

# Patient-Physicians: Identities and Expertise Brought Into the Light of Diagnosis and Treatment

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## Abstract

Researchers continue establishing a clear-cut division between identities of doctors and patients, but the perspective of the physician in the event that they became a patient is seldom analyzed. This article shows empirical evidence of the discursive construction of identities and expertise in the accounts of 24 patient-physicians diagnosed and treated for acute or chronic disease in the city of Bogotá, Colombia (2009-2015). An approach to these accounts from Science and Technology Studies, which is a perspective emerged among the field of social sciences during the 1970s that has achieved in our time a broader understanding of expertise, leads to the questioning of stereotypes about who doctors are and who patients are, and to illustrate the difficulty of drawing boundaries between experts and laypeople. Finally, it was concluded that identities and expertise are reconfigured in interaction, in a contingent and situated way, when considering diagnosis and treatment. New meanings of the relationship between doctor and patient were proposed, from a more symmetrical stance.

## Keywords

patient, physician, identity, expertise, diagnosis, treatment

## Introduction

In medical practice, there is a tendency to enforce the classical dichotomy that standardizes the identities and relationships between physician and patient, where, usually, the former represents authority and the latter subordination. But, the attempt to establish a clear-cut division between experts (physicians) and laypeople (patients) is complicated when analyzing cases of doctors who became sick, henceforth called patient-physicians.

We rely on Epstein's proposal of "lay expert" (1) to understand the "patient-physician" relationship symmetrically because it allows us to transcend the dichotomous tradition, although we realize that the "lay expert" category in Epstein's work pursues a strong agency, typical of activism; while here, the patient-physician category describes a subtle agency, to the extent that what doctors mobilize is their own illness and not that of others. However, both categories are similar because they highlight the relevance of patients' participation when making decisions about their diagnosis and treatment.

A literature review led to the identification of 5 groups with different approaches to the involvement of laypeople and experts in the process of diagnosis and treatment as follows.

Firstly, classic and contemporary views of sociologies of medicine and disease. In this group, two perspectives were identified: one, the functionalist model of Parsons, which is constructed from a dichotomous view between the role of physician and patient (2), and the other, the symbolic interactionism developed by Goffman, Freidson, and Strauss and Barney, among other trends inherited by the Chicago school, which initiated a sociological tradition that was interested in modes of organization of social interactions around disease at the hospital and other institutional contexts of health care (3–5).

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Secondly, interpretative views that emphasize subjective elements of patients' experience. These works address the evolution of the patient's role (6), differences between lay and expert knowledge (7), beliefs about health (8), discursive construction of strategies of the reincorporation of cancer sufferers into the social world (9), patients' decision-making, and search for professional support (10).

Thirdly, several autobiographical views. These are first-person accounts of doctors who went through the conflict that involves having had a serious illness during their professional practice (11–13). In those life histories, doctors recognize themselves in others, that is, in their patients.

Fourthly, a large variety of works located on the frontier of social and medical sciences, which frame what it means to be both doctor and patient, addressing questions about physicians dealing with cancer and Guillain-Barré syndrome (14–16), care for dying doctors (17), conflicts among physicians in the process of providing care for patient-physicians (18), anatomical and pathological descriptions (19), concerns about medical care for patient-physicians (20), practice of self-diagnosis (21), and the conflicts generated when a doctor tries to cure another doctor (22).

Finally, the discursive construction of social identity has been approached by Antaki and Widdicombe (23), Widdicombe and Wooffitt (24), and Horton-Salway (25). The latter focused specifically on "doctors" and "patients." Similarly, claims of expertise or ignorance have been studied by Myers (26), who argues that these are used as a resource for self-presentation, categorizing in broad social identities (as a physician, peasant, engineer, secretary, etc) or through the formulation of decision-making identities (careful, rational, skeptical).

The studies presented above continue establishing a clear-cut division between identities of doctors and patients because there is no questioning of the overlapping construction of those identities, like in the case of doctors who became patients. Although in some cases the doubts and tensions among both identities are revealed, like in autobiographies, there was no place for a discursive analysis that avoids falling into traditional dichotomies.

In that sense, Science and Technology Studies (STS) provides an innovative approach that sees to discourses of expertise and experience (27), to explore from a symmetrical stance how the apparent physician/patient dichotomy and the hierarchy that is expressed when the layperson/expert categorization is blurred. Also, it intends to open the black box of medical diagnosis and treatment allowing for a more reflective attitude to be adopted.

## Methods

### Sample

This article presents qualitative data obtained after applying snowball sampling as a recruitment strategy. Twenty-four patient-physicians diagnosed and treated for acute or chronic

disease in the city of Bogotá, Colombia (2009–2015) were told about the research aims and methodology in detail. In all cases, respondents signed the informed consent form and their diagnoses were confirmed using the medical records provided by them personally.

### Data Collection and Analysis

In-depth interviews, each lasting about 60 minutes, took place in different scenarios, most of them in the doctors' own consulting rooms. This could be considered remarkable, if we take into account that it is at physicians' workplace, where patients are usually heard about their ailments, but this time was the turn for doctors to speak about theirs.

A script organized in general topics was created to conduct interviews with a flexible arrangement. The script addresses the diagnostic process and treatment, including first suspicions, detection of symptoms, self-diagnosis, confrontation with laboratory tests, adaptation to the diagnosis, socialization with colleagues, self-medication, medication adherence, and alternative treatments.

Transcripts gleaned from the interviews were organized with the respective acronym (PP) that refers to patient-physician, accompanied by the respective page number.

Data collection and analysis were carried out by the same researcher in all cases, until having achieved saturation criteria. The researcher's own influence was examined, particularly as he is taken to be a coparticipant who contributed to the production of the accounts in the data extracts.

The analytical strategy included the definition of categories generated from data. Analytic rigor was achieved through expert checking for completeness and consistency. For that purpose, empirical data and analytical material were reexamined by both a peer reviewer and a senior researcher in the STS field to ensure consistency.

## Results

Results will be presented in 3 sections: self-diagnosis, diagnosis, and treatment. Each section contains fragments of interview and discourse analytic work of reflexive accounts in which doctors, through the narrative of their experiences of the disease, put strain on their professional training, their relationship with patients, and their applied medical knowledge in relation to their own decisions during the course of being "patients."

### *Self-Diagnosis: An Expert Who Fails or Succeeds*

Self-diagnosis was described by patient-physicians as a process in which a disease is discovered and it is based on what appears to be a special license that only doctors hold. It was taken to be a fundamental differentiation from the nonmedical patient:

One as a physician, one is empowered, let's say, to do self-diagnosis, as long as one has analytical criteria and good cognition, from that point of view; and for patients it is not very easy, because, sometimes, there are false positives that can lead to an error. (PP4, p.80)

In this way, physicians are introduced as subjects with superior analytical and cognitive abilities to patients, the latter are more likely to incur in an "error." Thus, truth is aligned with experts and error with laypeople. However, physicians' infallibility starts to be under question when they make mistakes in self-diagnosis. A patient-physician with a physical medicine specialty, who suffers diabetes, acknowledges having failed when issuing self-diagnoses:

Well, I made the discovery by myself, despite the fact that is not my specialty and I must confess that, sometimes, I failed in completing self-diagnoses. This time, it was mostly because of the symptomatology I had, and I knew very well that there is the triad: polyuria, polydipsia, polyphagia; that is to say that you start feeling increased appetite, thirst, and desire to urinate. Then, when I went to the hospital, I assumed, more or less, that I had diabetes mellitus type 2. (PP4, p.77)

The use of an attenuator: "although I must confess," indicates that he is not infallible, anticipating the possibility of being criticized because he challenged the specialist's cognitive authority. However, the introduction of this attenuator has created an expectation that physicians do not expect to fail and the public overestimates physician's infallibility. Therefore, this flaw should be kept secret and only to be revealed as a matter of "confession."

The patient-physician attaches authority to the specialist in the formulation of a diagnosis, but in turn, he challenges it. Notice, he pointed out that even without being a specialist in the field, he was capable to make a self-diagnosis. In this way, the patient-physician discursively constructs a hierarchy, but simultaneously undermines it.

The participant does interactional work by building an expert identity for himself and a nonexpert identity for the interviewer. This is accomplished by showing off his technical knowledge and reworking his account using nonacademic terminology to "facilitate" the interviewer's understanding.

### *Diagnosis: Talking About Experts*

Once diagnosed, patient-physicians must talk to experts. In interaction, they are confronted with the conflict of reconfiguring their identity and building themselves as patient and/or physician.

In the next fragment, a patient-physician constructs an autonomous self in the face of the identity conflict when he interacts with other experts. This psychiatrist with non-Hodgkin lymphoma mentions the self-awareness and the possibility of exchanging the identity of physician, for one of a patient:

It helped me a lot to assume a passive stance in front of this, to have an attitude of passivity in front of this, that is, I will trust my doctors, I will trust the treatment, and I will understand that I will be a patient. That was so, that today I ask myself, and in a moment I lost my entire role as a physician, it was completely gone. (PP1, p.7)

In this reflective exercise, the interchangeability of identities emerges as a possibility. In fact, the patient-physician discursively constructs a patient's identity, which depends entirely on a position and an attitude toward the physicians. It is in front of the other (physician) that this participant defined himself; it is in opposition to the identity of the physician that the patient emerges with his own characteristics: passive and confident. According to this participant, the patient's identity is not coexistent with the physicians' identity, because when the patient emerged, the physician "was completely gone."

The opposite case is described by a patient-physician diagnosed with a cold thyroid nodule, who maintains in her narrative a physicians' identity and not being able to detach from it, which is precisely what constitutes a disadvantage for her:

Physicians, when we have a disease, think it is the worst. At least in my case, I thought it could be a malignant tumor, that there would be problems during and after intervention. Until a definitive diagnosis confirmed by the pathological anatomy is reached, a great deal of anxiety is felt. (PP10, p.11)

In spite of her expert knowledge, this patient-physician elaborates descriptions in which she presents herself as expectant in front of the knowledge that is within the domain of other medical specialties. In that process, like the laymen, she experiences uncertainty.

Physicians are seen as neutral, as experts who distance themselves in their affection. It is another doctor, sometimes a friend, who detects the disease in a colleague. Many times, this can lead to questioning the physician's own role. This particular situation is evidenced in the communication at the moment of explaining to a colleague that is suffering an illness of certain seriousness. A patient-physician with non-Hodgkin's cancer explains the communication of his diagnosis:

I remember my oncologist when he showed up the first time, when he gave me the diagnosis [...] He tied his shoe and looking at the floor, he told me [\*\*\*] you have cancer, he did not look at me, and I understand that. Today for me, it's a droll anecdote; I understand the oncologist. He was afraid to tell me, but he told me, tying his shoe, trying to handle that with the utmost naturalness, but his attitude . . . today I talk to him and we laugh a lot of that. (PP1, p. 7)

In his narrative, the patient-physician reconfigures his identity as an expert, from the experience of his illness. This reflexivity allows him to award a new meaning to the disease

and to the diagnostic process, which tends to unravel everything usually taken for granted in allopathic medicine. The uncertainty surrounding the diagnostic process is further recognized and this tends to have effects on the doctor–patient relationship.

### *Treatment: Negotiating Between Experts*

In hospitalization, patient-physicians build their patient's identity with close links to stigma, but in the dynamics of institutionalized care, they begin to see medical issues with new eyes, realizing potential coproductions of knowledge, where both physician and patient participate in the treatment. A patient-physician with cancer gives account of his experience of care:

The process of attention was of total uncertainty; in treatment, there are many elements at play. I really did not know how far my participation could go. Despite being a doctor, I was not clear about many things, I used to ask as a patient and think like a physician; however, at times, I also took the initiative. It is complex to live what one has observed in his practice for a long time. (PP3, p.60)

In this fragment, the participant makes explicit his identity confusion, by means of calling the simultaneity of both identities, “physician” and “patient,” as a concern. The category “patient” is described as a subject who has no clarity, who asks the questions, while the category “physician” is aligned with rationality, a doctor's way of thinking. He also establishes a dichotomy between living/observing. The observer, who used to study illness from distance, is currently under observation.

A physician with diabetes complains about not having been recognized as patient, for him, being a physician becomes disadvantageous when the drug management begins:

In my case, being a doctor, it was understood that nothing should be explained to me. I did not know how I had to prick. Also, I had to imagine an insulin pump or pancreas transplant. They told me not to worry because, currently, there is snorting insulin. They gave me so much information that I could not manage it. Imagine a patient, if you suddenly give all this information to him. It distressed me. (PP15, p.10)

This patient-physician claims to have had little negotiation with health personnel and other experts, with regard to the pharmacological and therapeutic treatment. He starts recognizing himself as an expert: “In my case, being a doctor,” which allows him to question the differential treatment he has received, when compared to a nonmedically trained patient.

A lack of explanation about procedures and excessive information about therapeutic alternatives create a standard patient identity that would not be able to deal with that. He also builds a lay expert identity by claiming ignorance of the way in which he has to “prick” and a feeling of anguish when

facing abundant information, despite of having professional medical qualifications.

But, patient-physicians are not only in need of negotiating with experts (doctors), but also with lay experts. In the next account, a patient-physician claims to have learned from other patients:

You're looking for someone to help you. You realize that you are not the only diabetic in the world. In the room there are 40 diabetics; you get in touch with other people who are diabetic. This is a topic for me of the most interest. You see another person who in ignorance of medicine could carry the illness. For example, he did not know that I was a doctor and he told me how to prick myself. They told you their point of view (...) I avoided giving explanations in order not to be noticed as a doctor. It was a very special coexistence with people engaged in various activities, such as the farmer or the mason. (PP15, p.11)

The patient-physician explicitly elaborates an expert's identity by saying: “I was a doctor,” and at the same time, he creates an identity for other diabetics as “ignorant” of medicine. He introduces categorization devices (28) such as “the farmer or the mason,” which allows the listener to pigeonhole nonmedical patients into broad social identities, that is, as unqualified, working in nonspecialized activities.

Laypeople's opinion is relevant in this description: “They told you their point of view.” In such way, the cognitive is relegated, because nonmedical patients will not speak from knowledge, but from their subjectivity, since they have been able to “carry the illness.”

“Knowledge from experience” encompasses the technique of administering drugs (insulin). The “explanation” is presented as a domain of knowledge that becomes evident in front of others and that can reveal a hidden identity. The “explanation” is offered free of charge by the lay expert to the patient-physician. In turn, it is hidden by the latter to the first: “I avoided giving explanations,” so that the patient-physician does not reveal his medical identity, but rather keeps it hidden, because this is a distinction that he recognizes as his own (his medical status), which could make a person “noticed.”

## **Conclusions**

Science and Technology Studies' perspective adds new insights to what it means to be both doctor and patient, because it acknowledges from a symmetrical and reflexive stance and the sickness suffered by an expert in medicine and asks for the experience of the expert who confronts his own knowledge.

The empirical material collected shows that practices such as self-diagnosis put patient-physicians' own expertise under scrutiny, since they are sometimes ineffective, as it is often the case with nonmedical patients. The idea of discovery of their illness is no longer taken to be a strictly objective

medical fact, because it was illustrated how extrascientific factors, such as emotions, play a relevant role in its enunciation.

Participants construct either alternately or simultaneously their identity of patient and/or physician. Thus, there would not be preexisting identities and they should not be seen as fixed; quite the contrary, participants develop identity in the actual moment of conversation by making self-descriptions as laymen and/or experts.

Identity was relationally constituted in dialogue with the interviewer, colleagues, and other patients in health settings. Particularly, other opinions are recognized in the frame of the patient-physician-specialist relationship, demanding control over the diagnosis and treatment, because patient-physicians wanted to be coproducers and, therefore, to participate in the interpretation of their own disease. In this way, a reflexive process of critical distance is generated with the traditional scientific methods proposed by allopathic medicine.

### **Strengths and Limits of the Study**

There was resistance from the physicians at first to open up and many of the doctors canceled their appointments for interview claiming “lack of time.” These barriers for interpersonal communication could be attributed to threats to the physicians’ egos, when talking about their own disease. They may be afraid of putting their professional prestige at play, feeling vulnerable when revealing their privacy, unveiling their rugged disease trajectories, recognizing their own “bad practices” when making self-diagnosis, and fitting the stereotyped identity of a patient. This may be a reason why most of the physicians asked the interviewer not to record the interview and only to transcribe it partially. In that cases, only notes were taken, with no recording being made.

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