

Antonina Ostrowska  
Institute of Philosophy and Sociology  
Polish Academy of Sciences

## Poverty as a Factor Influencing Doctor – Patient Partnerships: Case Poland

### 1. Issue and historical context

In Poland, recent years have brought an increasing interest in the patient-physician relationship. There are few reasons behind this development. The first one is related to the systemic change. After the experience of standardized health services offered by the socialist system, expectations appeared for services that would be more individualized and of better quality. This was one of objectives of the health care reform, which was implemented in 1999. Among other things, it introduced free choice of a doctor (abolishing earlier division into territorial health care districts – “rejons”) and reinforced the institution of family doctor as the basic unit of primary care. In principle, the relationship between patient and physician was to be based more on a partnership than before. These reform measures constituted an attempt to minimize the effects of the asymmetry based on the advantageous position of physician in terms of competence, access to information and symbolic power. They were also driven by more and more obvious conviction that a good health care requires not only passive compliance of a patient with professional’s direction, but also his or her active participation in the process of diagnosis and treatment. The catchword “patients’ rights” has become increasingly popular in the public discourse.

The second reason that explains the interest in patient-physician relationship has to do with aspirations related to the accession of Poland to the European Union. The accession process required introduction of European standards to the Polish practice of medicine. According to the declaration of the Council of Europe adopted in

Amsterdam in 1994, the aim of patients' rights is to empower them with instruments that enable control over the process of curing and make it possible for them to have an active influence on it. In short, it creates reciprocal relationship between physician and patient.

Independently from local context of Poland, the need to depart from a paternalistic model of physician-patient relationship to the one based on partnership has been dictated, similarly as it was the case in the West, by changing patterns of disease. The fact that chronic diseases started to dominate on the market for health services has reinforced the demand for the relationship, which Szasz and Hollender (1956) named in their model as the relationship of "mutual participation" ("the physician helps the patient, so the patient could help himself").

Processes of change within the relationship between patient and physician have faced number of specific barriers. They derived mainly from conceptual and organizational blueprints of the socialist past. The organization of socialist health services was built on the principle of egalitarianism. It meant abolishment, at least in theory, of all differences and privileges based on one's social status; Socialist society was by definition a classless society. This principle led to substantial standardization of services offered in the national health services. Patients of different social status used the same services, which were provided by the same local outpatient health care departments and were taken care of by the same medical personnel. In hospitals, beds of, say, a company director and unqualified manual worker were placed in the same room, next to each other. Position and "power" of physicians were guaranteed by the administrative means. Compliance and obedience was built into their relationship with patients. The communication flow was one-way only. The autonomy of patients was limited. For years they did not even have a formal right choose a doctor, who was assigned on the basis of compulsory territorial health care districts.

In the end of 80s, when under-invested public health services became less efficient, the phenomenon of corruption became more and more prevalent. Very often access to services, which were nominally free-of-charge, required informal payment. This started the process of differentiating health services according to one's ability to

pay. For the less affluent, it meant increasing barriers of access. Despite the fact that the existence of corruption was a common knowledge, there were no official channels for imposing sanctions on illegal practices.

Open and institutionalized criticism of the medical system and medical profession started to be used as a form of patients' rights' enforcement only in the late 90s. Firstly, the system of accreditation started to operate. It rewarded organizations that fulfilled standards of accessibility and quality of medical services. It acknowledged the importance of degree of partnership in the patient-doctor relationship and degree of respect for patients' rights (the right to information, consent or refusal for treatment, choice of the doctor, choice of the proper care, confidentiality and privacy). Secondly, there appeared institutional mechanisms for filing complaints concerning the treatment, including adjudication of claims in courts. However, only a small percentage of physicians is found guilty by professional courts. This fact illustrates the problems of strong sense of professional solidarity and the lack of proper representation of sufferer's interests in the handling of cases by the professional courts (Sowa 2002).

To sum up, one may conclude that full respect of patients' rights and partnership in the patient-physician relationship has not yet fully crystallized. Definitely, their importance has not yet been commonly recognized. Apparently, such a conclusion provokes the question of whether there exist any social differences in this respect. Are differences in autonomy of patients related to their wealth? Is the lack of such autonomy perceived as an element of deprivation?

## 2. Hypothesis

The evidence from Western research provides number of arguments that support the thesis that patterns of health services utilization by people living in poverty diverge from patterns characteristic for middle and upper classes (Cassell 1986, Cockerham 1996). Explanations offered in the literature represent a broad spectrum of possibilities. Some arguments use the notion of culture of poverty or draw on concepts of limited life chances of the underclass. On the other hand, there are analyses based

on organizational theory and the concept of lifestyle. They tend to show that the rules on which the health services are based can have an equally important explanatory power as variables that characterize users (Coe 1978, Boulton 1986, Atkinson 1995). Arguments that are most promising in explaining the influence of social class on the existence of patient –physician relationships based on partnership can be summarized in following points:

1. Main premises, on which the structure of health services is built, are compatible primarily with values, expectations and lifestyles of the middle class;
2. Health care employees are part of the middle class and therefore they can better understand specific needs of patients coming from the same social class;
3. Patients who are similar to physicians in their social status are more likely to share a similar communication style and to communicate more effectively;
4. Patterns of socialization in the middle class equip the individual with the ability to perform more easily the sick role. Middle class representatives can better understand objective orientation of medical professionals. As the result, effects of unsubstantial differences in status can be minimized;
5. Such socialization, together with general advantages of middle class in education, makes it easier for them to adjust to existing organizational forms and to function in a bureaucratic setting. It also facilitates the development of communication skills useful in taking up negotiations with the physician, expressing one's feelings, expectations and needs.

Providing that the status of the above statements theses is fairly universal in the capitalist societies, one can expect that in the post-transformational setting of Poland differences between patients coming from middle and lower classes will appear. Namely, the representatives of lower classes will have less chance for attainment of the partnership model in their contacts with physicians. It would also mean that the socialist heritage of imposed egalitarianism ceased to exist. Undoubtedly, these issues are interesting for comparative research and related hypotheses will be also tested in the research project “Santé, Inégalité, Ruptures Sociales”.

### 3. Findings

In this paper I would like to show the impact of socio-structural factors (particularly related to social position) on the doctor – patient relation in Poland, with a special stress on achieved partnership. The empirical base for my analysis will be all-national survey conducted in 2002 on the representative sample of urban, adult population (2167 persons)<sup>1</sup>. Two types of indicators will be under consideration: 1) critical remarks concerning visits at doctor's, expressed by the patients, and 2) absence of partnership elements in doctor – patient interactions<sup>2</sup>. They are presented below, together with their frequencies:

(Figures 1 - 4)

In order to find a synthetic dimension of the presented above items, principal component analysis was used. Two independent factors, explaining 63% of variance (36% and 27% respectively) were formed. They correspond with two, earlier presented dimensions of the interaction. The first one represents deficiencies in partnership in doctor – patient relations, the second one reflects criticism towards the doctor's behavior.

(Table 1)

Treating the above dimensions of doctor – patient interactions as our dependant variables, let us see what is the role of socio- economic variables in shaping these interactions. The social and economic position of respondents is characterized by their level of education, household income per capita, subjective evaluation of their economic condition (five-point scale) [model I] and additionally selected occupations and employment status [model II]. In the last model, the professionals and unskilled

---

<sup>1</sup> The research conducted by the Institute of Rheumatology. The author would like to convey her appreciation to dr B. Moskalewicz for inclusion her questions related to doctor–patient interaction into questionnaire.

<sup>2</sup> The first indicator comprises of items which are answers to the question about **complaints** towards the doctors behavior. The second one takes into account occurrence of certain situations, **without their validation**

workers were chosen as occupations that are closest and most distant to the position of doctors. Also the unemployed belong potentially to the low status category. The basic demographic characteristics and size of the place of residence (city size) will be also taken into account.

(Table 2)

In table 2, the percent of explained variance is very low. All coefficients for socioeconomic data in both models are low and statistically not significant. One can conclude, that social position and economic status do not influence the partnership in doctor - patient interaction. Only sex of the patients seems to influence this relationship in more visible way.

Let us take a look now at the role of a socioeconomic status variables in explaining the complaints to doctor's behavior. In addition to independent variables presented in the table 2, the evaluation of health status of the respondents will be included [model III].

(Table 3)

Again, socioeconomic variables do not explain practically the variance of the dependant variable. Only the level of education has a little impact on the satisfaction/complaints with doctor's behavior ( $p < 0.05$ ). The role of material conditions, affluence or poverty is not visible. The situation changes, when the evaluation of health status is added (five point scale; 5 = very good). It indicates that criticism addressed to a doctor is a function of worse health status of a patient, and reflects probably higher expectations on his part, and more frequent mutual contacts.

#### 4. Conclusions

Certainly, the lack of significant relationship between the course of the visit and the degree of partnership between doctor and patient is a surprising and interesting

result. It seems that it can be interpreted in at least two ways. First explanation refers to the hypothesis of “the socialist heritage”. Accordingly, the results show that uniform attitude of doctors towards patients, which took shape in the previous system, continue to exist. Relatively new phenomena of social differentiation have not brought yet changes to the quality of contacts between patients and physicians and these contact do not reflect the increasing distances in the system of social stratification. This is a part of the broader issue, which, as one may suppose, is not confined only to the case of Poland. Results of research conducted in post-communist countries have shown that changes in habits, attitudes and life orientations in Central and Easter Europe take place slowly (Alwin et al. 1993). Attachment to egalitarian institutions is still visible in various spheres of life, as exemplified by the strong popular disfavor of income differentials (Domański 2002). One may expect that also in other countries in the region, in which there was a system of socialist health services, based on egalitarian principle, the relationship between patient and physician is still weakly influenced by stratificational variables. It would be interesting to study this problem in the future, when the process of developing of social divisions characteristic for the capitalistic societies will continue and will become better represented in the social consciousness. One could also expect that, similarly to the countries of the West, the emerging middle class will start to practice, in a more pronounced way, patterns of behavior characteristic for the consumerism, where a patient takes a more client-type stance and makes informed and sovereign choices in the area of health services.

The second explanation, which does not contradicts the first one, points out that the critical variables influencing the form of patient-physician relationship should be sought more in the characteristics of physicians than those of patients. Accordingly, one could find that there are doctors, who have generalized partnership attitude towards their patients and those, who have not, irrespectively of social characteristics of their patients. Search for explanation would then focus on such variables as individual sensitivity, type of professional socialization, conception of one’s professional role, expectations of the profession and, perhaps, the type of medical specialty or characteristics of the institutional setting, in which medical practice takes place. Here as well, one could expect changes in time, related to processes of

institutionalization of rules of the market and norms and values of the middle class (Domański 2002). Undoubtedly, evidence from other countries, of other traditions and systems of health services, can shed some light on this issue.

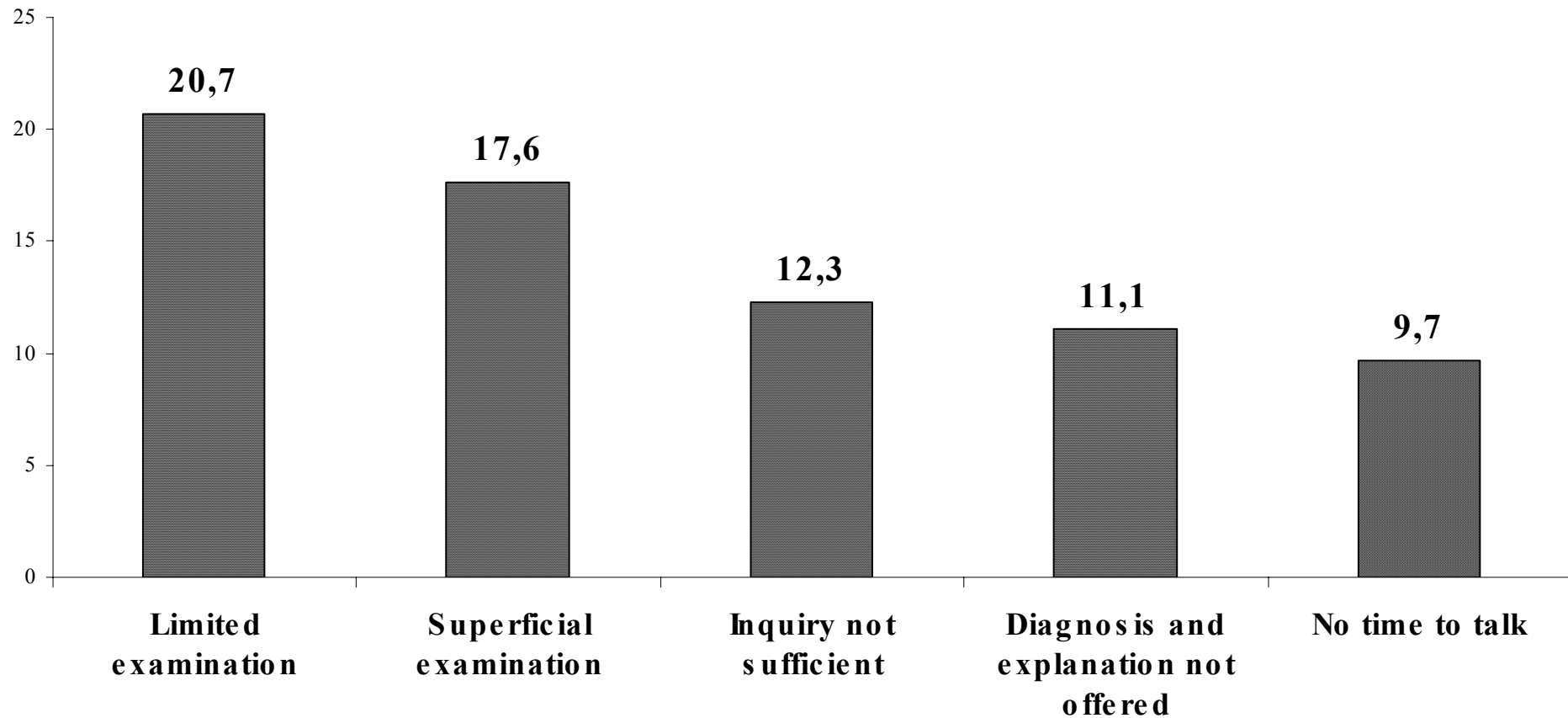
#### References

- Alwin, D., et al. 1993. Comparative referential structures, system legitimacy and justice sentiments [in:] J.R. Kluegel, D.S. Mason and B.Wegner (eds) Social justice and political change ....
- Atkinson, P. 1995. Medical talk and medical work. London : Sage
- Boulton, M., at al. 1986. Social class and the general practice consultation. *Sociology of Health and Illness*, 8:325-350.
- Carlsson, R.J. 1975. The end of medicine. New York, London, Sydney, Toronto: John Wiley and Sons
- Cassel, E.J. 1986. The changing concept of the ideal physician. *Daedalus*, 115:185-208.
- Cockerham W.C. Medical sociology, Upper Saddle River:Prentice Hall.
- Coe, R. 1978. Sociology of medicine, New York : McGraw –Hill
- Domański, H. 2002. Polska klasa średnia. Wrocław :Fundacja na rzecz Nauki Polskiej.
- Sowa, A. 2002. Upodmiotowienie pacjenta. [W:] S.Golinowska (red) Opieka zdrowotna w Polsce po reformie. Warszawa: CASE

## **Figure 1. Criticism of doctor's behavior**

- **The examination concerned only reported ailment, whereas more general was needed.**
- **The examination was very superficial**
- **The doctor did not ask precisely about disorders**
- **The doctor did not present the diagnosis and did not explain the causes of the disorder**
- **There was no time to talk about other problems**

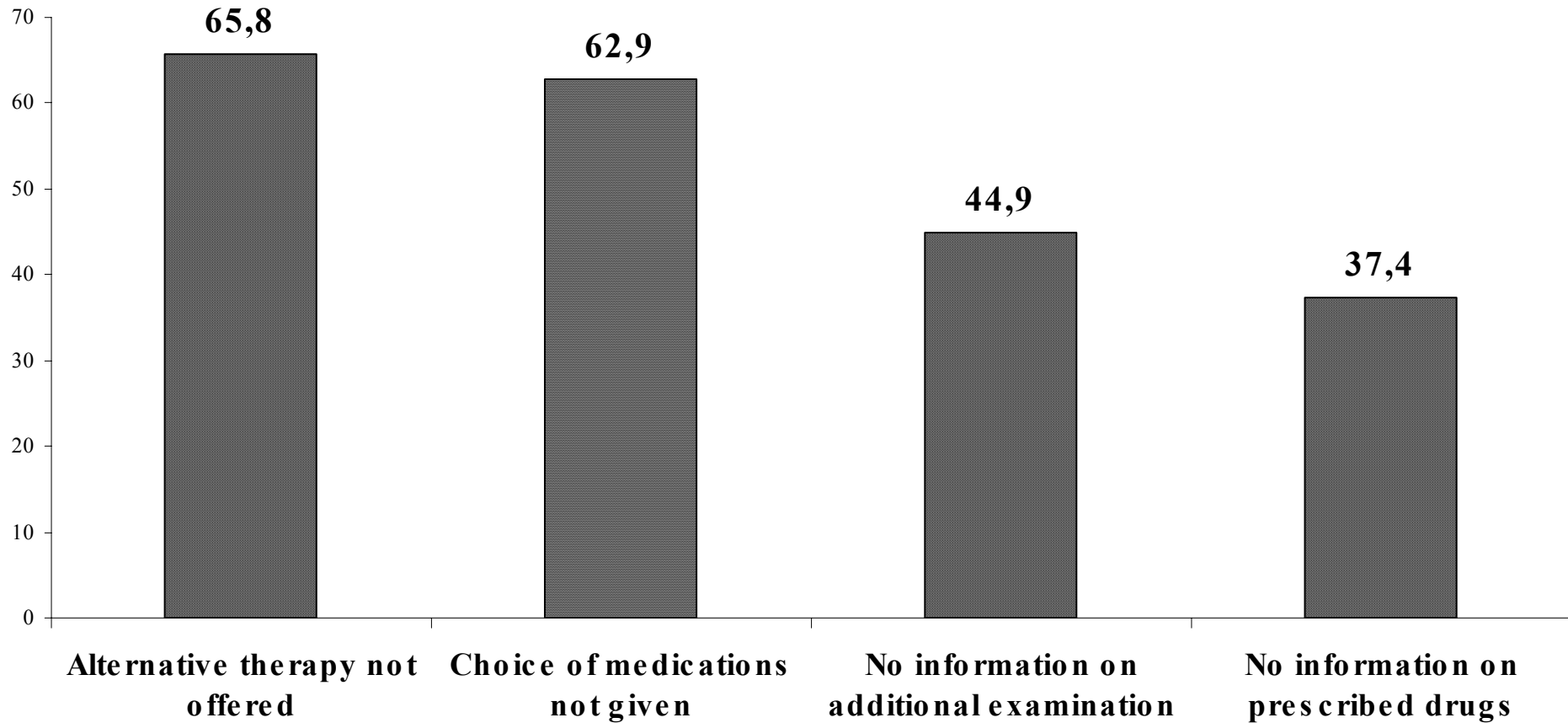
**Figure 2. Criticism of doctor's behavior  
(during last two years ; N=2167)**



## **Figure 3. Lack of partnership in doctor - patient relationship**

- The doctor did not offer an alternative therapy (e.g. to choose less inconvenient one)**
- The doctor did not offer a choice of medications (e.g. to choose less or more expensive)**
- The doctor did not inform about the purpose of additional tests, examinations**
- The doctor did not explain the way in which prescribed medications act.**

**Figure 4. Lack of partnership in doctor - patient relationship.**



**Table 1. Deficits in contacts with doctors. Principal components analysis (Varimax rotation)**

<b>Variables</b>	<b>Factor loadings</b>	
	<b>I</b>	<b>II</b>
<b>No alternative therapies</b>	<b>.86</b>	<b>-</b>
<b>No alternative drugs</b>	<b>.83</b>	<b>-</b>
<b>No information on additional examinations</b>	<b>.79</b>	<b>-</b>
<b>No information on drugs</b>	<b>.74</b>	<b>-</b>
<b>Inquiry not sufficient</b>	<b>-</b>	<b>.77</b>
<b>No time to talk</b>	<b>-</b>	<b>.77</b>
<b>No diagnosis and explanation given</b>	<b>-</b>	<b>.74</b>
<b>Superficial examination</b>	<b>-</b>	<b>.69</b>
<b>Limited examination</b>	<b>-</b>	<b>.63</b>

**Table 2. Regression of lack of partneship on demographic and socio-economic variables. (Beta)**

<b>Independent variables</b>	<b>Models: I</b>	<b>II</b>
<b>Sex (M=1, W=2)</b>	<b>-.11</b>	<b>-.11**</b>
<b>Age</b>	<b>-.05</b>	<b>-.07</b>
<b>Education</b>	<b>-.03</b>	<b>-.07</b>
<b>Household income per capita</b>	<b>-.06</b>	<b>-.07</b>
<b>Evaluation of economic conditions</b>	<b>.04</b>	<b>.03</b>
<b>Size of the place of residence</b>	<b>-.07</b>	<b>-.07*</b>
<b>Occupation: professionals</b>		<b>.06</b>
<b>unskilled workers</b>		<b>-.02</b>
<b>Unemployed</b>		<b>.04</b>
	<b>R<sup>2</sup></b>	
	<b>2.5</b>	<b>2.9</b>

**Table 3. Regression of criticism to doctors' behavior on demographic and socio-economic and health variables.  
(Beta)**

<b>Independent variables</b>	<b>Models: I</b>	<b>II</b>	<b>III</b>	
<b>Sex (M=1, W=2)</b>	<b>-.05</b>	<b>-.05</b>	<b>-.05</b>	
<b>Age</b>	<b>.02</b>	<b>.01</b>	<b>.10*</b>	
<b>Education</b>	<b>-.07</b>	<b>-.07</b>	<b>-.09</b>	
<b>Household income per capita</b>	<b>-.03</b>	<b>-.04</b>	<b>-.05</b>	
<b>Evaluation of economic cond.</b>	<b>.06</b>	<b>.06</b>	<b>.03</b>	
<b>Size of the place of residence</b>	<b>-.04</b>	<b>-.04</b>	<b>-.05</b>	
<b>Occupation: professionals</b>		<b>.00</b>	<b>.00</b>	
<b>                  unskilled workers</b>		<b>.00</b>	<b>.01</b>	
<b>Unemployed</b>		<b>.05</b>	<b>-.05</b>	
<b>Evaluation of health</b>			<b>-.18**</b>	
	<b>R<sup>2</sup></b>	<b>1.4</b>	<b>1.6</b>	<b>3.7</b>