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Patient v. physician – a positive relation, or possibly a conflict of attitudes or interests

The naturalist typically disregards sociological phenomena. Some of them even refuse to be exposed to them. Thus there is a continuity from the deliberately ignoring some figures or personages to the sheer inability of actually discerning them. In order to be able to catch sight of any definite figure from a given field one has to be in a peculiar readiness or frame of mind, which includes also the more or less compulsory ability to be oblivious to chances of other figures (Ludwik Fleck)

The perception of physician–patient relationship as an area of conflict is not very common. Yet it is, to a certain extent, inevitable and a permanent element of such contact. What's more, the phenomenon can be seen on several clearly distinctive planes, acting as a barrier in intercultural communication. The inability to come across a unique "area of cultural consistency" (4) does not bode well in the physician–patient contact. It is because the two sides value health and disease differently. These and a number of other reasons reveal an atypical relation here. The physician no longer plays an exclusively active role of a guardian and therapist, and the patient that of a person passively giving in to medical procedures. Even a superficial observation reveals a completely different pattern of bilateral relations, where the real issue is the conflict of interests, and attitudes as well, reflecting a different hierarchy of values. The physician appears to be more of a contracting party to a patient in the world where health more and more constitutes a measurable, economic value, and of a confidant and guide as well. At times he/she becomes even a patient's opponent, when the latter's attitudes and needs differ drastically from the physician's decisions. However, the doctor is neither an unquestionable authority for the patient, nor his/her "patron", in the Roman sense of this expression. Within the scope of the relations reviewed here, the patient also remains the active side. He/she is no longer obliged to, at all times, accept the forms of therapy, and its philosophical backing. The above quotation from a paper by Fleck of 1927 (2) signifies an inescapable conflict, stemming from the differently acquired perception of the world, its elements, and of building the concept of a comprehensive picture from them. This frame of mind, or "intellectual readiness", of medical community, and that of numerous groups of patients, differ considerably.

The inevitability of conflict discussed here is well rooted in history. By the end of the 18th century, and throughout the next century, increasing discrepancies emerged between the colloquial vision of "world and human being", with the concept of health and disease contained therein – and the picture created by the European medicine. The latter has hardly been a static phenomenon, having changed many times throughout this period. These changes have inevitably led to the paradigm, which is relevant in contemporary medicine. The point is that this process has contributed to increasing disparities between the scientific and the colloquial perspective of both health and disease perception. It has happened despite the evolving changes also in the field of vernacular knowledge subject to, e.g., intensive educational processes, and yielding to the great cultural transformation of the last two centuries. The barriers thus developed in communication between the patient and the physician are permanent, and not vulnerable to superficial popularising and educational activities. They spring from cultural attitudes of medical communities on the one hand, and of various social groups on the other. Numerous relations between the two protagonists

belonging to the same social group should therefore be analysed. The view that disproves the notion of "average" physician, and that of "average" patient as well, and even of "average" ("mean") attitude, is thereby sound. It is perhaps a proper moment now to consider what elements are involved in the attitudes of both the physician, and the patient.

The author considers one's own system of values as the basic "component" in the first case (creating a certain amount of allowable choices). Other elements are: a definite moral and ethical attitude, professional experience (not to be confused with the so-called professional routine), demonstrated (and offered) amount of expertise and general knowledge, general intelligence of a physician, partly influenced by his/her environment, and also certain personality traits.

As far as the patient's attitudes are concerned, the cultural perception of disease is considered the most important. Next in rank is the presence of disease in patient's life, and understandably, its subjective experience. Among other factors influencing the patient's attitude are knowledge gained from various sources and more or less critically absorbed, as well as certain stereotypes (opinions) about health care professionals. The "theoretical history of science" of Jerzy Kmita, accepting, e.g., pretheoretical phase in the development of science, where both the colloquial and the scientific vision of the world are closely associated, and then the successive phases of theoretical science, where the two visions differ fundamentally – they all could serve as a theoretical justification of the above-mentioned approach to the relations discussed here (1). This inaccurate interpretation of Thomas Kuhn's views allows, however, grasping contemporary dilemmas of social communication at the meeting point of both science and popular views on the world. A question arises then whether the above-mentioned area/areas of conflict are powerful enough to merit a tentative expression of *barricade syndrome*, where the differences in attitudes stem from the distinctness in "styles of thinking". The use of this notion leads straight to evoking the well-known concept of Ludwik Fleck – a suitable, it seems, interpretative tool in the present considerations (3). The dissimilarities between those styles in many a collective mind, and the differences within the so-called silent knowledge, are thought to form important categories here. The true barrier results then from these multifarious social and cultural circumstances. The formal or even actual access to medical knowledge, not a secret or reserved one, by people from outside the professional circles, does not promise to solve the issue of communication. That knowledge, being interpreted differently by the two groups, may even become the source of another conflict. Fleck neatly indicates the differences between a specialist and a learned dilettante.

Another, and considerably more evident, is the conflict of economic interests. The physician acts here as the administrator of the so-called medical services provided, under the contract, by competent institutions, and the access to them by the patient is thereby limited (5). That economization of medical services has led, every now and then, to dramatic consequences, bringing about the sense of violating the rules of professional ethics among the physicians. In this particular case, however, it is the result of the unfinished transformation of the health care system in Poland, although even the wealthiest society cannot afford to provide all citizens with a full basket of medical services, in keeping with the latest standards. Slower, in relation to the ongoing transformation, changes in the social consciousness educated, after all, in entirely different social and political circumstances (not all services are offered free of charge), should also be taken into consideration. Another point is that the period of economic transformation was, in the historical perspective, rather brief (a dozen years or so). Hence, the medical institutions established then are far from excellence. This may contribute to the widening of the area of the conflict discussed. The range of physician's competencies imposed by the National Health Fund (or else the set of medical procedures financed by the Fund), considerably limits the physician's diagnostic and therapeutical independence. The actions of certain provincial departments of the National Health Fund, widely commented in the daily press, concerning the refusal or restriction of financing certain medical procedures, with reference to patients with unfavourable prognoses (e.g. in those of advanced age), are the evident example here. The last area of conflict to be discussed which also merits attention, is the sphere of medical authority and violence, identified with the role of the physicians, performing official functions for the benefit of various groups of patients. The issue here is not only the conflict between diverse social groupings and the "medical authority", whose decisions

considerably affect their life-style, and what's more, interfere in the private sphere of the individual. Procedures like compulsory vaccinations, quarantine or periodical medical examinations, though socially accepted, yet at times evoke aversion. However, there is another important point. A quotation from a work by A. Zybertowicz will illustrate the issue: "(...) concepts and practices brought into being by medicine directly interfere in numerous spheres of human interaction (...) (6). He indicates that "...in the name of life and health protection technologies are being developed whose functioning deeply transforms previous systems of values. Methods such as *in vitro* fertilisation, selection of child's gender or HRT constitute modest beginnings of a process that is going to transform interpersonal relations more profoundly than the deeds of the greatest spiritual leaders, political reformers or inspired visionaries like Marx, Lenin, Stalin, Hitler or Khomeini..."(6). This is tantamount to opening the Pandora's Box, full of conflicts.

A final quotation: *The variety of pictures of reality is simply the result of the variety of the objects of cognition. (...) If [cognitive entities – W.B.] are endowed with separate, autonomous styles of thinking, there is not anything like "the same statement", because for one of them a statement of the other is incomprehensible or is misinterpreted (L. Fleck in debate with T. Bilikiewicz, 1939).*

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SUMMARY

The article deals with physician-patient relations, multi-planar in nature, yet including areas of conflict. The author points to some of such relations. One of them is the economic sphere where the patient's financial means are being confronted with the physician-designed treatment strategy, and possibly with the product of the pharmaceutical companies preferred by the latter. Both parties define disease differently, which leads to another potential conflict. The author refers here, in his own way, to the issue of intercultural communication. The lack of such "field of cultural consistency" between the patient and the physician does not show promise in their mutual contacts, because the two sides perceive the value of health and disease differently. These and a number of other reasons are the examples of an atypical relation. The physician no longer plays a solely active role of a carer and therapist, and the patient that of a person passively surrendering to the other's actions. From the point of view of a researcher, combining the experiences of a practising physician with the theoretical approach of a scientist, a completely different pattern of bilateral relations comes into view, where a conflict of interests, and attitudes as well, is very much the issue, reflecting a different ranking of values. The physician appears to be more of a contracting party to a patient in the world where health increasingly constitutes a measurable, economic value, and of a confidant and guide as well. Now and then he/she becomes even a patient's adversary, when the latter's attitudes and needs differ considerably from the physician's decisions. However, the doctor is neither an unquestionable authority for the patient, nor his/her "patron", in the Roman sense of this term. Within the confines of the discussed relations, the patient also remains the active party. He/she does not accept, at all times, the forms of therapy, and

of its philosophical potential. The "new age" movement, deriving from diverse cultural sources, has brought about influences different from those of the European culture, also concerning therapeutical strategies. Despite the strong protests of the medical profession, the patient is fully aware of his freedom to choose. Frequently he/she is also aware of the physician's dependence on the pharmaceutical companies, and thereby of the conflict of economic interests discussed here. The physician–patient relationship has gone, in the course of history, through various phases. The author attempts to define new relations, admittedly no longer based on partnership but where the patient feels increasingly entitled to call into question medical decisions.

Pacjent–lekarz – relacja pozytywna, a może konflikt postaw czy interesów?

Autor rozważa relację pomiędzy lekarzem i pacjentem. Ta relacja, siłą rzeczy wielopłaszczyznowa, zawiera jednak obszary konfliktu. Autor wskazuje na kilka z nich. Jednym z nich jest pole ekonomiczne. To tu stykają się możliwości finansowe pacjenta z kosztami zaprojektowanego przez lekarza leczenia i być może preferowanymi przez niego firmami farmaceutycznymi. Innym obszarem potencjalnego konfliktu jest odmienność definiowania choroby przez obie strony. Tutaj autor dotyka swoiście pojętej komunikacji międzykulturowej. Brak znalezienia swoistego „pola niesprzeczności kulturowej" nie rokuje dobrych wyników w kontaktach lekarz–pacjent. Rzecz idzie bowiem o odmiennie lokowane na skali wartości zjawiska zdrowia i choroby. Te i wiele innych powodów ukazują relację nietypową. Lekarz nie pełni w niej jedynie aktywnej roli opiekuna i terapeuty, a pacjent – osoby pasywnie poddającej się jego zabiegom. Z obserwacji badacza, łączącego doświadczenia lekarza praktyka z teoretycznym ujęciem naukowca, wynika zgoła odmienny układ dwustronnych relacji, gdzie można pytać o konflikt interesów, ale także postaw, za którymi kryje się odmienna hierarchia wartości. Lekarz jawi się tu bardziej jako kontrahent pacjenta w świecie, gdzie zdrowie posiada wymierną wartość ekonomiczną, czasem jest jego przewodnikiem czy powiernikiem. Niekiedy nawet przeciwnikiem, gdy postawy i potrzeby pacjenta radykalnie rozmijają się z decyzjami lekarza. Nie jest on jednak niekwestionowanym autorytetem i „mecenasem" chorego w rzymskim pojęciu tego terminu. Pacjent jest w tych relacjach także stroną aktywną. Nie zawsze akceptuje formy terapii i jej zaplecze filozoficzne. Czerpiący z różnych źródeł kulturowych ruch *New Age* także w strategii terapeutycznej przyniósł odmienne od europejskiego kręgu kulturowego propozycje. Pacjent, pomimo głośnych protestów świata lekarskiego, wie, że ma tutaj możliwość wyboru. Najczęściej jest też świadom zależności lekarza od firm farmaceutycznych, a więc owego konfliktu interesów ekonomicznych. Relacja lekarz–pacjent przechodziła w dziejach różne fazy. Autor usiłuje zdefiniować nowe relacje, gdzie stosunki nie są wprawdzie partnerskie, lecz pacjent czuje się coraz częściej uprawniony do kontestowania decyzji lekarza.