JOURNAL
of
APPLIED ETHICS
and
BIOLAW

ISSN 2501-529X
ISSN-L 2501-529X

JOURNAL of APPLIED ETHICS and BIOLAW

published by

the ASSOCIATION FOR EDUCATION AND RESEARCH IN ETHICS AND LAW - EDUCED

www.educed.ro

Subscription for hard copy:

100 Euros/year (4 issues) - including the shipping fees

Payment details: RO68INGB0000999905167265, ING Bank, Iaşi, Romania

Please send us a copy of the receipt by e-mail: contact@biojustice.eu

www.biojustice.eu

JOURNAL OF APPLIED ETHICS AND BIOLAW

Table of content

Re-Sacralisation of the Doctor-Patient Relationship

Mircea Gelu Buta*

* Prof. Dr., Faculty of Orthodox Theology, UBB Cluj-Napoca, e-mail: butamircea@yahoo.com

Abstract: *There comes a time when the doctor realizes that his/her life is not so good, lacking meaning and satisfaction that the profession was trying to offer before. Part of the new medical economy, adjusted to the market economy, the doctor is faced with a growing professional competition, strengthened by the fact that European countries have visible difficulties in financing health. The patient, in turn, is in the situation of having consumer behaviour not only wants to be happy, but also pleased with the quality of medical care services it receives. Although the doctor has the monopoly of decision on investigations, treatment and medical care by virtue of his diploma of study (brand attraction), the patient cannot have total confidence in him, unless he is willing to listen to his life and health problems, if is helped to overcome bureaucratic obstacles of the hospital or, in other words, if the doctor will pay personalized attention. Depending on the satisfying of those needs, the patient will express the degree of appreciation and fidelity with the doctor and the medical structure in which the doctor works. The respect for the ontological dimension of the patient, taking a perfected medical behaviour in determining the diagnostic and prescribing therapy, and provision of quality health care services advocates for the need of re-sacralisation of doctor-patient relationship, aspect that it is desired by both stakeholders and the society at large.*

Keywords: *doctor, patient, contractual relationship, medical practice, re-sacralisation.*

Introduction

In all specialties of the profession, elderly doctors realize that their lives are not as good as before, and that for the young ones, satisfactions as not as full as imagined at the time they started wearing the white robe. When explaining this dissatisfaction, doctors refer to the interference between the ever lower autonomy of their profession and the bureaucratic pressure they are subjected to; to never ending reports and electronic records; to the reduced time they spend with patients; to the senseless scientific reductionism; to the decline in social reward and the prolonged training; to the higher costs for studies; to increasingly demanding patients who, together with lawyers, threaten to sue for malpractice; to journalists looking for the sensational or at the service of medical supply companies which induce negative impressions and images of the medical staff in hospitals. Here are a

lot of causes that, combining at one point, produce the "burnout" phenomenon- total consumption, a feeling of alienation and dissatisfaction to the work doctors do [1].

Apart from personal causes, doctors are aware that there is also a collective sense of dissatisfaction which makes them feel that something is wrong and that the problem has much deeper roots [2].

Paradigms of Kirkergaardian irony in contemporary medicine

The discussion proceeds from Farr A. Curlin's article (2016), referring to J. Lear's work, published in 2011, which states that the discontent of physicians refects, in addition to deep anxiety, a corolary of misunderstanding [3].

The first paradigmatic moment of irony occurs when a physician realizes the gap that opens between his social representation and his aspirations in his medical career. In other words, it is about a person's representation of a doctor and what he or she should do to match the desired image even when, surpassing all imposed social standards, he or she finds that they do not meet the ideal of medicine in the classical sense. This is the moment when the doctor, aware of the dramatic loss of ideals, begins to experience living in irony.

The second ironic, otherwise unpleasant experience occurs when the doctor begins to ask radical questions: What is the disease? What does it mean to cure? Who are my patients? What can I do for them as a doctor? Do my efforts have a chance of success? It is the moment that sends us to the contemplation of Kirkegaard's ironic obsservation that becoming a man is not at all simple and little to do with the conscientious and devoted way in which we practice our profession [4].

In his notes, J. Lear reminds us that in our representation as doctors, we may miss because of duplicity, hypocrisy or even imposture in the worst sense of the word, and he states: „some is said to be a good doctor, when in fact it is all just a good facade" [5]. Of course, there are cases in which it is not about individual hypocrisies, but about situations in which the doctor, as conscientious representative of his practice, finds that in fact, the latter is the one that failed.

However, we must admit that it is not easy to be one of those exemplary physicians because of the practical nature of the profession, which includes implicit and explicit rules and requires a hard-to-end dedication. Sometimes it is hard to

listen to the patient, it is hard to follow if you are tired or busy, it is hard to deal with the sick if you have other obligations at the same time. That is why most of us are failing to give patients what the good medical practice teaches us: placing the suffering person in the center of attention, the patience to listen, the effort to understand the patients' suffering, the respect of the body and the soul, the approach to them, the care we should give them, etc.

On the other hand, many doctors fail to keep pace with medical science the way they think and know they should do, although their professors have shown them and taught them how hard it is to do it . When we are aware of these failures, it is no longer about irony, but simply recognizing that we do not present ourselves as we should against the rules established by society. Irony occurs when the doctor does not realize that he/she is out of the standards that society imposes on his/her medical career. Perhaps the problem would not be so difficult and the irony so important if reflection and self-criticism were not already part of the social practice [6].

Medical students and young doctors are always reminded that, in order to become and remain good doctors, their work should always require critical and correct reflection. Irony occurs when the doctor interrupts this reflection, creating a wrong and personal creed when he thinks he knows best what it means to be a good doctor.

Today, science together with its pompous daughter- technique, are undoubtedly the most important masterpieces of the beginning of the millennium, placing medicine, as a social representation, on a historic peak. Ultimately, it gives us a long life and the release of suffering, things we all desperately want. These successes have enabled medicine to become a powerful cultural force. In this state, critical reflection on medical practice becomes an expression of social representation, and correctly understood Kierkegaard’s irony not only leads to detachment, but also to the way social practices can be properly fulfilled. Since irony depends and evokes a person's desire to be a physician, the experience of irony should, in the case of this paradigm, stimulate doctors so that the old activities are re-committed in a new form, leading to a better outcome of the medical practice.

The power to be a patient

There is the opinion that nothing has changed so much in the health care system of recent decades as mankind's perception of its own health [7]. Today's patient knows well his/her rights and claims them

vehemently. Medical paternalism gradually diminished in favor of the consumer model that gives patients total control and accountability [8].

Surprisingly, the meeting between the doctor and the patient is undoubtedly motivated by the need of the patient to have access to the professional knowledge of the doctor, and the medical act itself appears to have a well-defined purpose, that of improving or even curing the disease based on applying medical knowledge.

However, things are not that simple, and the dialogue between doctor and patient is much more than just a discussion in which medical knowledge is applied. In medical language, the communication between the two is called clinical consultation, that is, an intimate encounter between the doctor and the patient when, from the notion of subjective signs and objectives, the doctor attempts to decipher the disease, formulating a diagnosis, prescribing a treatment, ending with the prognosis.

A relationship is established between the two interlocutors, which, if we reduce only to the biological aspect, would mean that we are getting rid of its human content. The patient is not only a living organism suffering from a dysfunction, but a being to be seen in its bio-psycho-social and spiritual integrity, which during the time spent with the doctor acquires the consciousness of a unique personal connection with a lot of meanings.

Nowadays, the doctor-patient relationship is based more on an accredited contract model, which is seen as an interaction between two equal agents, in which the physician undertakes not to abandon the patient and inform him/her so as to allow him/her to express his/ her options, taking into account four basic rights: access to relevant information, autonomy, fidelity, humanity. However, caught in the trap of the alternatives offered by the doctor (the choice between the different types of treatments and their risks), the patient, who is not a medical practitioner, can accept or refuse the proposed medical act without realizing if it is a good or a bad choice. By not being able to give consent as fully aware of the consequences, the patient is limited only to the ticking of administrative responses, the purpose of which may appear vague. The development of bureaucracy, which Max Weber describes as the "social mark of the world's dissipation", in which the physician-patient relationship, trapped in the technicalized system, descends into the dark and cold clutches of a meeting cut off by the mystery of human life. Finally, this model does

not deny the imbalance of power and recognizes the danger of going to an unwanted paternalism [9].

Most of the time, doctors strive to understand patients' opinions and to inform them about alternatives to diagnosis and therapy, giving medical advice a personalized look. As some patients dramatize and amplify their suffering, it is necessary to pay more attention to them; others do not want to live their lives under a minimum of dignity, and it is advised that the doctor respects their desires. In the face of indifferent or undisciplined people, the doctor must impose him/herself with energy, especially if, through their illness, they are a danger to others; anxious people need repeated reassurance. Every step of the physician must therefore be well thought out, because ultimately there develops a relationship between them, as the narrator thread of a story, that takes root in the miraculous and mysterious universe of the ontology to which the doctors must give the dose necessary for hope and well-being (good mood, trust, charm, optimism) [10].

As personality, the doctor may also be an optimist or pessimist, anxious or balanced, restless or calm. He is greatly influenced by his own health, fatigue or family problems. Where will he/she turn and what alternative will he/she choose? Proficiency and concentration power decrease naturally at the end of an on-call , and errors can occur more often. At such a time, to young doctor, a new case just brought by the emergency service may appear as a "torture machine ″ [11].

Even if it is often silenced, the social value of the patient is an element that the medical domain can not ignore. Hence the anxiety and interrogations of the doctor: how would I care for Einstein if he were my patient? But how much attention do you pay to the tramp from the street? Russian atomist physicist Landau, a member of the Academy, received the Nobel Prize after being taken out of a 44-day deep post-traumatic coma. However, artificial maintenance would have been interrupted, under normal conditions, two to three days after the disappearance of electroencephalographic activity ("brain death"). Fourteen specialists were mobilized at General Franco's bed at the terminal stage. There is, in reality, an "elitist" medicine for those who can afford it. At the antipode - the "statist" (budget-dependent) and the social insurance dependent medicine, which also has, like everywhere in the world, several steps, according to the price paid. We are once again turning to the decisive factor: money. The value of the patient apparently also depends on the size of their bank accounts! There

are private hospitals and hospitals for the poor. Healthcare has become more and more expensive, reaching an absolutely critical point [12].

Re-discovery of the doctor- patient dialogue

Secularization placed the desire for bodily health above of the desire for salvation of the soul, and trust in medicine replaced the hope promised by religion. Up to a point, the desire to have a perfect health and a long life, to correct physical deficiencies and improve the functional limits of one's body is undoubtedly a legitimate hope.

Contrary to the optimism inherent in science, we must not forget that the health of the body can not be a definitely acquired good. Moreover, in this world, it never exists absolutely and forever, representing nothing but a partial and provisional equilibrium, or even a state of reduced illness (Saint Simeon the New Theologist) [13]. In addition, the human body signifies more than just a network determined by biological rules. It represents the presence of a consciousness that starts from the biosphere through the Word and the responsibility to make this Word the instrument of its development [14]. We see how the Word embodies, and people realize that the time has passed when "pretending that medicine is a science, actually has to do with autistic medicine, which at the same time claims to be endowed with rationality and that her purpose is to do good" [15].

But when science is used without the consciousness of inherent presuppositions and limitations of "reason by itself", when man can no longer reasonably inquire about the essential things of his life, his withering, his imperatives and his permissions, about life and death, having to leave these decisive problems to a sense separated from reason, then he does not live in reason, but dishonors it. The disintegration of man, which occurs then, can generate a pathology of religion as well as a pathology of science, in equal measure [16]. That is why it is necessary to restore the connection of "scientific reason" with broader horizons, presumed by the dignified life which Christianity embraces with such generosity.

In this situation, contemporary medicine must rediscover the delightful force of words, in order to re-establish the relationship between the doctor and the suffering patients. The ethic of this dialogue does not in any way mean the interplay of a relationship of friendship or empathy, but the emergence of a therapeutic alliance through which words can contribute to the healing process.

Although there is an epistemological difficulty resulting from the inductive method of the process that does not allow quantification of the importance of words in any of the possible situations, the result of this process can be seen in the growing desire of patients to tell their disease history as a confession in which they actually seek physical healing [17].

Prayer is no longer considered today a chimera of the soul, but rather a support on the path of healing. In fact, the terms "medical paternalism" or "medical information transmission" are no longer relevant, because medical rationality does no longer belong exclusively to the doctor. In order to improve the quality of their medical performance, doctors will have to learn the re-sacralisation of the doctor- patient relationship, by returning to the Word and thus to the imaginary. Here is a new mission for Christians, that of promoting our and God's concept, in controversies around people. God Himself is the Logos, the original (Urgrund) rationale of everything that is real, the creative reason that the world results from and that mirrors the world. God is Logos - meaning, reason, word, and therefore is reflected in man by opening and promoting reason, that can not be blind to the moral dimension of the being. In fact, healing and the use of reason lead to the recovery of morals, in a society that tends to dissolve it in utilitarian considerations or the exercise of power [18].

References

1. McKinlay, J.B. and L. Marceau, „New wine in an old bottle: Does alienation provide an explanation of the origins of physician discontent?". In „International Journal of Health Services; Planning, Administration, Evaluation", nr. 41, 2011, pp. 30-35.
2. Farr A. Curlin, „What Does Any of This Have to Do With Being a Physician? Kierkegaardian Irony and the Practice of Medicine", in Rev. „Christian Bioetics", vol. 22, nr. 1, Oxford University Press, 2016, pp. 62-79.
3. Lear, J., A Case for Irony, Cambridge, MA: Harvard University Press, 2011.
4. Soren Kierkegaard, Opere I, Despre conceptul de ironie cu permanentă referire la Socrate, Ed. Humanitas, Bucharest, 2013.
5. Lear J., op..cit. p. 12.
6. Farr A. Curlin, op. cit, p. 67.
7. L. Thomas, 1977, cited by Dumitru Dumitraşcu, Medicina între miracol şi dezamăgire, Ed. Medicală Universitară „Iuliu Haţieganu", Cluj-Napoca, 2009, p. 33.
8. I. Turcu, Dreptul sănătăţii, Ed. Wolters Kluwer, România, 2010, pp. 154-155.
9. Max Weber, Etica protestantă şi spiritul capitalist, Ed. Antet, Bucharest 2003; see also Marcel Gauchet, Dezvrăjirea lumii. O istorie politică a religiei, Ed. Nemira, Bucharest, 2006.
10. Stéphane Bauzon, La personne biojuridique, Ed. Presses Universitaires de France, Paris, 2006.
11. Dumitru Dumitraşcu, op. cit., pp. 61-62.
12. Ibidem.
13. Cv. Sf. Simeon Noul Teolog, Cateheze, XXV, pp. 124-125.

14. Mircea Gelu Buta, „Dialogul dintre ştiinţă şi credinţă în definirea noţiunii de boală". În Medici şi Biserica, vol. V - Teologie şi ecologie (coord. Mircea Gelu Buta), Ed. Renaşterea, Cluj-Napoca, 2007, pp. 234-238.
15. Dominique Lecourt, Le mort de la clinique, Paris, PUF, 2009, p. 27.
16. Joseph Kardinal Ratzinger, Glaube - Wahrheit - Tolernaz. Das Christentum und die weltreligionen, Herder, Freiburg, Basel, Wien, 2004, p. 127.
17. Stéphane Bauzon, op. cit., p. 4.
18. Marga A. Absolutul astăzi. Teologia şi filosofia lui Joseph Ratzinger, Ed. Eikon, Cluj-Napoca, 2010, p. 304.