

Preparing for Patients and Preparing for Physicians

Knowledge, Values, and Skills of Healing Cooperations and their Ambivalences

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The complexities of healing cooperations and how they change over time are of central concern in studying healing practices by the social sciences and humanities. Much has already been written, but the ongoing transformations of healthcare warrant a continuous engagement with the topic. In this issue of *Curare*, we focus on a specific aspect of healing cooperations in biomedical settings. The contributions will shed light on the ambivalences that accompany different constellations of patients and physicians, ranging from psychiatry to oncology, general practice, and chronic diseases. Understanding healing as a cooperative practice, the focus lies on multiple agents and how they negotiate different needs and potentials. Each biomedical setting enacts its own sets of knowledge claims, values, and skills (BERG & MOL 1998).

Such negotiations of healing cooperation are usually based on asymmetrical relations between healer and patient. Especially in biomedical contexts, the asymmetry of the patient-physician relationship has long been a main criticism (PILNICK & DINGWALL 2011), and empirical studies have time and again reasserted fundamental disparities between those seeking and those providing health services (BEGENAU, SCHUBERT, & VOGD 2010). At the same time, these asymmetries are constitutive of the healing encounter, because they form a functional difference between healers and clients. Without specific expertise, skills, and knowledge of healing, there would be no need for consultation, and often patients are looking exactly for such an asymmetric relation to put themselves in the hands of an authority they can trust. Nevertheless, this asymmetry has often been criticized, especially in the realm of modern biomedicine and psychology, and especially in the context of chronic and rare diseases. Professional dominance (FREIDSON 1970) and a paternalistic imbalance in healer-patient relationships have thus led to an increasing claim for shared decision making

and informed consent in order to empower the patient vis-à-vis her or his healer. The aim is to develop therapies and forms of interaction that explicitly seek to re-balance the relationship by taking into account the patients' knowledge (e.g. in many psychological therapies), or even trying to turn the asymmetric healer-patient relationship around and calling for full responsibility of patients themselves (e.g. in many esoteric therapies).

How physicians and other healers conduct their encounters with clients is an integral element of their training. Nevertheless, this knowledge is only partly provided by official channels or courses; rather, it is often learned in a subtle and implicit manner during practical apprenticeship. Despite broad investigations of the professional encounters between healers and their clients, few studies have addressed the question how exactly these skills and attitudes are learned. In contrast to biomedical contexts, the encounter of non-biomedical healers with their clients is often conceived as being less hierarchical. Yet, we would assume a similar functional difference between them. We assume that how these asymmetries and differences are managed and performed in daily practice is largely learned in the formative years of apprenticeship.

Since the seminal studies "The Student Physician" (MERTON, READER, & KENDALL 1957) and "Boys in White" (BECKER, GEER, HUGHES, & STRAUSS 1961), there has been little in-depth research on how students of healing practices acquire such skills and how they are transmitted in learning contexts. These studies have shown how novice physicians learn to cope with the contingencies of daily work and how they learn to balance responsibility and experience. Fine-grained ethnographic fieldwork enabled researchers to show how such skills and attitudes are learned in the processes of becoming a competent member of a healing profession, by observing and imitating role models and by being sensitive to the

norms and values displayed by significant others. In line with BECKER, GEER, HUGHES, & STRAUSS, we assume that most of these skills are part of the tacit learning in the “hidden curriculum” (HAFERTY & FRANKS 1994). The hidden curriculum refers to those aspects of learning contexts that do not figure prominently in official accounts, but are learned as part of becoming a member of a healing profession. Despite (or because of) their informal character, they serve as powerful orientations that slowly become taken for granted, in many cases without explicit recognition by those who teach and learn them.

Irrespective of the given healing cosmology, healing knowledge is ordered in specific systems that are organized in rules, schemes, and procedures that need to be adapted to the individual healing cooperation. Therefore, every healing cooperation is laced with fundamental uncertainties – not only with respect to treatment, but also to interaction (cf. FOX 1980; HENRY 2006). And all healing apprentices learn how to cope with these contingencies. The subtle transmission of a “paternalistic” model of physician-client interaction in biomedical education might account for the longstanding asymmetry that is part of the official program of medical education, despite longstanding calls for “shared decision making” and “informed consent” (STOLLBERG 2008). Consequently, “professional dominance” (FREIDSON 1970) is a skill that needs to be learned before it can be practiced.

But patients also often prepare for contact with healers. The Internet offers new possibilities for getting information and sharing experiences about a perceived inefficacy or even harmfulness of popular and officially accepted therapies, on the one hand, and the efficacy of unknown and unconventional approaches, on the other, which may lead to distrust of professional or institutional authorities. Thus, patients can develop many strategies to carry out their own ideas and plans against a healer’s advice, if they disagree about the cause of the illness and the right course of treatment. Such strategies also may include simulating or neglecting specific symptoms to get a desired prescription, to avoid a specific treatment, or to get a temporary or permanent certificate of illness.

But empowerment is ambivalent. Patients are often torn between trust and suspicion, between the wish to be guided by experts and the wish to

become an expert on their own, to give up or to keep responsibility for their health. Too much information can turn empowerment into confusion, and empowerment can also turn into manipulation, e.g. when pharmaceutical companies encourage patients to ask their healers for the drugs they sell (cf. DUMIT 2012). Thus, empowerment is hardly straightforward. For instance, in which direction is empowerment oriented? Is it an extension of the patients’ biomedical knowledge? Or does it facilitate increasing demands on doctors, who are approached by patients who figure as consumers or customers? Does it include the right to remain a passive patient? Empowerment does not necessarily pit an autonomous patient against a dominant physician. This *mélange* opens up questions about the modes and means of empowerment. Who, beyond patients, has an interest in empowerment? Are Internet media engines of emancipation or sources of confusion?

The focus on ambivalences offers insights into the contingencies of care and healing and how they are resolved on the micro-level of healing encounters and healing cooperations. The sources of such ambivalences are manifold. First, the general uncertainties connected to medical practice have not decreased through the increase of medical knowledge and technologies (e.g. in surgery, CRISTANCHO, APRAMIAN, VANSTONE, LINGARD, LORELEI, & NOVICK 2013). Second, the emancipation of patients in recent decades has shifted the legitimacy of knowledge claims to include so-called “lay-expertise” (EPSTEIN 2023), while also bringing consumerism into healthcare, at least in the last three decades (LUPTON 1997). Third, current digital devices, such as apps and activity trackers, increase the complexities of healing once again by introducing novel data and metrics that rest in an uneasy space between lifestyle and medicine (WILLIAMS, WILL, WEINER, & HENWOOD 2020). Thus, the ambivalences of healing can be perceived as a threat to medical authority, casting doubt on what is often conceived as biomedical objective truth.

The continuing “social authority” of medicine shows that this is not necessarily the case, however; there might be shifts in the “cultural authority” of medicine (EPSTEIN & TIMMERMAN 2021). The social authority of medicine typically rests on the cooperation of patients and phy-

sicians: either patients granting authority based on ascribed expertise and not challenging their physicians' knowledge and skills (HAASE, AJJAWI, BEARMAN, BRODERSEN, RISOR, & HOEYER 2023) or physicians carefully navigating and negotiating their authority by managing ambivalences in daily interaction (STIVERS & TIMMERMANS 2020). Seen on a larger scale, the cultural authority of medicine, i.e., the broader cultural legitimacy of biomedical knowledge, values, and skills, might have lost some of its dominance over the past decades, culminating in a crisis of credibility during the COVID-19 pandemic (GOLDENBERG 2021; HARMBAM & VOSS 2023).

The contributions to this issue engage with the issues raised above. The first two contributions by ANNA HÄNNI about *In-Patient Psychiatric Care as a Space of Ambiguity* and by NICOLE ERNSTMANN, SOPHIE ELISABETH GROSS, UTE KARBACH, LENA ANSMANN, ANDRÉ KARGER, HOLGER PFAFF, MARKUS WIRTZ, WALTER BAUMANN, & MELANIE NEUMANN about *Patient-Physician-Relationship in Cancer Care* study the interactions between patients and physicians in psychiatry and oncology and how a stable course of treatment is maintained. They analyze how the social authority of physicians is maintained in heterogeneous settings with diverging values and interests. Ambivalence is a constant feature of such complex treatments, where medical authority is not directly under attack, but physicians need to manage the emerging ambivalences in order to remain in control of the trajectory. The following two contributions by NICK FOX about *Neoliberalism, Digital Health Technologies and "Citizen Health"* and by MÁRCIO VILAR about *Unexpected Amelioration among Sick Health Professionals through Displacing Medical Cooperations in Brazil* study how patients engage with biomedical authority and how they try to mobilize knowledge claims that are not part of mainstream biomedical treatment plans. The cultural authority of medicine is at stake, either from outside, through a democratic access to data, or from inside, when physicians themselves become patients and, by off-label use of drugs, start to contest medical assumptions that are taken for granted.

From all four studies, we can see that all major trends that have characterized biomedical healthcare in recent years each create their own ambiv-

alences. The ambivalence of empowerment and emancipation, shifting authority from physicians to patients while at the same time shifting the burden of responsibility. The ambivalence of knowledge and technology, where new insights and instruments may lead to less certainty and credibility. The ambivalences of cooperation, where trust and credibility, skills and values are being disrupted as well as maintained. The ambivalences of care, in the tension between individualized and standardized treatments, in the tensions between personal and profession relations, and in the tensions between participation and domination. How these ambivalences may be resolved is an empirical question in each of the fields under study. What the empirical studies show is that this is hardly an abstract issue, but one that is negotiated in the physical realities of bodies and technologies in biomedical healthcare.

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