



Self-interpretation of the Medical Profession: Physicians' Narratives

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This paper is an attempt to examine the senses and meanings attributed by physicians to the medical profession. The collected material is part of a larger project devoted to the physician-patient relationship reconstructed on the basis of individual narratives provided by physicians. The conducted research is closely linked to the qualitative perspective: Interpretative Paradigm and Interpretive Paradigm. The study was performed in 2015-2017. The examined group consisted of 16 subjects (6 female and 10 male physicians) from several regions of Poland, all highly esteemed (subjective opinions) by their patients. The empirical data was collected by means of narrative interviews and the methodology applied for the analysis of the content was that of phenomenography.

KEY WORDS: doctor, physician – patient relationship

Introduction

We are not who we are, but what we make of ourselves¹

One of the oldest in the world, medical profession is associated with extensive knowledge and skills employed in the service of

¹ A. Giddens, *Nowoczesność i tożsamość*, Wydawnictwo Naukowe PWN, Warsaw 2012, p. 107.

patients. In hindsight, it is clear that the medical profession has gone through various phases, and yet the interest in the profession and physicians has continued to this day. This is evidenced by the pieces included in *Historia medycyny* edited by Tadeusz Brzeziński², and *The Century of the Surgeon* and *The Triumph of Surgery* by Jürgen Thorwald³, which cover both success and failure stories in the pursuit of medical knowledge. John Chrysostom refers to physicians as *iatros*, a Greek term for one who treats people, who takes care of the sick. Please note that John Chrysostom also qualifies doctors with terms such as: ‘outstanding physicians’, ‘competent physicians’, ‘smart physicians’, ‘well-experienced physicians’, ‘physicians handling their patients with great care’, thus denoting not only their medical knowledge, but also great skills. Importantly, he also argues, some physicians have mastered the art of medical practice and dealing with patients better than others⁴.

The presence of physicians has always been and will likely be important to every human being, especially patients⁵. This is because of both specialized knowledge and skills necessary in the event of serious diseases, as well as skills typical of a caring parent, who will do everything to help their child (“transfer response”)⁶.

Literature offers few explanations of the term ‘physician’ itself. The ones you can find mostly point to qualified healthcare professionals, who have acquired graduate degrees and are primarily committed to preventing and treating diseases⁷. It is thus argued

² Cf. T. Brzeziński ed., *Historia medycyny*, Wydawnictwo PZWL, Warsaw 2000.

³ Cf. J. Thorwald, *Triumf chirurgów*, Wydawnictwo Znak, Kraków 2010; Id., *Stulecie chirurgów*, Wydawnictwo Znak, Kraków 2009.

⁴ W. Ceran, *Jan Chryzostom o leczeniu i lekarzach*, “Acta Universitatis Lodziensis”. Folia Historica 1993, No. 48, pp. 6–7.

⁵ This argument is corroborated, among others, by *Pamiętniki lekarzy*, ed. K. Bi-dakowski, T. Wójcik, Spółdzielnia Wydawnicza CZYTELNIK, Warsaw 1968.

⁶ Cf. M.M. Hollender, *Stosunki między lekarzem i pacjentem*, [in:] *Psychologia w praktyce lekarskiej*, ed. M.H. Hollender, PZWL, Warsaw 1975; A. Kępiński, *Poznanie chorego*, Wydawnictwo Literackie, Kraków 2002; J. Bogusz, *Lekarz i jego chorzy*, PZWL, Warsaw 1984.

⁷ P. Kostrzewski, J. Ziółkowski, ed. *Mała encyklopedia medycyny*, Wydawnictwo Naukowe PWN, Warsaw 1999, p. 426.

that the term 'physician' applies only to those who have acquired medical knowledge⁸. The Law on Medical Profession (Journal of Laws of 2011, No. 277, item 1634, Article 2, item 2.) provides that the career of a physician consists in a qualified person, i.e. one holding applicable qualifications, providing healthcare services: deliver health examinations, identifies and prevents diseases, treats and rehabilitate patients, and provides medical advice and opinions and certificates"⁹. However, we may readily complement and enrich the concept of a physician in soft skills based on biographies of eminent physicians or the writings by the authors who define the features that define good physicians. A physician, claims Krzysztof Leśniewski,¹⁰ who draws on ancient Greece, was not just an expert on diseases and related treatment methods, but also a sage, or a philosopher, treating body and soul, alike.

This paper presents the meanings and senses that medical professionals attribute to the concept of a physician and their profession.

Research methodology

The collected material is part of a broader project that covers the physician-patient relationship as reconstructed on the basis of individual physicians' narratives. The research was carried out in line with the Interpretative Paradigm / Interpretive Paradigm¹¹, which looks at the human being as an actor drawn into the world of their own life, constructed with the meanings negotiated within social interactions¹². The

⁸ W. Ceran, op. cit.

⁹ *The Law on the Medical Profession* Journal of Laws of 2011, No. 277, item 1634, Article 2.2.

¹⁰ K. Leśniewski, „Nie potrzebują lekarza zdrowi...” *Hezychastyczna metoda uzdrawiania człowieka*, Wydawnictwo KUL, Lublin 2006.

¹¹ P. Chomczyński, *Paradygmat interpretatywny*, [in:] *Słownik socjologii jakościowe*, ed. K. Konecki, P. Chomczyński, Difin, Warsaw 2012, p. 211.

¹² D. Urbaniak-Zajac, *Jakościowa orientacja w badaniach pedagogicznych*, [in:] *Badania jakościowe w pedagogice*, ed. D. Urbaniak-Zajac, E. Kos, Wydawnictwo Naukowe PWN, Warsaw 2013.

nature of reality is, thus, processual and ambiguous, and each actor that co-creates this world seeks to make it a reality they can readily recognize. The researchers using the interpretative paradigm primarily seek to explain the way social actors construct their worlds through everyday experience¹³.

The research project aims to examine the physician-patient relationship and shed light on how physicians conceive of their profession and the very notion of 'a physician'. This study aims to dissect the relationship¹⁴ between doctors and patients, and, more accurately, the meanings attributed to the concept of 'a physician' and the medical profession.

The research problem has been formulated as follows: how do physicians perceive their profession/vocation and what meanings do they attach to it?

This research was carried out between 2015 and 2017. The group was selected in a deliberate manner, meaning that the survey covered a group of doctors who are highly esteemed by patients, as reflected by subjective opinions from patients¹⁵. The opinions addressed both clinical knowledge (doctors were seen as competent professionals) and communicative skills (very nice, focused on the patient, explaining their doubts). The doctors lived in several regions, including *warmińsko-mazurskie*, *podlaskie* and *pomorskie*. Both the age of the respondents and their practical experience varied. The youngest one was 30 years old, the oldest – 68. The Table 1 provides a detailed specification of the group¹⁶. My study refers to the respondents alternatively as speakers, respondents or narrators.

¹³ B. Sławecki, *Znaczenie paradygmatów w badaniach jakościowych, Badania jakościowe. Podejścia i teorie*, ed. D. Jemielniak, Wydawnictwo Naukowe PWN, Warsaw 2012.

¹⁴ The author used the opinions posted online as well as spoken testimonies provided by patients.

¹⁵ I was primarily interested to study the physicians highly esteemed by their patients. Arguably, these are the physicians any patient would be happy to deal with, who are likely to fulfil their requirements and expectations. I have deliberately omitted physicians who did not get on well with their patients or were not esteemed. I sought to look at the profession and people behind it primarily from the angle of physicians who get on well with their patients.

¹⁶ Presentation of the data in the table reflects the chronology of interviews.

The research material was collected through narrative interviews. The method I subsequently used to analyse the collected material was that of phenomenography.

Table 1. Speakers defined in terms of their work experience and specialties

Physician ID No./interview No./sex	Work experience	Specialty
I/1/M	38	Paediatrics, 2 nd degree of specialization
II/2/K	10	Dentistry
III/3/K	45	Paediatrics, 1 st and 2 nd degree of specialization
IV/4/M	34	Obstetric-gynaecology, gynaecological endocrinology
V/5/M	19	Neurosurgery
VI/6/M	23	Family medicine
VII/7/M	23	Oral and maxillofacial surgery Palliative medicine
VIII/8/K	30	Paediatrics, paediatric oncology
IX/9/M	36	Orthopaedics, 2 nd degree of trauma and orthopaedic surgery
X/10/K	26	Internal medicine, nephrology, transplantology
XI/11/K	15	Internal medicine, nephrology
XII/12/M	8	Internal medicine, pulmonary diseases
XIII/13/M	14	Urology
XIV/14/M	18	Internal medicine, sports medicine and emergency medicine
XV/15/K	25	Oncological surgery
XVI/16/M	14	Paediatrics, gastroenterology

Analysis of research results

Physicians' statements addressing their concepts of their profession and themselves as individuals can be divided into three categories:

1. Metaphorical category (physicians' profession being compared to other professions);
2. Social category (associated with the social perspective);
3. Everyday category (associated with the requirements of everyday reality).

Below is a specification of all of these categories.

1. Metaphorical category

This category consists in physicians themselves and their profession being compared to other vocations or social/family relationships while at the same time pointing to its uniqueness.

"(...) It is the constant contact with the human biological material on spiritual, emotional and intellectual levels. This is absolutely unique (...)" (X/10/K)

Please note that this category is the most numerous one as it crops up with virtually every respondent; however, it is not just typical of the narrators' way of thinking. In describing physicians, patients also employ this concept, the content of which is pretty broad: it covers such diverse qualifications as superhuman features, the possession of supernatural powers that can restore patient's health and prevent their death or just postpone it for a while, and the concept of physicians being fellow-creatures or brethren.

The most prevalent metaphor is the one where the doctor is compared to **God**. This metaphor may originate from the oath formerly made by doctors, with which they would establish an agreement with gods, thus embedding their moral authority in the sacred realm. The oath provided physicians with a duty: they became assistants to gods and goddesses in restoring and keeping other people's health. It was a task due to the gods¹⁷. A physician is thought

¹⁷ Cf. K. Szewczyk, *Bioetyka. Medycyna na granicach życia*, Wydawnictwo Naukowe PWN, Warsaw 2009. The religious roots of medicine are also mentioned by

of as someone exceptional, gifted with healing and saving power. It is someone who possesses knowledge, skills and tools needed to restore one's fitness or health. The god concept definitely points to the creative power and agency¹⁸, the physician being elevated to the rank of a saint. However, this concept also comes with certain limitations. The narratives mention no other divine attributes such as gentleness and mercy. This conceptualization cropped up mostly in the narratives by three physicians (a neurosurgeon, a transplant physician and an emergency department physician), who often witness patients die despite the measures they undertake, but they also save patients from death. Here are the examples of such concepts:

„(...) The truth is a doctor is God in this country, really. Although everybody seeks to strip this profession of esteem... this is a person that one's life often depends on. Indeed, we can do a lot. We can shorten one's suffering - eliminate or reduce it. A competent doctor may cure a patient to the point of preventing a disability. (...) If a doctor is competent and can do it, it's cool. That's the way it should be.” (XIV/14/K)

“Let me put it this way: in my specialty, this uniqueness is about what doctors have in their hands... they decide whether his patient is going to survive. Are they going to be able-bodied? Are they going to be mute? Are they going to be paralyzed or not? These are often the sort of things in my hands” (V/5/M).

Anselm Grun and Meinard Dufner, who claimed that ancient doctors believed that the whole power of healing came from the God. A healthy lifestyle was supposed to be combined with the worship of gods, the proper relationship with the creator of the universe. Cf. *Ta choroba zmierza ku życiu*, Wydawnictwo Salwador, Kraków 2008.

¹⁸ W. Szumowski refers to anyone who has the power, ability or a gift to heal others as a healer. In his view, this group primarily includes doctors. Originally, anyone who knew how and wanted to treat could commit to treating people. Self-proclaimed healers included witch doctors, wizards, priests, chiefs, then replaced by professional physicians. In temples, this role would be played by priests, Jesus Christ, and the Saints. All of the above-mentioned people were healers. Medical practice certificates were required in the Middle Ages among Arabs and issued by the Salerno Medical School, especially since the famous Constitutions adopted by Emperor Frederick II. Cf. W. Szumowski, *Filozofia medycyny*, Wydawnictwo Marek Derewiecki, Kęty 2005, pp. 113-114.

“(…) To be able to communicate about things that others have no access to seems to me like being the master of life and death. Because this is so, indeed. You put a man to sleep on the table. There comes the surgeon and everything is in his hands. He might have golden hands or be a bodger. He might lead another human this way or that way. These things are unique. This is the daily existence at the interstices of life and death” (X/10/M).

The reason for this interpretation is probably (also) the fact that patients increasingly want to constantly enjoy good health, reduce pain at all costs and avoid suffering and death. They have the illusory hope for postponing death, a happy life and even longevity. Many expect doctors, and thus medicine at large, to achieve impossible things and think of doctors as the preachers of longevity, the kings of life and death, and the prophets of human's fate¹⁹. Now, speaking about significant challenges they face daily, doctors themselves mostly point to the knowledge and skills needed in their profession to save patients' lives. Nobody who is not a doctor (does not study medicine, has no medical training) cannot perform actions reserved to doctors and does not bear such responsibility. Sometimes, the narratives show that doctors might be tempted to think of themselves as gods, especially if treatment is successful despite the slim chance of success.

Another issue worth mentioning is the medical training system, which envisages omniscience and infallibility and makes students adopt this view. A person who embraces this concept of their profession becomes someone else, has a disturbed concept of their capacity and cannot see their limitations, and thus accept failure. Failure might either result from a mistake or the biological capacity of a specific patient's body. This way of thinking makes it difficult to function in the professional realm as it becomes a source of stress and constant dilemmas and responsibilities.

“(…) In tough and hopeless cases, I continued to do all I could as if I wanted to turn the fate around. This was unnecessary. It was awful.

¹⁹ Cf. K. Leśniewski, „*Nie potrzebujq...*”, op. cit.

Now, with a more professional mind-set, I realize what it was about then. I was so charged it seemed to me that every hour, every day is so important, without regard for the quality and what is really going on (...)" (III/3/K)

„(...) Medicine requires all of them to be omniscient, to know everything, know what needs to be done. Doctors are required to be supernatural in a way. Doctors cannot be wrong. They cannot. If they do, they are good doctors. Now, who wants to be a bad doctor? To them, their profession does not accept a failure; they think they “cannot go wrong in their profession.” They think: “I will never go wrong.” It would be cool not to ever be wrong; patients would benefit from that, and there would be no damage. There will be damage, though, because I might always go wrong. (...) If medicine, society and patients expect that a doctor will know answers to all questions, always know what to do etc., the physicians somehow adapt to that; they want to actually respond to that demand. “They expect something from me, I will do it”. I always need to know, I need to know it right now, I need to know for sure, and this is often not the case. (...) This is the kind of a human who thinks they always know, they know everything, they know better, they don't need to listen to their patients, they don't need to talk to them”(VI/6/M).

The doctor/God concept is likely to translate into hierarchical relationships between doctors and patients and objectification of the latter. This is a trap of sorts that leads to a utopian image of the way doctors function in their profession, a sense of superiority, their adopting a higher position in the social hierarchy (both among people and professionally). Thus, the reflection, humility and the real judgement of reality (a given medical situation and one's possibilities) are needed.

The narrative shows that the educational system that trains medical professionals is not the only source of the conceptualization in question. What is equally important is the society that expects doctors to be infallible and near-omniscient. All patients love doctors who make no mistakes and are confident about their decisions. Any doctor is a God until they go wrong²⁰.

²⁰ The expectations regarding doctors are excessively high: patients think of doctors' actions in terms of miracles. Only doctors receive requests and wishes that inherently cannot be fulfilled, as if they possessed unlimited knowledge of diseases

“(...) Let me just say one more thing – patients think doctors must keep smiling and have no right to be sick. They have no right to have problems of their own. It is a common case with our profession. “What, the doctor sick?” I recall the following situation that happened back in the days. We are having a briefing. A patient comes in [and asks – B.A.] “is Doctor X around”? He is not [I respond – B.A.], he is sick. “How come he is sick?” [the patient is surprised – B.A.]. The concept of a doctor always enjoying good health and being satisfied still prevails in our society. They have no right to divorce, no right to be troubled, have a child sick or have had a sleepless night (...)” (IX/9/M).

Although it makes the role of a physician difficult, this metaphor is also a source of privilege and prestige. „It’s a burden, but also a privilege to an extent” (V/5/M). It is worth noting that the God metaphor does not only apply to actions taken with regard to the patient, but also to doctor’s social status, which rests on doctor’s medical knowledge and skills. The society is of the view that having a doctor for a family member or a friend helps oneself handle health-related matters (e.g. obtaining a diagnosis or a referral to an appropriate specialist), and thus provides a sense of security and peace. It is worth noting that this belief is universal and often borrowed from others²¹.

„(...) As I about to divorce, my mom said: You’re a doctor. You always win.” I told her it wasn’t the case. I didn’t agree with her. As time went by, though, I realized she had been right... I don’t mean it in the mean way or with satisfaction, but with regret, because I used to think (...) (XIV/14/K).

Another metaphor similar to the God metaphor is that of the **shaman**²². It occurs in one narrative only but it is worth highlight-

and death, noted Stefan Schwarz. Cf. S. Schwarz, *O zawodzie lekarza, Przegląd lekarski* 1973, No. 5, p. 418.

²¹ L. Peter Berger argues that identities are allocated in a social fashion. They need to be reaffirmed socially on a regular basis. We become what others think of us. Cf. Berger, *Zaproszenie do socjologii*, Wydawnictwo Naukowe PWN, Warsaw 1988, p. 97.

²² Shamans would act as intermediaries between human and supernatural forces in various matters, often health-related issues. They may be regarded as some of

ing. A shaman is represented as the chosen one; one who 'brings' good health and discards the disease. The narrator also emphasises having various values at their disposal, with the most important being life and health.

„(...) This is a bit of a shaman profession, that is, you have many values in your hands that others have no access to. The fight against the disease often happens the interstices of life and death” (X/10/K).

Another metaphor is that of a **priest (confessor)**, whom one can confess their secrets to knowing they will never reveal them to anyone²³. As pointed out by Roman Tokarczyk²⁴, the priest conceptualization is of the universal and timeless variety – “if a priest deals with human souls, then doctors are priests dealing with human bodies”²⁵. However, it seems that this framing applies to problems that are not directly related to patients' somatic aspects, but their mental life.

„(...) You are often a bit of a confidant (...), one supposed to listen to what patients have to say rather than just recommend a dose or so” (XVI/16/M).

„The doctor is supposed to be helpful (...) and in a way becomes a close person to the patient. (...) This mother is going to tell you everything. Patients can say things to doctors that they would not to many others. They may get to talk about their family problems. Even their own problems (...)” (III/3/K).

“(...) This is a profession in which patients reveal their secrets to us; we know things... the abuse of this trust could make us unbelievably rich, wealthy. God knows what else, but this would compromise your career (...)” (VII/7/M).

the original physicians, cf. T. Brzeziński, *Wprowadzenie*, [in:] *Historia medycyny*, ed. T. Brzeziński, PZWL, Warsaw 2000, p. 26.

²³ Patients should confidentially provide their doctors with all information that can help the doctor properly diagnose the patient and design a treatment process.

²⁴ R. Tokarczyk, *Normatywne aspekty relacji lekarz-pacjent*, [in:] K. Imieliński ed., *Humanizm i medycyna. Relacje lekarz-pacjent*, Warsaw 1993, p. 92.

²⁵ *Ibid.*

„(...) People tell doctors things they cannot reveal to anyone else. Sometimes, doctors know more... I often jokingly say: „Please tell me everything from the beginning, because you need to tell your doctor more than you would to a priest at a confession or a prosecutor”. I found out about that on many occasions. Some of the situations have been hair-raising (...)” (IX/9/M).

„(...) Patients tell us things you usually don't reveal in a wider circle. You don't undress in front of others. (...) The boundaries not to cross in other relationships are crossed naturally in this profession. This is quite unique. Even at the stores, we use changing rooms. And in this case, one meets another person for the first time and gets naked in front of them. It is unique that natural resistance and boundaries have to be broken for us to do a good job [...]. Because of our profession, we get to experience what others normally don't, and we ought to respect it” (XI/11/K).

The priest metaphor points to the culturally entrenched belief that some of the standards of social interaction are being suspended in doctor-patient relationships, for instance the standards manifested in one's refraining from intimacy and keeping certain reserve. The medical relationship between doctors and patients is marked by the asymmetrical contact that consists not only in the disparity in the knowledge and power, but also patients' revealing their personal, intimate and concealed problems. The patient comes out with these problems and the doctor might choose to attentively listen to them without revealing any of their own weaknesses, dilemmas, trouble or secrets. This narrative implies that this perspective might be considered in terms of a problem. Such a perspective is typical of patients. From physician's perspective, we can also see some uniqueness about this phenomenon. Both perspectives are valid, but one should not disregard patient's optics and view it as less important, or just another part contributing to diagnosis. One should also reduce the shame that comes with all situations related to examinations, diagnostic situations and hospitalization and make them as impersonal as possible.

Another conceptualization of 'a doctor' may be associated with the symbolic **brother**. A doctor is seen as a brother, the relationship

being compared to the relationship between brothers²⁶. The relationships between brothers in tribal communities are relationships by kinship, which exist since the moment of birth, due to one's origins²⁷. Another significant type is brotherly relationships between biologically unrelated individuals, who want to 'be like brothers' to each other. The original source of these relationships is rooted in religious and magical beliefs²⁸. Fraternal obligations are reciprocal. When one of the partners does something valuable for the other, the latter is expected to do something valuable in return²⁹. This, however, does not mean that the obligations need to be identical. "It depends on the extent of help each 'brother' needs from the other, and how much each can actually do for the other"³⁰.

"(...) This hospital has always been like a family place. Should anyone say: "Listen, I've got a problem," then they would always get helped at that hospital, and even if they work somewhere else, they would always get there. (...) And yet I think of a janitor's and a professor's children in the same way: they are just children suffering from a disease. The only criterion in this case is the severity of the disease, and not the profession or connections, and I have pretty much acted this way so far. (...) I remember that child (...) who arrived from an orphanage. They suffered from anencephaly. They had severe pneumonia and were dying during my call. Nobody wanted to do anything with that. I told nurses that they should not worry, that I would take it upon myself. But "take it upon myself" implied I knew what needs to be done. I have graduated in oncology and palliative care (...), with the awareness of dying and holding this child's hand. Watching the screen as it is

²⁶ "One can also be a brother exclusively in a given matter. Should the connecting link go missing, people will just live one next to each other; they won't be connected to each other anymore. One cannot be a brother in isolation". Cf. A. de Saint-Exupéry, *Nocny lot. Ziemia planeta ludzi. Pilot wojenny*, Biblioteka Klasyki Polskiej i Obcej Wydawnictwo Literackie, Kraków 1974, p. 339.

²⁷ F. Znaniecki, *Relacje społeczne i role społeczne*, Wydawnictwo Naukowe PWN, Warsaw 2011.

²⁸ Cf. *Ibid.*, p. 183 et al.

²⁹ *Ibid.*, p. 186.

³⁰ *Ibid.*

shutting down. It is more of pure presence, because one could have done little there, but this story has a follow-up to it. The next day, a man came who introduced himself as this boy's father and told me, crying: I had been told he would be useless, and so I gave him up and abandoned him at an orphanage." I could have told him: You did wrong." I didn't, I thought that this was a one-in-a-lifetime moment to him. I told him: "Please, don't worry, I have substituted you by holding this boy's hand. Nobody would have done it better than I did. Please, rest assured that he had a father by his side." I showed him that he had done wrong yet someone else fixed it. (...)" (I/1/M).

The narratives also featured comparisons between doctor's work and **hairstylist's**, **fairy's** and **psychologist's** work. The similarity is highlighted to stress the significance of conversations in all of those professions. They appear to differ from each other, but in the light of their context, they are similar and complementary. The doctor comes across as one who will change patient's life for the better, will make life more beneficial to the patient. Hence, the doctor has a 'fairy-tale power' of changing patient's life. Then, the comparison to the hairstylist points to the direct change in patient's body. Like a hairstylist, a physician has to be technically able, his actions being aimed at transforming both patient's appearance and his frame of mind. For the change to satisfy the patient, the doctor needs to know their needs and desires, something only a friend or a psychologist can do. The allusion to a psychologist is probably not accidental because it alludes to previous statements about meeting patients' non-medical needs, i.e. those related to mental, spiritual and social realms. It is worth noting that all of the above-mentioned terms were made in the unique context of the narrator's speciality, that is dentistry. In this case, the act of 'transforming' the patient from outside seems more understandable.

The last comparison is to **an official**. This is about the purely service-based exchange between the parties. The doctor acts in the capacity of an official and is obligated to execute actions pursuant to their mission. Official's career used to come with significant esteem and prestige, unlike today - though it ultimately depends on

a community. Doctors often point to such attitudes among patients, who view them solely as service providers (e.g. issuing certificates, prescriptions and other documents). This situation is confirmed by the Head of the Ethics Commission of the Lower Silesia Physician Council³¹, who said that, in light of 'medical services/procedures' and 'operational algorithms' in place, physicians have come to be service providers. Accordingly, not only do a large number of patients approach physicians expecting them to have services rendered to them, but they also seek to hold their physicians accountable for these services. However, the treatment process – as arguably pointed out by the author – is something more than merely a service.

„(...) This occupational group has definitely lost some respect from their patients. We are often treated like officials. Patients want something from us, we need to give it to them, as if they were applicants. They take the roles of applicants themselves and treat us like officials. (...) Patients acting as applicants, and physicians acting as officials: these are not good roles (...)” (XV/15/K).

“(...) I get in touch with a GP, and he tells me: “Doctor, when the patient with an untreatable tumour had been discharged, they brought me this list of tests. They want to have tests for their thyroid and prostate cancer. They probably searched for information online and have no idea about it all. They told me I was the one supposed to provide them with prescriptions (...). What should I do?” And I see this is as absurd and pointless (...)” (VII/7/M).

„(...) There are more and more papers, we are in front of computers all the time. We count points. We do things that should be done by someone else. (...) This worries me (...)” (XVI/16/M).

2. Social category

Another major category is associated with **the social view of the profession**, which reveals some grand ideas, emphasising public

³¹ M. Orlicz-Benedycka, *Dehumanizacja medycyny zagraża lekarzom i pacjentom*, „Medium” 12/2012-1/2015.

trust³² and responsibility for patients' life and health. In this context, it is worth pointing out that physician's practice is governed by a number of regulations such as the Law on Physician's and Dentist's Professions, and the Law on Healthcare Institutions³³. Now, the ethical rules that govern physician's practice are set forth within the Medical Code of Ethics³⁴.

This group's narratives clearly point out that the occupation in question is a distinguishing feature, something that elevates their social rank, or puts them in a special position. The rank of the medical profession has been built as medicine has developed. As Jan Hartman points out³⁵, in the 20th century, doctors reached the heights of social prestige. However, the essence of doctor's occupation as such has not changed and is thought of as the service based on a special calling. It is worth pointing out that at the heart of both ideas – the service and the calling – is Christianity. Although doctor's service and a priest's serving God are not identical, one should think of the former as the healthcare service for the humanity at large and the specific individuals.

"(...) These are people whom you should trust the most. If you trust me, I should live up to it. It is not that I get it as a bonus... I often tell my kids that putting yourself in this position comes with a greater pressure than positioning yourself as one among many. I think this is a great elite that should act as a role model (...)" (XIV/14/K).

"Medical practice is one of the few vocations referred to as "the profession." You say "medical profession" and you understand what it is about. The word 'profession' (...) is derived from the Latin word 'pro-

³² "Medical profession is one of the vocations with 'a social mission', as observed by B. Bajcar, A. Borkowska, A. Czerw, A. Gąsiorowska in *Satysfakcja z pracy w zawodach z misją społeczną. Psychologiczne uwarunkowania*, GWP, Warsaw 2011, p. 17.

³³ Journal of Laws of 2008, No. 136, item 857; Journal of Laws of 2009 No. 219, item 1708; Journal of Laws of 1991, No. 91, item 408.

³⁴ B. Bajcar, A. Borkowska, A. Czerw, A. Gąsiorowska, op. cit., pp. 18–19.

³⁵ J. Hartman, *Bioetyka dla lekarzy*. Wydanie 2, LEX a Wolters Kluwer business, Warsaw 2012.

profession', i.e. an oath. There are several vocations that differ from others in that their members are bound by an oath. (...) The essence of this profession is that patient's welfare is the most important thing, that I will keep self-improving and work with my colleagues, other physicians" (VII/7/M).

„And then comes selflessness: I should help them even if I don't get paid because I'm a doctor. The Medical Code of Ethics says: "Physician should receive decent remuneration for their work. However, if they face a situation where they can help someone without getting paid, they still need to help them" (X/10/K).

Upon taking an oath, a physician is bestowed upon a special position. They come to be thought of as a professional. One aspect of this concept is "a competent professional that has the responsibility for their patients' health." Another is that doctors need to constantly improve their qualifications; at last, the third aspect is about doctors' need to work with their colleagues. Doctors' medical practice rests on their knowledge and craftsmanship. Having attained this craftsmanship and improving it is obvious part of the medical ethos. The concept of craftsmanship has been extended to cover organizational and social skills related to one's working as part of a group under specific conditions. This refers to one's being routinely efficient, technologically savvy, capable of using their work tools and working within healthcare system. In terms of professionalism, physician's activity seems to boil down to the rendition of services, but this would be too simplistic a view³⁶.

The narrators are aware of the obligation towards their patients, which might not always be able to pay for their services and planned treatment process. All of this instils some optimism as nowadays the image of the healthcare industry and the people behind it is not quite optimistic. We can easily come up with a list of failed medical interventions, conflicts between physicians and their patients, all of which have ruined the trust and faith in selfless help.

³⁶ B. Bajcar, A. Borkowska, A. Czerw, A. Gąsiorowska, op. cit.

3. Everyday category

The third category shows that the realities of the career that has no time standards and is associated with the strong commitment to patients' problems. These statements often feature the term '**total profession**'. The narrators point to heavy workloads and related (patients') problems. Here are some examples:

„In my view, this is not a 9-5 profession, where you clock out and go home. (...) This profession is actually your life, I have always known that (...)”(XVI/16/M).

“We go home, depressed about something that happened at work. The hospital as seen from a physician's perspective is full of sick, suffering people. If you spend a lot of time there, you leave some of your energy there. (...) This surfaces in conversations with my wife. She carries her patients within, she keeps the things that happened, the tragedies, within herself. You invest a lot of your emotions in it. This definitely changes your mind-set. I tell my students that medical practice will make them act different in life. If I need to make a hard decision, I will cut off all of the extreme options and pick the safest solution. This is physician's way of thinking. (...) This translates into your entire life. It is a profession full of tension (...)” (I/1/M).

„(...) I pick up 40 patients' phone calls a day. I do not know if it's good, it is just the way it is” (IV/4/M).

„Yesterday, I left my home at 7:10 and got back at about 22:10. I spent the whole time at work. I was on the ward. I was at the hospital. I was at my office, and then I came to carry out the surgery in the evening. Of course, I was lucky not to be alone, I worked with my team. As I returned home, my kids were already asleep (...). I saw them for a couple of minutes while having breakfast (...)” (XIII/13/M).

“(...) To this day, if I have a patient with a critical illness, my thoughts keep being elsewhere. These days, it is different, though. This has to be a seriously ill patient. In the beginning, a complex problem was enough for me to have my mind occupied with that patient. This has had a huge impact on my life” (X/10/K).

"(...) This is a profession that requires you to be very careful, it is not just about what you say but also how you act" (VIII/8/K).

The narratives that make up this category primarily show the amount of effort put into work. The narrators focus primarily on ordinary, daily activities and actions taken with respect of their patients. They also speak of physicians in terms of normal human beings, who have certain physical capacity, resilience and problems. Furthermore, as they emphasise a lot, in the doctor-patient relationship, a medical professional is requested to handle their task well. In that process, he is, on the one hand, a specialized professional and, on the other, a human being who understands the other: their patient.

"(...) Normal people in the face of concrete challenges (...) (I/1/M).

"A doctor has to be, above all, a human (...)" (VI/6/M).

"(...) Physicians who primarily approach themselves with distance. They should not be condescending. They should be good people. They need to have the right character to handle stress well" (XII/12/M).

The way medical profession is conceived within this category oftentimes disregards the unique position, i.e. the authority, the great respect and esteem physicians enjoy, something that used to be stressed a lot. Some narrators reduce their profession and related duties to the difficult work that comes with great responsibility and burden. At the same time, they point to various doctor/patient relationships, which involve power and knowledge.

Professional training

The presented meanings and senses attributed to the profession of a physician carry certain implications for both medical and educational practice. It is primarily about training physicians in a way that provides them with sensitivity towards their patients' needs, their subjectivity, autonomy and dignity. One's conceiving of their

professional role in terms of a special calling and service for the good of another human being translates into the quality of their decisions and the way they perceive other people, for whom they take their actions. The research project by Neeli M. Bendapudi and her research team³⁷ shows that 'accuracy' was most often mentioned by patients as "the best kind of behaviour they have experienced from a physician", and 'empathy' was the least frequently mentioned. The 'worst kind of experience' was mostly disrespect and lack of sensitivity from the physician. The authors behind the survey concluded that the low quality of physician's service, as articulated by patients, results from physician's arrogance, manifested in their disregard for their patient's contribution towards treatment, the physician's disinterest in their patient as an individual, impatience in responding to patient's questions or callousness in discussing possible treatment outcomes. Without a doubt, the *strictly medical* obligation is easier to execute than the one related to soft skills, including communication with patients. It is impossible to help patients without comprehensively considering their individuality – their living conditions, family situations and emotions experienced due to their diseases and other matters. We differ from each other as individuals. On the one hand, each of us is special and unique, on the other, hard to interact with because of the diverse experiences that have constructed us³⁸.

Medical training should primarily address patients as special and unique individuals. It is, therefore, essential for the medical education to draw upon anthropological categories formed within Christianity, which facilitate individual's deeper commitment to their vocation/profession, and thus the help provided to the suffering. Physicians shall want and be able to communicate with other people (patients) if they want to deliver their duties well and live up

³⁷ M.N. Bendapudi, L.L. Berry, K. Frey, Turner, J. Parish, W.L. Rayburn, *Patients' perspectives on ideal physician behaviors*, "Mayo Clinic Proceedings" 2006, vol. 81, No. 7, pp. 338–344.

³⁸ Cf. for instance W. Eichelberger, I.A. Stanisławska, *Być lekarzem być pacjentem. Rozmowy o psychologii relacji*, Wydawnictwo Czarna Owca, 2013.

to the expectations. The way we behave towards others is decisive in whether we are human or not. Furthermore, the above-mentioned categories clearly accentuate human's spiritual dimension, which allows physicians to establish personal relationships with their patients and initiate the process of providing help, accompanying and being with the patient, "the internal healing," something covered in greater detail by Małgorzata Krajnik³⁹.

The training programme for the medical profession should offer more course time as part of the courses dedicated to communication and development of soft skills in prospective physicians⁴⁰ (it would make sense to audit the teaching programmes of those courses as well). Special teachers may be involved in teaching some courses or issues. It is worth pointing out that special education, especially special medical education, shares a lot with medicine, e.g. the similar objective: the recovery of what has been damaged or impaired in one's body, although the paths to achieve this objective are obviously different⁴¹; nevertheless, they complement each other. Aware of the human body's compensation capabilities and the way that patient's acceptance of their own disease or disability impacts their lifestyle, special teachers, or special medical teachers, can use their many years of experience with patients to transfer their practical (and also theoretical) knowledge and make prospective physicians more attuned to their patients' problems.

Medical schools should consider offering medical graduates obligatory courses in communication with patients (by analogy to the courses provided for prospective teachers). Such courses would aim to provide future physicians with a rudimentary set of communication skills through appropriate training methods and techniques.

³⁹ M. Krajnik, *Whole-person care – hope for modern medicine?*, "Polish Archives of Internal Medicine" 2017 (on-line in press).

⁴⁰ A cursive look into teaching programmes at medical universities shows that the time allocated to courses teaching communication and non-medical knowledge and skills cover are too few.

⁴¹ Cf. J. Doroszewska, *Pedagogika specjalna*, t. I, Zakład Narodowy im. Ossolińskich Wrocław, Warsaw, Kraków, Gdańsk 1981.

The value of physicians' undeniable knowledge and skills aside, it is worth stressing the importance of physicians' humility with respect of themselves and their achievements. Humility shall help physicians constantly improve their knowledge and skills and make them approach others as they do themselves. "A physician will never be a miracle maker. Regardless of the progress of science, we will never succeed in creating a utopian world, in which we will be able to cure any disease and get rid of any structural defect of the body. It would be so good if medical practice came with a kind of humility based on the understanding of the imperfections of this practice", says Zbigniew Szawarski⁴².

Bibliography

- Bajcar B., Borkowska A., Czerw A., Gašiorowska A., *Satysfakcja z pracy w zawodach z misją społeczną. Psychologiczne uwarunkowania*, GWP, Warsaw 2011.
- Bendapudi M.N., Berry L.L., Frey K., Turner Parish J., Rayburn W.L., *Patients' perspectives on ideal physician behaviors*, "Mayo Clinic Proceedings" 2006, vol. 81, No. 7.
- Berger P.L., *Zaproszenie do socjologii*, Wydawnictwo Naukowe PWN, Warsaw 1988.
- Bidakowski K., Wójcik T. ed., *Pamiętniki lekarzy*, Wydawnicza Spółdzielnia czytelnik, Warsaw 1968.
- Bogusz J., *Lekarz i jego choroby*, PZWL, Warsaw 1984.
- Brzeziński T., ed., *Historia medycyny*, Wydawnictwo PZWL, Warsaw 2000.
- Brzeziński T., *Wprowadzenie*, [in:] *Historia medycyny*, ed. T. Brzeziński, PZWL, Warsaw 2000.
- Ceran W., *Jan Chryzostom o leczeniu i lekarzach*, "Acta Universitatis Lodziensis". Folia Historica 1993, No. 48.
- Chomczyński P., *Paradygmat interpretacyjny*, [in:] *Słownik socjologii jakościowe*, ed. K. Konecki, P. Chomczyński, Difin, Warsaw 2012.
- Doroszewska J., *Pedagogika specjalna*, t. I, Zakład Narodowy im. Ossolińskich Wrocław, Warszawa, Kraków, Gdańsk 1981.
- Eichelberger W., Stanisławska I.A., *Być lekarzem być pacjentem. Rozmowy o psychologii relacji*, Wydawnictwo Czarna Owca, 2013.

⁴² Z. Szawarski, *Mądrość i sztuka leczenia*, *Obraz/ Słowo/Terytoria/* Gdańsk 2005, p. 352.

- Giddens A., *Nowoczesność i tożsamość*, Wydawnictwo Naukowe PWN, Warsaw 2012.
- Grun A., Dufner M., *Ta choroba zmierza ku życiu*, Wydawnictwo Salwador, Kraków 2008.
- Hartman J., *Bioetyka dla lekarzy*, Wydanie 2, LEX a Wolters Kluwer business, Warsaw 2012.
- Hollender M.M.H., *Stosunki między lekarzem i pacjentem*, [in:] *Psychologia w praktyce lekarskiej*, ed. M.H. Hollender, PZWL, Warsaw 1975.
- Kępiński A., *Poznanie chorego*, Wydawnictwo Literackie, Kraków 2002.
- Kostrzewski P., Ziółkowski J. ed., *Mała encyklopedia medycyny*, Wydawnictwo Naukowe PWN, Warsaw 1999.
- Orlicz-Benedycka M., *Dehumanizacja medycyny zagraża lekarzom i pacjentom*, "Medium" 12/2012-1/2015.
- Regulation of the Minister of Health of 2 January 2013 on doctors' and dentists' specialties* (Journal of Laws of 8 January 2013, item 26)
- Schwarz S., *O zawodzie lekarza*, "Przegląd lekarski" 1973, No. 5.
- Sławecki B., *Znaczenie paradygmatów w badaniach jakościowych*, *Badania jakościowe. Podejścia i teorie*, ed. D. Jemielniak, Wydawnictwo Naukowe PWN, Warsaw 2012.
- Szawarski Z., *Mądrość i sztuka leczenia*, *Obraz/Słowo/Terytoria*, Gdańsk 2005.
- Szewczyk K., *Bioetyka. Medycyna na granicach życia*, Wydawnictwo Naukowe PWN, Warsaw 2009.
- Szumowski W., *Filozofia medycyny*, Wydawnictwo Marek Derewiecki, Kęty 2005.
- Thorwald J., *Stulecie chirurgów*, Wydawnictwo Znak, Kraków 2009.
- Thorwald J., *Triumf chirurgów*, Wydawnictwo Znak, Kraków 2010.
- Tokarczyk R., *Normatywne aspekty relacji lekarz-pacjent*, [in:] *Humanizm i medycyna. Relacje lekarz-pacjent*, ed. K. Imieliński, Warsaw 1993.
- Urbaniak-Zajac D., *Jakościowa orientacja w badaniach pedagogicznych*, [in:] *Badania jakościowe w pedagogice*, ed. D. Urbaniak-Zajac, E. Kos, Wydawnictwo Naukowe PWN, Warsaw 2013.
- Law on the medical profession Journal of Laws of Laws of 2011, No. 277, item 1634, Article 2.2.*