between the process and this study may distort the perception on the actual process.

Participants

The sample is composed by two distinct groups that participated in two different studies:

1. *"The sense and significance of the psychotherapeutic process from the beneficiaries perspective"* N=103. This group was composed of people who benefited from psychotherapy with an average age of 32 years and with a varied level of education, from high school and to PhD. The declared reasons for which they had psychotherapy sessions were represented by: clinical aspects (anxiety, depression, phobias), N=57 and personal development/ optimisation N=46. The type of therapy undergone was: behavioural therapy, N=30, dynamic/ psychoanalysis, N=13, humanistic/existential, N=36 and the client didn't know the type of therapy he had N=24. The participants were recruited via virtual platforms between 12.11.2017 and 3.02.2018.
2. *"The sense and significance of the psychotherapeutic process from the therapists perspective"* N=137. This group was composed by psychotherapists, 19 male and 118 female. Other relevant characteristics for this analysis are: the form of practice (Romanian official ranking): under supervision N=47, autonomous N=46, specialist N=32, principal N=12; the schools of therapy in which they were formed, Adlerian N=10, transactional analysis N=2, emotion focused N=1, person centred N=2, behavioural N=33, Eriksonian N=12, experiential therapy of unification N=18, integrative N=29, positive N=2, psychoanalysis N=10, drama therapy N=4, , systemic N=9, short termed therapy N=3 and gestalt N=2. The last level of education was: bachelor N=15, masters N=110 and PhD N=12. Their experience in psychotherapy varied from 1 to 22 years, M=8.31. The participants were recruited via virtual platforms between 20.05.2018 and 12.06.2018

Results

The categories were analysed by adapting Charmaz's method *line by line coding* to the coding of the main idea of the participants verbatim, therefore line by line coding became the analysis of the emerging ideas in each paragraph. This kind of analysis is closer to *incident to incident* coding (Charmaz, 2006, p.51).

The significance of the therapeutic process from the clients' perspective

As mentioned above, the clients verbatim were analysed based on the underlying idea of each statement. For example, for the verbatim "*It was a way for me to see things differently, to access resources that I didn't knew I had*", the assessed code was self-knowledge, therapy as a form of self-knowledge and for " *The solution for a situation that seemed to have no solution"*, the given code was *answer* etc. The advantage of this type of coding is the possibility to aggregate answers in larger main themes.

Figure 1. Client's verbatim distribution (N= 103)

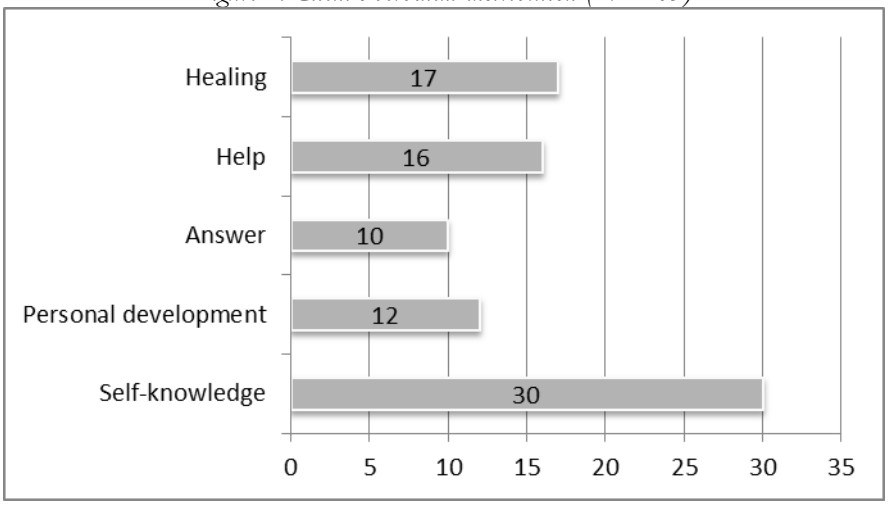


Table 1. Client's verbatim categories

Category	Code	Count	Codes %
Psychotherapy as a form of self-knowledge	Self-knowledge	30	29%
Psychotherapy as a chance for personal development	Personal development	12	12%
Psychotherapy as a solution for ones' problems	Answer	10	10%
Psychotherapy as a form of help	Help	16	16%
Psychotherapy as a form of treatment	Healing	17	17%
Other	Other	18	17%

The highest frequency was psychotherapy as a form of self-knowledge followed by healing, answer, personal development and help.

Self-knowledge

Knowledge and self-acceptance.
Developing a deeper perspective regarding introspection and revealing a different view (C26).
*A way to know myself better and to accept myself (*C36).
An occasion to explore myself and to know my weak points and to limit their effects on my personal and professional life (C39).
An opportunity to know myself (C53).

Psychotherapy differs from other methods of individual healing through the central role that the ego plays in the dialogue between therapist and client. All the psychotherapy systems and practices are based on implicit models of the ego that have a profound cultural dimension (Kirmayer, 2007).

Healing

Healing (C77).
Getting myself back on track (C82).
Treatment (C86).
Settling my stormy thoughts (C96).
I was able to cry for things I couldn't on their given time (C93).
[…] *Abatement of my condition and a better state* (C33).

In these interpretations, it is best to underline the vast number of processes that play an important role in the results of therapy such as social context, social interaction models, mental models of the client and so on (Kirmayer, 2004 apud Kirmayer, 2007). In opposition to the *self-knowledge* theme, *healing* implies a rather immediate solution of a problem that an individual faced when he began therapy. This theme can be also considered a result of self-exploration in a secure space, the therapists' office.

Answer

Answers and an understanding of the stages […] (C33).
Another answer to my questions and doubts in my attempt to break free from uncertainty (C32).
An answer to my question (C48).
A way to find answers myself (C71).

The idea of psychotherapy as an answer to the questions that one could have regarding oneself and others was a major theme in the clients discourse.

Personal development

Personal development (C84).
A respite to better understand my life story and to integrate and redefine certain aspects (C66).
[…] *polishing for me to become my best version* (C57).
Emotional development (C5).

The **personal development** theme is complementary to healing and self-knowledge. These categories can be viewed not only as a series of different themes, but as a temporal process. To develop good characteristics one must go through self-knowledge and healing first.

Help

Help received in a difficult time (C57).
Help (C79).
A significant support […] (C91).
A little support (C99).
Support (C29).
A help for healing (C25).
Something important for me to help my child (C24).
Help received at the right time (C15).

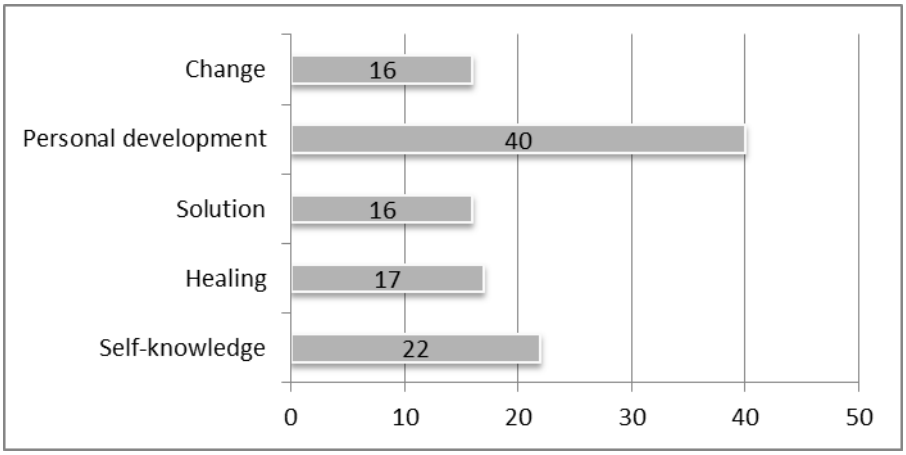
The *help* category received and sought in therapy is one of the themes that appeared from literally interpreting the verbatim, not by searching for the meaning of the discourse. While the other themes seem to illustrate an idealised vision of psychotherapy, healing of one's wounds, personal development to reach your best self and so on, the *help* category is marked by pragmatism, maybe derived from the reasons that brought the client it the therapists office.

The significance of the therapeutic process from the therapist's perspective

Table 2. Therapists answer categories

Category	Code	Count	Codes %
Psychotherapy as a form of self-knowledge	Self-knowledge	22	16%
Psychotherapy as a form of healing	Healing	17	12%
Psychotherapy as a form of problem solving	Solution	16	12%
Psychotherapy as a form of personal evolution	Personal development	40	29%
Psychotherapy as a form of change	Change	16	12%
Other	Others	26	19%

Figure 2. Therapists' verbatim distribution (N=137)



Personal development

Different from client to client, but the general meaning I consider it to be that of traveling together from one perspective to new ones to help him be more conscious, present and more proactive (P50).
The way or the most efficient path to help yourself to evolve in order to "find joy" within yourself and all that is around you (P54).
To grow together (P61).
Growth and balance (P74).

Self-knowledge

Redefining one's self image, and the image of others in a safe environment (P5).
It is a journey to yourself […] (P7).
Self-knowledge (P36).
Recovery, understanding of oneself and healthy settling on the inside (P58).
Introspection and change of the perception of oneself and the world (P65).

The idea of growth through psychotherapy and self-knowledge can be interpreted as the most general, yet most vague approaches to psychotherapy. That is because the *growing* process can be attributed to vast aspects of the client's life. Heinonen et al. (2012) identified in one of their study[1] a relation between the style of approach a therapist has regarding his practice and the results obtained in therapy: the therapists who were cautious, non-intrusive had better results on the long term and low self-esteem and a lack of enthusiasm were correlated with weaker results (Heinonen, Lindfors, Laaksonen, Knekt, 2012). An attitude marked by enthusiasm can be correlated in this case to the probability of describing therapy's significance in positive terms of growth and self-knowledge. Moran considers that self-knowledge must be treated identical to the way we treat other beliefs, through a reflection of reasoning and judgements of what we *must believe* of these reasoning (Moran, 2001 apud Strijbos, Jongepier, 2018). Self-knowledge can be considered a mechanism that can validate change.

Change

Change of behavioural patterns (P121).
A significant encounter between two people in which the client acquires faith that there is another way to be seen as a person and that he is deserving, and he acquires the strength to change in the direction that is comfortable for him (P107).
That the desired changes are produced and are maintained (P113).
The change of the life scenario and the creation of a new individual one (P92).
[…] *the interpersonal relationship between client and psychotherapists through which the change of perceptions, attitudes, behaviour of the client are produced* (P85).

Through the therapist discourse analysis regarding psychotherapy as a form of change it can be deduced that the result of the psychotherapeutic process implemented with success for the client is: *change*. What is not described is the way this change can be obtained. In actual practice you can only observe what the client describes as change without the possibility of validating it or further implementing it.

Solution

[…] The solution to frustrating life situations (P86).
Finding the adequate way (P112).
A conversation between two people about a topic proposed by the client that leads to the solution of the problem illustrated in that topic (P115).
Diminishing the functional deficit (P119).

[1] *Therapists' professional and personal characteristics as predictors of working alliance in short-term and long-term psychotherapies*

As a result of the therapeutic process the client can become more conscious of his own blockages and his ways of overcoming them or even resolve them completely […] (P72).

Even if the response were not by therapists formed in the solution focused therapy, the theme of psychotherapy as a solution, as a form of disposal of one's conflicts was often found in therapists discourses. The standard manner of constructing the discourse was to identify a certain problem of a potential client and to address it through psychotherapy. Authors like Miller (1994) observed that in practice when the focus is on solutions and the reduction of symptomatology, the number of sittings tend to decrease in number (Miller, 1994).

Healing

Healing (P14).
An efficient way of work for processing various themes, life events and of healing emotional disorders. (P16).
Psyche repair (P18).
Of common effort by the therapist and client for healing and becoming (P37).
Healing relationship (P53).

The *healing* theme is complementary to the *change* category. The healing process, used typically in medicine work, the action of curing an individual, implies a previous state marked by illness that has been approached in psychotherapy. This category of answers can be considered a meta theme of which all the other themes are a part of.

Comparative analysis of psychotherapists and clients themes

Table 3. Answer themes of psychotherapists and clients

Clients	Psychotherapists
Self-knowledge	Personal development
Healing	Self-knowledge
Help	Healing
Personal development	Change
Answer	Solution

The answers provided by the clients and the psychotherapists were complex, and their assigned significances of the therapeutic process were vast with various meanings for each depending on a series of personal and professional factors. A number of answers could not be put into categories as a result of their unique nature. The only difference that can be observed between the categories listed in Table 3 is a conceptual one, the therapists aimed at an ideal process and the clients related to their own process of therapy that they had. This analysis can be considered a comparison between an ideal and a real personal process. The clients' representations are circumstantial whereas the representations of therapists are a sum of circumstances and ideals. The similarities

between these themes may indicate a homogenous psychotherapy practiced and experimented by both groups. The most important aspect that must be underlined here is that almost all of the categories identified in the clients verbatim have a correspondence in therapists' answers and this may indicate an efficient manner of developing the therapeutic relation with one's client. The only categories that are a slightly different are *help* (clients) and *change* (psychotherapists). This difference can be attributed to the position that each party has in the therapy process. If the therapists consider the finality of the therapeutic process as a changing experience for the client, the client seeks help in the therapists' office for various life issues. Some researches note that therapists tend to overestimate the number of clients that are able to heal or to reach their objectives through therapy (Parker, Waller, 2015). This kind of perceptions can also be found in the verbatim from this research project: "*Elucidation, evolution, increasing the trust in the good inside and outside*" (P9), "*To be the one that opens different horizons/ways that can help the client see things from different perspectives and that helps him sustain himself*" (P35). Here, and also in other answers, you can see that the therapists describe a sum of objectives that are not always fulfilled or even possible to fulfil in every therapy.

Conclusions

To offer significance to individual experiences is a human action that facilitates understanding and integration of different life situations that one encounters. In this research, I explored the concept of situational sense, operationalized as a manner through which individuals understand, build and give significance to particular life events (Park, George, 2013). The particular event in this research is the therapeutic process. It is a given that a series of factors that were not mentioned in this analysis can influence the meaning that someone gives to the therapeutic process, but the main objective of this study is to explore the similarities and differences of the significance given to this process. The manner in which these significances were created is unique for each individual, for example self-knowledge may have different meanings for different persons. In this study, these conceptual differences were not analysed as a result of the impossibility of exhaustively analysing the manner in which the meanings were created, therefore these answers were analysed as a whole. What clients and therapists described are nothing but symbolic representations of personal experiences regarding the therapeutic process. These personal prototypes of the therapeutic process found their correspondence in therapists and clients answers, in both categories. The most frequent categories identified in the clients group were *psychotherapy as a form of self-knowledge* followed by *healing, help, personal development and answers.* When interpreting emerging themes it is important to underline the number of processes that are at the base of the results obtained in therapy such as the social context, social interaction models, mental models of clients etc. (Kirmayer, 2004, apud Kirmayer, 2007).

The perceptions of the therapists on the therapeutic process are mediated by a series of factors that can include therapy orientation, personal beliefs, values and even their therapeutic experience. In a qualitative study the expectances of therapists in training were recorded. The participants were 24 psychotherapist participants at the beginning of their career, with both psychodynamic and behavioural approaches. Relevant for the present research is that the therapists with behavioural orientation focused on the

desire to learn new techniques of intervention adapted to what one may encounter in psychotherapy sessions and the therapists with psychodynamic orientation were prone to focus on the therapeutic relationship and elements like transference and countertransference (Nikendei, Bents, Dinger, Huber, Schmid, Montan, Ehrenthal, Herzog, Schauenburg, Safi, 2018). The therapists' orientation is the factor that modulates the beliefs about the process, but also their empirical practice. This study had the goal of identifying the similarities in the given significance to the therapeutic process regardless of the therapeutic orientation. In practice, therapists use multiple techniques and a differentiation based on orientation may be redundant.

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THE IMPACT OF THE INFORMATION REVOLUTION ON RAISING THE CHILDREN OF HOUSING INSTITUTIONS IN ROMANIA

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Abstract: *We live in a time of speed, when everything is rapidly changing around us. Not long ago, mobile devices were fiction, and we would only see them in movies, while here we are now, living in a period of voice and video calls through a 'mobile phone' device. This device represents a real technical revolution, especially through the modern applications that open up – for us and our children – areas that were difficult to access earlier, such as science, sports and other, more negative media, like pornography sites. We have been able to easily segment and categorize search engines, but how could we classify social networking sites and apps? It is difficult to say whether they are bad or good, the reason for this being that the problem is not in its programming but in its users. Children are in danger because of the Information Revolution we are experiencing, especially two categories of them – the first category includes children of families where parents work for a long time, both or one of them, or those missing from home for a significant period of time. In this category, parents may sometimes avoid mistakes by addressing the danger to their children and thus protecting them, while the second category includes orphaned and abandoned children, or children that for various reasons find themselves in social protection centers and do not benefit from any such protection. These mentally and physically healthy children, due to their presence in these centers, are vulnerable, and we can diagnose them with a special sort of disease ('social centralization complex') because they suffer psychologically from their abandonment, their presence in these centers and the absence of adoptive chances. Regardless of the quality of the services offered in said placement centers, this mental complex remains, which creates a weak point with a profound impact on the rest of the lives of the respective children. To overcome their reality, children rebel against everything that surrounds them, and if they can conceal reality, then they do so by any means necessary. Due to the facts that these children do not have a strong educational*

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base and that it is difficult to compensate for their lack of a familial atmosphere, the impact of the Information Revolution on them is strong, and trying to find solutions in order to avoid or correct the negative effects in various personal areas is a necessity.

Keywords: *information revolution; housing institutions; placement centers; electronic learning methods; abandoned children*

Introduction

This paper aims to study the impact of the Information Revolution on institutionalized children's education, health and way of thinking. The article develops in two directions. The first is to emphasize that we are normally born with a family that takes care of us biologically and socially for much longer than the rest of the living beings that we might encounter. Childhood is important to us because it affects all aspects of our lives as adults. We live within societies that each have their own customs, traditions, and institutions. Our ability to curb our instincts and act in a civil way is what allows us to live in harmony with each other and with other creatures, so any dysfunctionality that may appear in a family is a real danger to society. The second direction of the article is to establish reasons with theoretical and methodological grounds for the study application.

One of the predominant aspects of the times that we live in is the spread of the phenomenon of family disintegration, which coincides with our transition from diverse societies to a singular virtual society. Opinions differ on the reason for the increase in the number of families that are disintegrating. The reasons are diverse and include the possibility of womens' employment in a vast number of work sectors, economic insecurity or the absence of one or both parents within the family. Unfortunately, all these factors can only be seen as secondary elements of the outbreak of this phenomenon, compared to the absence of a strict social system and laws that would oblige parents to care for their children and their families in the best possible way.

Both the number of children benefiting from the services of social institutions, as well as that of children belonging to disintegrated families are large. Consequently, there are lots of children who lack a family as their most important source of guidance, which makes them vulnerable to delinquency and to the negative effects of the virtual world. Therefore, it is important to limit the different effects of the Information Revolution on children in housing institutions because they lack any sort of real guidance and evaluation elements other than the respective social institutions in order to direct them towards their own interests and the interests of the wider society.

Theoretical Background

IT Revolution

The word '*revolution*' is used to describe a change in the fundamental construction of society. The Information Revolution witnessed nowadays is linked to the birth of the digital world and the continuous qualitative development in networks and information systems and technologies, in addition to the further development of industries tied to pop culture, such as the direct satellite broadcasting. The modern society is being characterized by an explosive expansion of information, which has been generated and accumulated in such short periods of time that humans seem incapable to efficiently cope with.

We can compare the transition brought upon by the Information Revolution with the shift from an agricultural to an industrial society. It is a revolution that transcends ideologies and eliminates national borders in order to build a mental system through communication. The technological development created by the human mind has become an important element in the flow of knowledge. It has even greatly contributed to the development of the human mind itself. A specific definition of the Information Revolution cannot be formulated, but Odeh (2013) offers some basic elements of this concept – the emergence of an international community environment based on the selection of information, knowledge, and communication, through the creation of an effective and organized relationship between man and other things, as follows:

- Man and the state;
- The state and the environment;
- Various societies without regard to geographical boundaries, religion, language or ideology.

The biorhythmic course that aims to clarify the relationship between society and its people includes the latters' physical, emotional, intellectual and intuitive characteristics (prediction), as well as the freedom to receive market information and knowledge, removing and overcoming geographical barriers between nations, countries and peoples. The Information Revolution is an important historical event in human life, which has led to the emergence of a productive system of wealth primarily based on the human mind, and not on machines or muscle power. Knowledge is the key to economic growth and development in the 21st century. The revolution of modern communication technologies has thus overcome both time and space.

The era of the Information Revolution has several features and characteristics that distinguish it from other ages, such as:

- The control of information in various areas of life;
- The economy and security of countries are based on the information industry;
- Acquisition of information and the marketing of goods and services;

- The exploitation of human thought through the conduct of intellectual analyses, studies and scientific research in addition to the continuous development of mechanisms in order to cope with the different requirements of life;
- An increased investment in modern technologies such as communications, electronics, computers, and a high degree of inter-operability through their regular integration;
- Ease of dealing with computers and their use in various areas of military, economic, political, cultural and social life;
- The significant increase in the flow and production of information;
- The spread of networks overlaps significantly, due to their transformation from local to regional and global networks.

The Information Revolution and the spread of technology have greatly influenced social life. Some of the most impactful aspects are (Badrawi, 2003: 319-321):

a) *Social Structure*: The emergence of the information and communication revolution has created a gap between two categories of society:

   • The category that owns, uses and trades information;

   • The category that does not have the information and finds it difficult to use and circulate it.

This gap widens with the increasing impact of the large amount of information produced and with the widespread means of communication available. The Information Revolution has also affected the participation of women in society. Their participation and personal development have increased in services, information, and communications. The impact of the revolution is not limited to the social structure of the time period. Information technology has changed the perception of people with special needs as well, particularly in relation to their ability to participate effectively in society.

b) *Violation of the principle of equal opportunity*: The production and use of information technologies have contributed to the reduction of equal opportunities. The Information Revolution has led to disparities in opportunities between individuals and communities. While the general wealth has increased, the poor have grown poorer, affecting the quality of lifestyles and jobs, as well as incomes and livelihoods.

c) *The tremendous growth in information volume and the speed of its spread*: The accumulation of knowledge began in the late twentieth century due to the increase of the level of information and the emergence of many new sciences. Over time, the flow of knowledge has continuously increased and, as a result, the production of books and documents of various types has also risen.

d) *The growing sense of alienation*: The rapid transformation and constant change in economics have led to a significant change in the nature of jobs and professions, with the emergence of new jobs. As a result, some individuals have been forced to

further diversify their skills in order to keep up with those rapid changes. Some of them have lost their job or have been forced to change it. This has led to a reduction in the positive societal participation of individuals and the increase of unemployment rates. This causes the individual to create a kind of comparison between their society and other societies, with a negative effect on morale.

Abandoned children

Children described as "*abandoned*" lack family care for the following reasons:

- The death of one or both parents and the absence of other relatives who could care for them;
- The family's lack of economic and health conditions that would allow it to support and raise children;
- Parents may be exposed to health problems (disability);
- Addictions of almost any kind.

When one or more of these reasons is true, the state will include such children in housing establishments after checking that there are no relatives who can take care of them at that time. These institutions allow persons up to the age of 26 to live there and benefit from various services, such as:

- *Housing institutions/placement centers*: Government or community institutions that shelter children deprived of family care. The children are categorized within the shelter institution according to age, gender and sometimes school year. Each group is supervised by educators and psychologists as well as specialized medical personnel who cares for the childrens' health.
- *Electronic learning methods*: E-learning means the employment of IT&C solutions to assist education with an ultimate goal of performance enhancement. Using informatics in learning allows the gathering of knowledge in a beneficial and fun way. Pedagogical methods (simultaneous and asynchronous) have to be adapted in order to meet the need for the rapid acquisition of information.

Through personal observation and previous studies on sheltered children, a similarity was observed regarding the structure of social enterprises in Romania and those in third world countries. We noticed similar behavioral problems experienced by abandoned children in most countries of the World. The most important problems – serious emotional disorders that must be acted upon – identified are:

- Theft, which can appear at early ages (starting with 4 years of age). Unless remedial action is taken to prevent it from developing, theft can develop over a long course of years;
- Lying;
- Aggressive behavior;
- Hyperactivity;
- The so-called "laws of the jungle" that dominate human actions and everyday situations.

Methodology

The importance of this research stems from the fact that we live in an era of speed; the rapid development of technology that has affected not only our lives but, in particular, the lives of institutionalized children, whose ability to distinguish between good and evil is weak. Adding to this that such children are passionate enough to follow the latest trends, IT&C development can result in a danger unless properly managed.

This research has studied the impact of the Information Revolution on institutionalized children, trying to present solutions to minimize its negative effects (there where these existed) and to protect our society from a potentially turbulent and unstable future generation.

The participation in this study occurred voluntarily as part of a PhD research paper conducted between 2016 and 2019. Subjects were allowed to withdraw from the project at any time. For participants under the age of 18, their tutors were asked for consent prior to the start of the actual research. The sample consisted of 45 adolescents aged 13 to 21, both male and female, belonging to two housing/placement centers in Constanta, Romania.

The main research question asked was: *How are institutionalized children affected by the Information Revolution?* The research started from the assumption that there is a statistically significant relationship between the Information Revolution and the change of institutionalized childrens' educational principles and their behavior. Subsequently, the research hypotheses were:

a. A relationship of statistical significance exists between the decline of educational, health and behavioral standards in children from educational institutions and the Information Revolution;

b. Educational methods based on modern IT&C technologies exist that can counter and correct the behavioral and educational problems suffered by most children from housing institutions.

To verify the research hypotheses, the following methods have been used:

1. A questionnaire, structured in eight self-administered items;

2. A focus group with eleven participants from the two children housing institutions. This method was used for a more in-depth understanding of the quantitative findings.

The focus group method was used to gather in-depth data on the following:

- The information that institutionalized children have about the Information Revolution;
- The importance of mobile phones and other electronic devices and ways to obtain them;
- Dangers and benefits of available electronic games;
- Time spent on the Internet;
- Friends from the virtual world.

Several meetings have been held with five groups of adolescents to discuss the aforementioned items. A group consisted of maximum six persons.

3. An interview was conducted with fifteen caregivers (specialized educators who look after the children). They were asked the following questions:

   I. What is the impact of the Information Revolution on these children?

   II. Do you use modern IT&C technologies in your profession?

   III. What are the most important changes that have aroused your attention regarding a specific product of modern IT&C technology?

Results

Table 1 displays the results of the self-administered questionnaire.

Table 1: Results of the self-administered questionnaire

No.	The question	Answers	Frequency (N respondents = 45)
1	Time spent using electronic devices within 24 hours	between 1-3 hours per day	8
		3-6 hours per day	9
		6-12 hours per day	15
		12 or more	13
2	I watch pornographic sites	YES	34
		NO	11
3	I do not mind communicating with outsiders in the virtual world, especially those who admire their external appearance	YES	28
		NO	17
4	I use Microsoft Office	YES	8
		NO	11
		I don't know anything about it	26
5	The Internet is often used for	Entertainment, social networking, and chatting	35
		Studying	10
6	I prefer to watch horror and crime movies	YES	37
		NO	8
7	I do not mind meeting strangers whom I met on the Internet	YES	28
		NO	17
8	I consider owning a mobile phone:	It is imperative and necessary	31
		This is not important to me	14

Source: Authors' own representation.

The reliability of the questionnaire was tested using Cronbach's Alpha. The coefficient obtained was (,927). The results of the questionnaire show that, with regard to the first question, there is a relationship of statistical significance between the decline of educational, health and behavioral standards in children from educational institutions and the Information Revolution. Many studies have confirmed that the spread of technology has led to the provision of materials (pictures, movies or electronic games directed at adults or children) that expose violence among individuals in societies (Hanewald, 2008; Peterson, Densley, 2017). Young people are greatly affected by these mediatic outputs that expose violence in a direct or indirect manner, affecting their behavior.

The questionnaire indicates that 15 out of 45 of children spend between six and twelve hours a day using any given technological mean, as well as 34 out of 45 who visit porn sites, in addition to 37 out of 45 who prefer violent games and movies, which negatively affect their mental and physical health, leading to a change in their behavior and habits.

According to Bassam (2011) the number of Internet users is increasing daily. Many users reach the stage of addiction, becoming subject to family and health problems. This is exactly the case of the children from housing establishments, 35 out of 45 of whom prefer to use the Internet for entertainment. This is an indication of internet addiction, since only 10 out of 45 children use the Internet to study. Modern technology has made it easier to engage in behavior which is erroneous for weak and young persons, such as drug addiction. Technology sometimes isolates youth and allows them to escape reality by creating a virtual world, leading to innumerable problems. 31 out of the 45 study respondents are willing to do anything to get a mobile phone. There are cases registered with the police, about children who have stolen mobile phones. This draws attention to how vulnerable children are to the attractiveness of technology.

Focus group discussions revealed that knowledge of modern technologies owned by children in shelters is good and varied. These children have a high awareness of the dangers of social media and new technologies to their lives, yet they are not afraid to take on dangerous adventures because they do not care about these risks. In their opinion, they have nothing to lose compared to what they have already lost. When it came to IT&C, the participants mentioned that they do not believe in its importance for science and education, but only in the material gains and entertainment that IT&C provided. Respondents prefer to spend their time playing games and watching movies, and believe time allocated to use the Internet for such purposes should be unlimited. "Aims justify the means" is the principle that most of those children follow daily in their lives, even if sometimes they have to break the laws in order to reach their goals.

We have also found that there are educational methods based on modern technology that can help supervisors (and parents alike, where applicable) to correct the behavioral and educational problems experienced by most children of housing institutions.

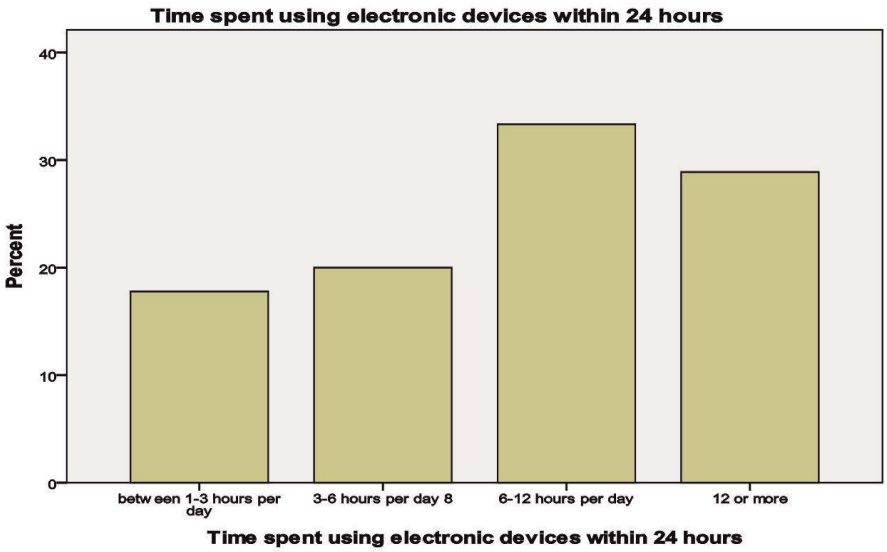
Figure 1 shows that the majority of the studied institutionaluized children are addicted to technology, and the comparison with the results about the purpose of using the Internet becomes more evident through the Figures 2, 3 and 4.

The research further reveiled that children lacked the foundations that would help them to improve their future with modern IT&C technology. Instead, 34 out of 45 children watched pornographic movies. So, to address this danger through technology, we can only use some educational films about the risk of addiction to these sites and psychological guidance. It would be important to fill the spare time of these children with useful activities that have a positive impact on their mental and physical abilities.

Technology is able to help children receive a better education, so it is necessary to increase the number of 10 out of 45 that use technology to study by training the other children as well to use search engines and other applications, in order to increase their knowledge. 26 out of 45 children did not hear about the MS Office programs, and 11 out of 45 mentioned they will never use it. Since MS Office is one of the most important programs necessary to be acquainted with in order to find employment, several hours a week must be included to teach children how to use said programs.

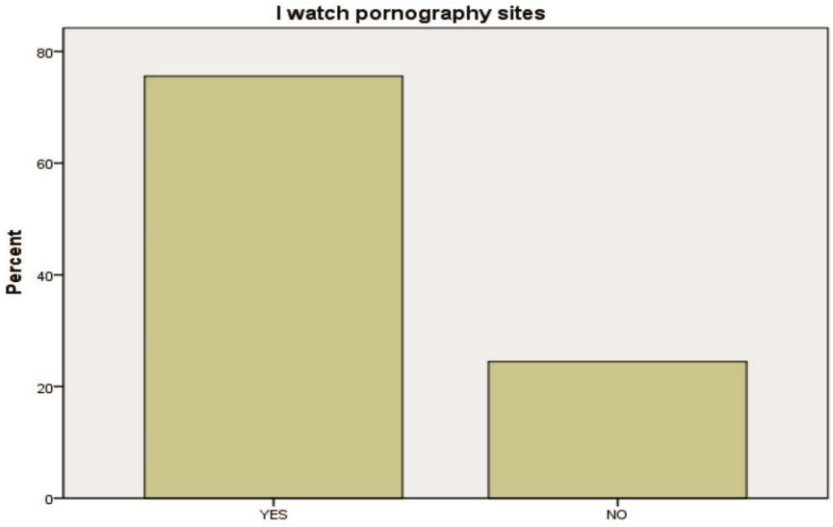
Technology has advanced rapidly, and many other applications are also currently available to help children to study and to learn basic life abilities, as well as to provide them with global knowledge. These children are held back from benefiting from the advantages of IT&C technology due to the absence of family and due the absence of professional and trained counselors to fill their basic educational needs.

Figure 1: Time spent using electronic devices within 24 hours



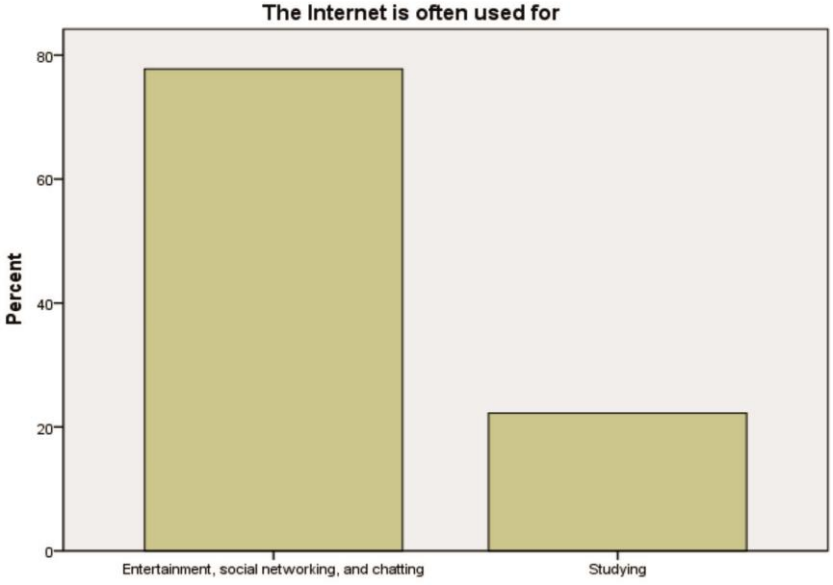
Source: Authors' own representation.

Figure 2: Watching pornographic materials



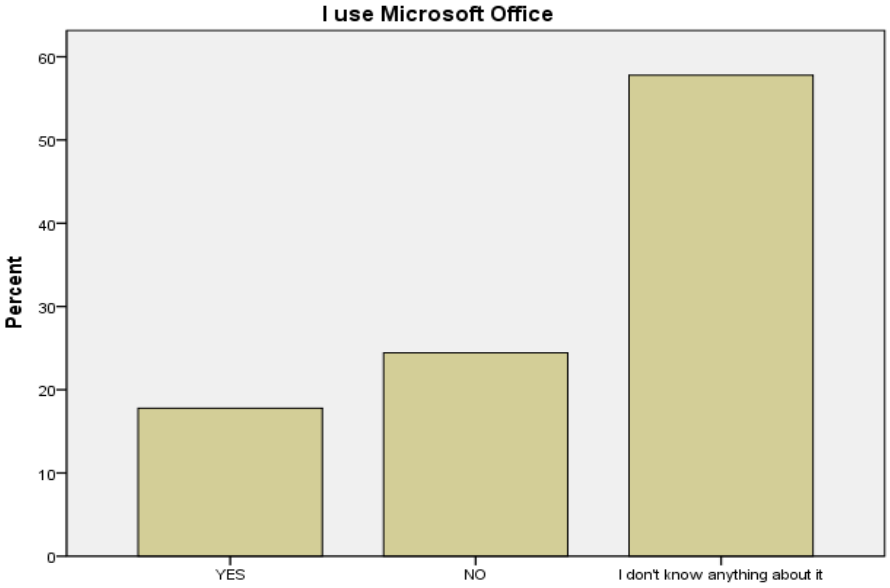
Source: Authors' own representation.

Figure 3: Use of Internet



Source: Authors' own representation.

Figure 4: Use of Microsoft Office



Source: Authors' own representation.

The interviews with the caregivers revealed that the IT&C revolution has had at least some sort of negative impact on the institutionalized children, since most of them have broken a law at least once in order to get access to a mobile phone or to other modern gadgets. The caregivers confirmed the findings of the questionnaire by stating that, indeed, the time that the children spend on the Internet is mostly just for fun. Most of the caregivers said that they do not have ways to direct children towards the positive side of IT&C. Caregivers also noticed an increase in violence and behavioral problems after the children became addicted to one of the technological means, especially upon losing one of those devices.

Conclusions and recommendations

Considering the findings of this research, the national social system should consider making some improvements so as to help institutionalized children benefit from the advantages of IT&C technologies. The immediate and directly applicable interventions that one can think of are:

- Providing professional IT&C training to social workers;
- Providing materials to children that contains messages to be delivered in order to modify a behavior, communicate an idea etc. The material which includes the

message is displayed by video, short or long film, song etc. and reproduced by means of overhead projector, TV, computer etc. Multilateral interaction is necessary under the direct supervision of the caregiver, who has to be present in order to explain some points and direct the sessions towards their main purpose indirectly; the topics discussed should require interactive reaction by the children and a direct feedback when it is necessary to link the material to real life situations.

- The children should be directed to activities that help them organize their leisure time in a qualitative and efficient manner. Most importantly, it is necessary to involve them in activities of a familial nature.

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