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PATIENT IN THE PHYSICIAN'S PERSPECTIVE. NARRATIVE RESEARCH

Abstract

This theoretical and research paper focuses on the physician-patient relationship, and more specifically on the meanings ascribed to the notion of "patient". Authors of relevant literature indicate that particular models of the physician-patient relationship depend on the understanding of the notion of "patient" as well as on the understanding of two basic terms in medicine: health and illness. This assumption was the starting point for the presented analyses.

Research was conducted within an interpretative paradigm framework. The study group consisted of physicians with different levels of experience and lengths of professional employment, as well as of various specializations. An analysis of collected data allowed for the identification of three categories of the notion of "patient": personal, subjective-objective and objective.

Keywords: physician-patient relationship, patient, help

POJĘCIE „PACJENT" W ODBIORZE LEKARZY. BADANIA NARRACYJNE

Abstrakt

Prezentowana praca ma charakter teoretyczno-badawczy i dotyczy relacji lekarz – pacjent ze szczególnym uwzględnieniem znaczeń przypisywanych pojęciu „pacjent". W literaturze wskazywany jest fakt, że określony model relacji lekarz – pacjent zależy od rozumienia osoby pacjenta, a także od rozumienia podstawowych dla medycyny pojęć: zdrowia i choroby. Powyższe założenie stało się powodem podjęcia prezentowanych analiz.

Badania prowadzono w paradygmacie interpretatywnym. Grupę badawczą stanowili lekarze o różnych specjalizacjach, z różnym doświadczeniem i stażem pracy. Analiza zebranego materiału pozwoliła wyłonić trzy podstawowe zakresy rozumienia pojęcia „pacjent": osobowy, podmiotowo-przedmiotowy i przedmiotowy.

Słowa kluczowe: relacja lekarz – pacjent, pacjent, pomoc

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> "Act in such a way that you treat humanity, whether in your own person or in the person of any other, never merely as a means to an end, but always at the same time as an end" (Kant 1984, 62).

Introduction

The physician-patient relationship can be defined in terms of a phenomenon remaining in the center of interest of the humanities as well as medical or social sciences, both in theoretical and empirical dimensions. Scientific works clearly concentrate on components of communication, its verbal and non-verbal language as well as factors enhancing its effectiveness. Researchers also direct their attention to the subjects of relationships in which the person of the physician aroused (especially formerly) and still arouses much more interest (although they are usually assessed from the perspective of patients). Currently, the focus of interest is more and more often shifted to the patient and to highlighting his role in the complex relationship with the physician. The role of the patient, i.e. the somewhat neglected but important subject of that relationship is rightly noticed, since it is his activity, commitment or personality traits that build the relationship with the physician and have an impact on the outcome of the therapy.

Taking a closer look at various conditionings of the physician-patient relationship may help prevent formulation of extreme opinions and apportioning unfair blame for failed physician-patient relationships. The relationship in question has a multidimensional character and it evolves continually due to our changing approach to the concept and nature of diseases, the physician's attitude to the patient, universal and publicly available medical care (reforms in the field of healthcare), as well as to a whole series of administrative, political or financial factors (Ostrowska 2011).

Physicians, when establishing contacts with patients, use their knowledge to support them in achieving broadly understood state of health. This help cannot be provided without establishing a personal relationship, or in other words, without surpassing the instrumental dimension reduced to purely medical knowledge, and reaching the expressive dimension which encompasses the attitude of the physician (as a specialist and as a human being), communication with the patient and other skills relevant in interpersonal relations. It can undoubtedly be demonstrated, based on the research and observations, that the patient's recovery is conditioned not only by a properly selected chemical substance (being sometimes a means of last resort), or a medical surgery, but above all by the person of the physician. Cartesian dualism, and its reductionist implications have long ceased to be regarded the only remedy for human ailments. A holistic, integrated and humanistic approach to the patient whose important role in medical treatment has long been acknowledged, is now strongly reemerging. It requires a change of attitudes and beliefs not only of medics but also of patients. Medical knowledge, undoubtedly necessary in caring

for the sick, needs to be complemented with an appropriate attitude of the physician towards the patient's problems. Examples include patients whose disorders have no medical background, namely, those suffering from psychosomatic diseases, whose understanding, apart from biomedical data, requires the knowledge of other conditions such as family situation, nutrition style, physical activity and social bonds.

Interest in patients and their problems, respect for the treated person, emphasizing patients' subjectivity and autonomy, as well as including them in the therapeutic process, will ultimately enhance its effectiveness. In this context, it is important to sensitize physicians to the needs of others as persons who should not be treated in a reductionist way at any stage of treatment. Patients who feel that they are treated in a personal manner find it easier to accept a disease, they cooperate more effectively with medical staff and eventually recover faster (Antoszewska 2018). The history of medicine proves that physicians with educational background or interests related with the humanities were among those who paid attention to the complexity and multifaceted aspects of the disease (Guzek 1999, 62).

Consequently, it seems justifiable to analyze how medics perceive patients and what meanings they assigned to them, because the ways of perceiving the patient largely determine the model of the physician-patient relationship as well as the means and type of offered help. Literature provides examples of statements proving that the model of the physician-patient relationship is determined by the understanding of the person of the patient, as well as on the understanding of such basic terms in medicine as "health" and "illness". Kurt Ludewig (1995) contends that the image of man implies the existence of a specific interpersonal relationship relevant to the healing process. The author explains two perspectives on humanity. The first assumes that the physician understands humanity "as an abstract value, independent of what is individual and changeable, for such a physician «health» will constitute a norm" (Ludewig 1995, 23). According to the second perspective, the essence of humanity lies in "what is individual, susceptible to changes, and «health» will mean the current state of human development. Consequently, illness will be understood as a deviation from the ideal or as a temporary phase of the process of life" (Ludewig 1995, 23). In the light of this concept, treatment can respectively be divided into restoring the ideal state or achieving the next phase of an individual life process. Man, according to K. Ludewig (1995), can therefore be seen as an autonomous or a heteronomous entity. In the case of autonomy, the physician and the patient are partners in the treatment process, which means that the medic is an accompanying person, who helps the patient in the treatment process, shares his or her knowledge and remains at the patient's disposal. In turn, in the case of heteronomy, the domineering role of the physician who takes full responsibility for the treatment process, i.e. makes individual decisions and leads the treatment, is clearly indicated.

1. Research methodology

The presented data constitute an unpublished part of a broader project related to the physician-patient relationship, reconstructed on the basis of physicians' statements. The research was conducted according to the Interpretative/ Interpretive Paradigm (Chomczyński 2012, 211), in which, as Danuta Urbaniak-Zając observes, man is an actor drawn into the world of his life, created from meanings negotiated in social interactions (2013, 44-45). Consequently, the reality has a processual and ambiguous character and all actors who are involved in its creation strive to make it readable for themselves. According to the interpretative paradigm, the essence of research consists in explaining how to construct the world in the everyday experiences of social entities (Sławecki 2012).

The aim of the study was to describe the physician-patient relationship, to present the meanings ascribed by physicians to consulted, treated or encountered patients. The subject of the study was the relation between physician and patient, or more precisely the meaning ascribed to it. The research problem was formulated as follows: How do physicians perceive patients and what meanings do they ascribe to them?

The research was carried out in the period of 2015-2017. The group was deliberately selected, which means that the selection criteria had been established before. The selected physicians enjoyed very good (subjective) opinions of the treated or consulted patients. The opinions concerned both their clinical knowledge (they were described as very good specialists) and communication skills (approachable, very nice, patient-focused, explaining doubts). Besides the ratings posted on ZnanyLekarz.pl, oral opinions were also taken into account. Medics came from several Polish provinces, including the Masovian and Warmian-Masurian. The respondents were between 30 and 62 years old. Their clinical experience also varied. The study group consisted of 17 physicians, including one dentist. The characteristics of the respondents are presented in Table No. 1.

Table No. 1. Characteristics of respondents.

Number of physician/ interview/sex	Years of work experience	Specialization
I/1/M	38	2nd degree pediatrics
II/2/F	10	dentistry
III/3/F	29	internal medicine, diabetology
IV/4/M	34	obstetrics gynecology, gynecological endocrinology
V/5/M	19	neurosurgery
VI/6/M	23	general medicine
VII/7/M	23	maxillofacial surgery, palliative medicine
VIII/8/F	30	pediatrics, pediatric oncology

Number of physician/ interview/sex	Years of work experience	Specialization
IX/9/M	36	orthopedics, 2nd degree orthopedic and traumatic surgery
X/10/F	26	internal diseases, nephrology, transplantology
XI/11/F	15	internal diseases, nephrology
XII/12/M	8	internal diseases, lung diseases
XIII/13/M	14	urology
XIV/14/M	4	orthopedics and traumatology of the musculoskeletal system (in the course of specialization)
XV/15/F	25	oncological surgery
XVI/16/M	14	pediatrics, gastroentereology
XVII/17/F	18	internal medicine, sports and emergency medicine

2. Steps of analysis

The research findings analysis consisted in giving meaning to text data. Therefore, it involved preparing data for analysis, reaching into deeper layers of meaning. All activities included in the qualitative data analysis were conducted according to John W. Creswell (2013, 200-202).

Step 1. Organizing and preparing data for analysis – transcription of interviews, ordering handwritten notes.

Step 2. Perusal and analysis of the acquired data – generalizing, categorizing various meanings. The following questions were found helpful: What general content is contained in the respondents' statements? What is their general overtone? How can their reliability and utility be determined?

Step 3. Detailed analysis – the coding process. The material was organized into shorter – significant segments, which were assigned names derived from actual statements. The coding process requires a decision whether to create codes based solely on information obtained from research participants; use predefined codes or combinations of predefined and emerging codes. The analysis used coding based on the terms appearing in narratives.

Step 4. Using the coding process to describe the situation or people and the categories or topics for analysis. The description was based on a detailed presentation of information about people, places and events in the course of the research. During further coding analysis several thematic ranges or categories were identified and used as headings for the results section. It is worth noting that the thematic ranges are used in research in many ways, which creates additional layers of complex analysis. This section also includes specific quotes and evidence.

Step 5. Determining the method of presenting the description and thematic ranges in the narrative of the qualitative research.

Step 6. Interpretation, i.e. explaining the meaning. Its essence was best reflected by the following questions: What does this mean? What is the conclusion or gained knowledge? The gained knowledge can be the author's/researcher's own interpretation formulated in accordance with the knowledge contributed by the author and drawn from his or her experience or social background. It can also be an explanation derived from a comparison made with information contained in literature or other theories.

3. Findings analysis

The concept of "patient" appearing in narratives is located in the area of everyday life, which very clearly refers to the space of contacts established and maintained with the physician. It is worth noting that initially the narratives concerned interpersonal relationships from various areas of social life, which indicated that the relationship with the patient is the same as any other. However, in further passages there appeared details and indications primarily related to the provided help. When talking about the relationships with patients or patients themselves, the narrators ascribed different meanings to them. An analysis of the collected material allows to distinguish the following understanding and approaches to the patient:

1) personal,
2) subjective-objective,
3) objective.

The first of these meanings includes personal interpretations and meanings. Medics refer to patients as persons endowed both with their own specific characteristics and those that are common to others. This approach highlights the exceptionality and uniqueness of each encountered person, requiring an individual approach that excludes schematism and routine. The personal approach to the patient shapes a more human or "purely human" attitude in physicians which implies taking into account respect not only for the uniqueness, but also for the dignity of each encountered person. It is worth reminding the thoughts about the essence of man of Karol Wojtyła who emphasized that: "Man is a person. He is not only an entity within his species, but each such entity, each human individual is endowed with this particular feature and personality trait" (Wojtyła 2003, 95).

> "There are no two identical patients, no two identical families. (…) there are no two identical people" (II/7/M).
> "Each patient is unique in his own way" (XII/12/M).

Consequently, narrators fill their personal meaning with such terms as "sick", "needy", "with a problem" that appear in the generally accepted (non-medical) definition of the term "patient". At the same time, they highlight the problem which a person comes to a physician. It should be noted that the exceptionality and uniqueness of the patient is associated not only with specific medical symptoms,

but also (though less often) with passion or life history. Regardless of the nature of the problem, the patient always constitutes a challenge for the physician, which he or she as a specialist should face. The narratives also provide examples of ways to approach the child-patient. The relationship with the child obliges physicians to be up to date with the interests of small or several-year-old/teenage patients. This knowledge helps to get closer to them, get to know them, and thus maintain a relationship. The physicians' interest in non-medical aspects is meant to show the child that they are interested not only in the illness but also in the child as a person. The physician's interest is meant to open and make the patient familiar with the medic. One can also venture a conclusion that the patient is in the above-presented context a constant teacher of the medic.

> "We meet a particular man with his history, upbringing, school, passions. Of course, the more wealth he has in himself, the better life tastes. This imposes a certain responsibility on the physician, he must cope with it (…). I should know a bit about sailing, but also about Reggae bands, and maybe about fashion, about toys that are entering the market and a hundred different things…? About fairy tales? This diversity means that I have to adapt to it" (I/1/M).

The above statements refer not only to the issue of the knowledge acquired from the patient, but also about constant learning within the profession, i.e. about expanding strictly medical knowledge but also about acquiring clinical skills generated by a sense of responsibility and medical professionalism. The learning narrators talk about is done almost simultaneously. The following narratives provide background to the presented analyzes:

> "A patient's uniqueness lies in the fact that he constitutes a challenge for us. A new patient means a new situation, and it is precisely what makes this work interesting, because every patient becomes an incentive for our further learning, for the fact that we need to read something somewhere, check, become interested in it, look for it, and this precisely is the patient's uniqueness. In addition, patients teach us work" (II/2/F).
> "The patient's uniqueness means his rare disease" (IV/4/M).
> "[The patient] suffers from a disease, a health problem. We try to help the patient with our attitude in our relationship and with medicines. It is unique that they entrust their lives and health to us. It sounds very lofty, but it is so to a degree, because we do not deal with a factory, production, but with people" (XII/12/M).

What is more, the terms falling within the scope of the discussed personal meaning indicate that the relationship with the patient is recognized by physicians as the one in which both sides gain. The physician helps the patient overcome a disease, alleviate its symptoms or accept the situation, and patients besides enriching the clinical experience with their ailments arising from the disease and

personal experience, also allow the physician to grow internally through their personal uniqueness. This is highlighted by the following statements:

> "The main axis of the profession [of the physician is the relationship with the patient]. When does it come up? In crisis situations I return to the relationship with the patient. It is organic to me, the most atavistic and maybe primitive. It takes place at the stage of the hypothalamus" (X/10/F).
> "He or she is the subject, the most important person. Medicine apparently means people and tools, but the patient is the most important thing in all this – but it is often overlooked. (…) But patients are the basis. It is for them that one works, studies and teaches" (IX/9/M).
> "[The patient is] someone who helps me do my job. Because it is only with the patient, because I cannot with anyone else (…), first of all it is someone whom I can help by the fact that I have the skills to do something" (XV/15/K).

The physician's activity clearly resonates in the context of help provided to the patient. It refers to the applied medical treatment. The physician is a person who should help. Narrators use such terms as: I must (we must), it is necessary to, one should, I can.

> "Certainly the kind of person I need to look after and whom I should help. (…) It is so that he or she is a person who needs help and whom I can take care of. I definitely have a nurturing instinct" (XVII/17/F).
> "You have to help him with a problem. This is a man with a problem who asks me for help" (XIII/13/M).
> "We must help. [The patient is] first of all a man who comes to me because he or she has a problem. I also have such patients who come to me because they don't like something, because they have a mole and they are afraid that there might be a problem with it" (XV/15/F).
> "[The patient is] another person in need (…), they are simply people who for some reason, they are often not blamable for, because most diseases do not result from some negligence, as it may happen, who simply need help and support, who must be helped" (XI/11/F).

Those type of statements point to the necessity of providing help. Medics clearly say that patients cannot be left without it. They are not able to handle the problem themselves, they have neither proper knowledge nor skills. Patients appear to be helpless. The above-mentioned narratives fail to mention the question of solving the patient's problems together, and therefore they seem to be close to the paternalistic model of the physician-patient relationship. In addition, they reveal the kindness of the physician who, because of the suffering of another person, offers help, tries to relieve the patient. As pointed out by Władysław Szumowski (2007), in the physician-patient relationship it is only the physician who is merciful, and therefore mercy is a one-sided principle. Quite often, literature on the physician-patient relationship explores to the parable of the Good Samaritan. The physician

is identified with him. Taking care of the needy, he washes the wounds, takes him to the inn, and leaves money for further care.

Patients cited in narratives vary significantly from the educated, clean, cultural, undemanding and, conversely, aggressive, demanding, etc., but they always need the physician's help[2]. The narrators themselves, while emphasizing that none of patients can be left without help, at the same time admit that they establish various relationships with them.

> "We must help the one who is mean and the one who does not like us and ostentatiously demonstrates it to us. We do not make a difference between someone who hurt himself while drinking alcohol and one who behaved piously and had an accident. There is no question of categorizing a patient. I have to treat everyone equally" (I/1/M).
> "Actually, sometimes we are much more involved in the lives of patients than it would be justified by our work, especially of those who… Well, sometimes we have such patients whom we treat for several months, we know their life history, they keep coming back even though they were in the ward, we meet them in the clinic (…) If you are a physician, they also come with family problems, very different, of all kinds" (XVI/16/M).

Personal involvement is strongly visible in all interviewed physicians, but it is particularly manifested by pediatricians, oncologists or hospice physicians. The narrative of hospice physicians clearly exemplifies instances of help offered based on non-medical criteria, because in a terminal illness the priority is to care for the quality of life of a dying person, his or her spirituality or "inner healing" (Krajnik 2017).

> "We often can't help effectively, that is, we can't cure the disease. Well, the point is that we must somehow help the patient differently. So, I can't cure the disease, but I can help this patient after all. Because he comes to me for help although he knows that I will not cure his illness, but that I will help him somehow. But this help has to be provided on many levels, sometimes it is just help offered by one human being to another human being, i.e. simply talking, holding a hand, examining. I often examine patients, although I know it doesn't make sense. I use the stethoscope, listen to it, nod, etc. I don't need it that much, because in most cases I don't learn anything new, but I know that patients expect it and want it. (…) The patient feels somehow interested. Somehow safer anyway, right? Someone got interested in him. «I am not alone with my problem» – [he thinks]. Very often, this is what matters (…) Very often, our medical relationship in the physician's office or at the patient's bed is simply a simple

[2] Art. 3. The Medical Code of clearly indicates that the physician must provide help to every patient. "The physician should always perform his duties with respect for man regardless of age, sex, race, genetic equipment, nationality, religion, social affiliation, material situation, political views or other conditions" and it allows unequal treatment of patients where the only criterion is the patient's clinical condition as indicated by Jan Duława (*Kodeks Etyki Lekarskiej* 2013).

> relationship between two people. (…) For the most part, a suffering man comes to another man who is to somehow alleviate his suffering in various ways (…). Just look, listen to what this man has to say, let him pour out his heart and say: «This is a very difficult matter. We will try to do something about it». I say it and I don't know if I will try or not, I say it and it makes this man already feel better" (VI/6/M).

A different character is given to the physician-patient relationship characterized by the subject-object perspective. It is definitely less frequent, because it clearly appears only in a few narratives. The first situation concerns the physician's conversation with patients, face-to-face contact (during consultations, before surgery, after surgery, while in hospital in the ward'/clinic, etc.), i.e. while getting to know patients and presenting them the course of treatment. In turn, the duration of the procedure, focus on strictly medical activities, the precision of their performance – imposes the need to treat the patient as an object. The words of Jürgen Thorwald, who writes: "Compassion is the worst advisor for an operating surgeon" (2010, 437), seem quite accurate. This does not mean that the physician forgets about the person of the patient, but for some time the precision of performing a particular action which in the long run has a chance to improve the quality of his or her life becomes most important. The relationship/contact with the patient is then transformed into a subject-object relationship. The physician views the patient through the prism of physiological symptoms and diagnostic categories, which more or less correspond to certain medical models and expertise, treating the patient in an objective and at the same time reductionist or mechanistic manner. The perception of the patient as an object may result from the physician's sense of responsibility[3] and the treatment philosophy/strategy adopted/taught during studies.

> "It depends on the circumstances. When I operate him, he is an object. (…) If you still perceived him as a patient, as a person with feelings, etc.… Well, you wouldn't just plunge a knife into him (…) It's not that easy (…) You would have to be not right in the head to consciously, thinking about this person, drag a scalpel through someone's body. Thus inflicting pain. Even if someone is anesthetized. There is a limit. You cannot [go beyond it]. You really need to have this switch" (XIV/14/M).

In situations not related surgery, the approach towards the patient as an object appears only in two circumstances. The first is induced by the patient's behavior (e.g., when the patient is aggressive, demanding or anxious, humble) or the ("official") reason for the visit. Physicians faced with aggression or demands

[3] Antoni Kępiński writes that: "no man can bear such a heavy burden of responsibility. No wonder that psychiatrists defend themselves against it, looking at the patient through the prism of somatic or psychological theories by which the patient becomes «objectified», he becomes more or less an object of examination and action according to a predetermined concept" (Kępiński 2002, 45-46).

on the part of patients, while entering into a relationship with them, do so in an objective manner, namely, they perform an examination and provide professional medical assistance.

In turn, patients expecting from the physician various types of documents (e.g. certificates, sick leave), necessary to obtain discounts or benefits, and sometimes referrals to additional tests, which from their perspective are necessary for them (often they cannot justify it), are treated in an instrumental way. The narrators clearly indicate that they do not like those types of visits.

> "A patient is a person who comes because he needs help from me. Sometimes it is help, let's call it, instrumental, i.e. they come because they need a doctor's certificate, a sick leave, examination, medicines" (XVI / 16 / M).
> "[People visiting physicians] are very demanding patients, i.e. they treat the physician-patient relationship as an arrangement me-client – you-seller of regulated services financed by the National Health Fund. [They say] «Because I would like this and that. I would like to do such and such examinations». [I ask] «What do you need it for?», «Well, because I would like to know if there is something there». [I say] «But you won't find out. And even if I order it, where will you go with it?», [They answer] «Well, I don't know it yet. We will see»" (VI / 6 / M).
> "there are a lot of such patients, there are more patients who, it is not that a patient should always be a petitioner, it is not about that, but it is the question of those patients, who think that they are entitled to a number of things. They also naturally have different experiences with physicians. Well, the problem is that, for example, they might be entitled to something but I cannot, for example, offer it to them, because I am limited by some rules connected with the National Health Fund (…), so I have such and such restrictions. I have to follow these recommendations because he won't pay me for it, for example. Such a prosaic thing" (XV/15/F).

The above-presented narratives reveal the demanding attitude of patients, who demand that medics meet expectations that are not always justified and relate to the patient's state of health. The obtained statements outline the question of various experiences with patients. Therefore, the nature of the relationship with the patient is sometimes determined by the reason or problem of the medical visit, as well as the patient's attitude.

The situation changes in the case of contacts repeated systematically and lasting many months or even years, those caused by a chronic disease, disability or terminal disease. The physicians' help then surpasses the strictly medical sphere and induces deeper involvement (sometimes conscious or unconscious). According to Talcott Parsons' (2009) terminology, this is a type of help based on expressive actions. Parsons himself did not recommend establishing friendly, relations engaging the physician, since he wrote about universality, emotional neutrality or specificity of function.

The second narrative, falling into the scope of the relationship objective category of the relationship, concerns treating the patient as a kind of source of satisfaction and income. This approach characterized a dentist having a private office.

> "I earn a living and despite the fact that I'm a woman and I like to talk a lot, I like contact with people, it gives me great pleasure, I must remember that I have bills to pay, so the patient is the source of my satisfaction and a source of income" (II/2/F).

Rollo May refrains from criticizing the approach placing man within a range of subject – object meanings by pointing out that "The human dilemma is a dilemma that emerges from the human ability to simultaneously experience oneself both as the subject and the object. Both are necessary – for psychology, therapy and useful life" (May 1989, 14).

The obtained narratives reveal an emerging change in patients' attitudes, associated with their greater knowledge of diseases, but they also relate to a more demanding, sometimes even aggressive attitudes. The second change is much more common. There are probably several reasons behind it, but I will signal two of them. Patients' demanding attitudes seem to be frequently resulting from a greater awareness of their rights, or vice versa, by the lack of it. Claims or aggression have their source in stereotypes regarding inefficiency of the healthcare as an institution, but also inefficiency on the part of individual healthcare professionals or in publicized unsuccessful medical cases. In addition, as noted by Mieczysław Gałuszka (2003), patients often do not understand the complex nature of financing the healthcare services system, they only experience its shortcomings.

Conclusion

Latin terminology associated with the word "patient" has connotations with a person who suffers – *patior, pati, passus sum; patiens; patientia*, however, as Zbigniew Szawarski notes (2005, 27-40), this is not the only way of perceiving patients, because they can be ascribed other meanings related to their ability to act, either lost or not developed. Leaving the patient unattended may result in the loss of life. Therefore, depending on the type of help required, the author distinguishes two types of patients, i.e., the medical and the moral one. If the administered help results from the love of neighbor, care or solidarity with the suffering, then the person can be referred to as a moral patient. If the main motive is to help solve a specific medical problem, the person becomes a medical patient. Z. Szawarski believes that each medical patient is at the same time a moral patient, but a reverse relationship is not a norm. In the presented examples one can find similarities of the analyzed concept, especially in relation to a medical patient seeking help. Interviews with physicians allow to distinguish three

meanings and approaches to the patient: personal, subjective-objective and objective. The first is related to the exceptionality and uniqueness of each patient. The narrators, when referring to the life stories of patients, their diversity, always emphasized the necessity of helping them. The second is primarily focused on actions taken for the benefit of the patient. Such an approach is closely related with concentration and accuracy of the performed activities or tasks. Physicians faced with a specific task to perform (e.g. a specific procedure, surgery, etc.), focus only on a sick organ, trying to eliminate a disease process, remove an irregularity. They try to help in accordance with the existing standards and knowledge. They temporarily "turn off" thinking about the patient as a sick person. The third understanding is related to the very behavior of the patient who treats the physician in an instrumental way. The patient's behavior enforces this treatment on the part of the physician. The analyzed narratives reveal a paternalistic approach to patients, lack of emphasis on educating the patient or encouragement to cooperate with the physician.

The question of treating people in a way conditioned by ascribing to them a specific meaning is an important element of any relationship. Man as a person constitutes the basic relational dimension. In the case of physician-patient relationships he or she defines the whole treatment process. If a specific treatment/therapy or rehabilitation is to make sense, writes Wiesław Przyczyna (2014, 25), a personal approach to the patient cannot be overlooked. Human being is a person who has a face (Greek: *ops*) directed towards (Greek: *pros*) someone or something, in other words, he faces another person, remains in a relationship or in relation to another person (Leśniewski 2015, 41-45). Treating a patient as an object can only be justified in a specific period of time (although this is largely also a matter of dispute), it cannot become a daily practice, because it leads to routine and schematic behavior, and above all to objectification of interpersonal relations, repairing/improving "defective organs". Forgetting the fact that that man is a person, that he has a spiritual dimension, reduces him "to the role of biological unity, which is realized in a specific place in the development chain and makes him dependent on the law of natural selection and other laws of nature. If this happens, then the self-preservation instinct plays a special role in a social symbiosis based on reductionist principles", indicates Krzysztof Leśniewski (2015, 13).

The conducted analyzes indicate the need to constantly sensitize physicians (although not only physicians themselves, but also other professionals) to the perception of another person through the prism of a person. Only such a perspective enables full knowledge of and understanding of patients. What is more, only in a personal relationship can we clearly see concern for human dignity by alleviating suffering and supporting him in his development. "The condition and progress of medicine should always be assessed from the position of a suffering patient, never from the position of a person who has never suffered", notes Jurgen Thorwald (2010, 68). In the current medical reality, it should always be remembered that medicine must serve the good of the sick, and it can never be the other way around. Healthcare workers should be both educated and competent

in the field of their specialization, as well as constantly bear in mind that each person (also a sick person) is unique and that this uniqueness must be respected.

The idea of active inclusion of the patient in the treatment process that has been proclaimed for several years now is becoming possible thanks to a different view of the patient. More and more often, patients can become partners who are well-informed about the nature of illness they suffer from as well as the possible ways of minimizing its effects, and sometimes, how to accept it. This idea can only be put into practice on condition of changing the attitudes of both physicians and patients. It is necessary for both parts to approach each other with respect and to acknowledge their mutual rights. As a result, the patient's mature and responsible participation as well as the physician's acceptance and recognition of patients will lead to a better quality of healthcare, healthy lifestyle, more effective disease prevention and responsible therapy.

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