КОНФЛИКТНЫЙ ПОТЕНЦИАЛ ПРОФЕССИОНАЛЬНОЙ МЕДИЦИНСКОЙ ДЕЯТЕЛЬНОСТИ: ОРГАНИЗАЦИОННЫЙ И ЛИЧНОСТНЫЙ АСПЕКТЫ

CONFLICT POTENTIAL OF PROFESSIONAL MEDICAL ACTIVITY:
ORGANIZATIONAL AND PERSONAL ASPECTS

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Аннотация:

В статье представлен обзор современных подходов к исследованию конфликтного взаимодействия в медицинской сфере. Обоснована ограниченность традиционных моделей взаимодействия врача и пациента в современных условиях. Представлен частотный анализ субъективных и объективных причин возникновения конфликтов, описаны психологические механизмы, отражающие стереотипное восприятие друг друга сторонами конфликта. Приведены данные оригинальных исследований автора по оценке эталонных образов врача и больного. Обоснована перспектива применения организационно-структурного и личностно-ролевого подходов в дальнейших исследованиях конфликтного потенциала медицинской деятельности.

Abstract:

The article provides an overview of modern approaches to the study of conflict interaction in the medical field. The limitedness of traditional models of interaction between a doctor and a patient in modern conditions is substantiated. A frequency analysis of the subjective and objective causes of conflicts is presented, psychological mechanisms are described that reflect the stereotypical perception of each other by the parties to the conflict. The data of the author's original studies on the assessment of reference images of a doctor and a patient are presented. The prospect of applying the organizational, structural and personality-role approaches in further studies of the conflicting potential of medical activity is substantiated.

Ключевые слова:

конфликтный потенциал, медицинская деятельность, врач, пациент, модели взаимодействия, причины конфликта, организационно-структурный подход, личностно-ролевой подход.

Key words:

conflict potential, medical activity, doctor, patient, interaction models, causes of conflict, organizational and structural approach, personality-role approach.

The interaction of a doctor and a patient in modern medical practice is significantly different from the idealized picture of communication between a doctor and a patient, which has evolved over the centuries and is presented in the classical literature on medical ethics and deontology. The traditional communication models proposed by R. Witsch: engineering, paternalistic, collegial and contractual [1], do not fully reflect the specifics of the doctor-patient interaction. In the engineering model of communication, the doctor considers the patient as a mechanism that needs to be returned to a state of equilibrium and health through certain influences. The patient does not have the necessary knowledge about his own condition, his opinion is not only useless, but can even be harmful. Paternalism infringes on the rights of the patient as an autonomous person, since the interaction is built not as an equal, but as a vertical, parent-child. In the deontological medical literature it is emphasized that paternalism in modern practice is acceptable in the areas of medical communication, where the patient's mental state is specific due to age, personality and situational reasons (pediatrics, geriatrics, psychiatry) [2,3]. Within the framework of the collegial model, the patient is more equal in interaction with the doctor. Their relationship is built on a mutual understanding of a common goal and mutual trust. However, in real communications, the complete coincidence of the positions of the patient and the doctor is, rather, the exception; it is assumed that this is most achievable when the patient himself is a doctor. However, the doctor in the role of the patient is most often perceived negatively by his attending physician, which is explained by professional competition, psychological defenses and other psychological laws. In the contract model, the interaction between the doctor and the patient is carried out according to the principles of a social contract. The doctor acts as a provider of medical services, and the patient – as a client, directly or indirectly buying this service. A plus is a clear legal and medical regulation of services, and a minus is the lowering of the role of humanistic values. At the same time, trust and empathy go by the wayside, communication becomes more formal and superficial.

The modern digital era, providing universal access to information about the functioning of the body, diseases and treatment technologies, leads to the desacralization of the image of a doctor. Accordingly, the dispositional structure in the dyad “doctor-patient” is changing. If before the doctor dominated as being able and giving his knowledge and skills to the patient, now the development of the Internet gives the patient the illusion of complete medical knowledge. The doctor is perceived not so much as the exclusive owner of medical information and treatment technologies, but as a specialist who provides social services. In assessing the work of a doctor, attaching increasing importance to communicative qualities: goodwill, courtesy, attention to the patient. In this sense, the popular media image of a sociopathic doctor represented by Dr. House, focused only on the result of medical care and neglecting the socio-psychological norms of medical communication, is a

funny exception. Doctors are often not ready for such a quick change in the structure of their professional competencies.

On the other hand, a trend is also observed that is associated with the increasing technocratization of medical interaction. Improving the methods of clinical and laboratory diagnostics often reduces the role of diagnostic information obtained in a conversation with a patient in the eyes of many specialists. In addition, its bureaucratization is becoming a negative feature of the healthcare system. Documentation regulations, strict treatment standards do not allow the doctor to concentrate on interacting with the patient. He loses interest in the subjective picture of the patient's disease, turning into an operator that responds to key nosological signs.

The character of the modern patient is also changing. This is an active, knowledgeable and demanding consumer of services, focused not only on the medical effect of treatment, but also on the quality of life, social and psychological aspects of his condition, the cost of treatment. The contractual relationship between the doctor and the patient takes on new complex contours, which leads to unrealistic representations of the patient about the possible results of treatment, doubts about the competence and honesty of the doctor.

A. Ray and V. Pathak-Ray figuratively call the current situation in the communication between the doctor and the patient a “withering” of confidence that occurs when there is unlimited access to medical information from the Internet, which many patients “venerate as the gospel” [4]. Conclusions about the decrease in confidence in medicine are confirmed by domestic statistics. According to VTsIOM (2017), about 30% of the population trust modern medical care, 20% do not trust, and very many (44%) found it difficult to answer this question. 57% of Russians with a disease go to doctors, the rest are self-medicated, resort to folk methods, use the services of healers. For comparison – in 2010, over half of Russians (53-56%) trusted doctors, every fifth respondent spoke of distrust on average (20-22%, 16% in 2013) [5].

The consequence of a decrease in the level of trust is an increase in the level of conflict in the medical sphere. Due to the interdisciplinary nature of medical conflicts, works devoted to the analysis of this phenomenon are very diverse and heterogeneous. Many of them are a sociological analysis of medical conflicts [6-8]; often described legal, economic and deontological reasons and features of the course of conflicts in the medical environment [2,9-11]. The psychological analysis of medical conflicts is much less common. As a rule, conflicts are analyzed in the context of medical communication and the problems of violation of trust and empathy in the dyad “doctor-patient” [4,12-14].

M.E. Volchansky as an object of study of the conflict in medicine identifies the objective and subjective reasons for their occurrence. Objective reasons arise regardless of the behavior of the doctor (organizational, technical, financial and economic problems, organization of the treatment process). Subjective reasons are

connected both with the personality of the doctor, and with the communicative and therapeutic strategies that he prefers [8]. V.D. Chetverikov identifies the most common subjective and objective causes of conflicts in the medical environment: low literacy and culture level of the population (29%), deficiencies in the work of health facilities (21%), negative attitude of patients to medical personnel (18%), low drug availability (13%), the mental state of patients (10%), excessive workload of doctors (8%), insufficient competence of medical personnel (1%) [15]. As you can see, the causes of conflicts related to the personality of the doctor make up 9%, which, in our opinion, does not reflect the reality of medical communications and are the result of a biased approach to conflicts by the medical community.

Overcoming professional stereotypes regarding conflicts in the medical environment allows a socio-psychological approach aimed at studying the mechanisms of medical communication, and not just social ideas about conflicts. In the framework of social psychology, the conflict interaction between the doctor and the patient can be considered as organizational, structural and personality-role interaction. In the first case, medical conflicts are specific organizational conflicts. As the mechanisms of such a conflict, we can distinguish an imbalance of responsibility and power, functions and means, rights and obligations of entities arising from the ineffective implementation of the basic function of the organization [16,17].

Based on the work in the field of medical management, it is possible to identify areas of effectiveness of a medical organization [18]. Vice-rector of the Higher School of Organization and Management of Health Care N.F. Prokhorenko identifies five basic factors that determine the effectiveness of medical care (zones of influence): the doctor's competence, the conditions for the implementation of medical activity, the motivation of the doctor's professional activity, patient behavior, and individual characteristics of this therapeutic case. The management of these factors is defined as the areas of responsibility of different subjects of medical care: the state, medical institution, the physician personally and the patient [19]. Using the scheme N.F. Prokhorenko, at each subject level, it is possible to consider the zones of effectiveness or inefficiency of an organization, determined by the absence or imbalance of influence and responsibility. Together, the imbalance of these mechanisms and determine the conflicting potential of activity (table 1).

Table 1.

Organizational and psychological mechanisms to achieve the goals of the organization

		Areas of responsibility				
		Doctor's competencies	Conditions for the implementation of the doctor	Motivation of the doctor	Patient Behavior	Individual features of the patient
Subjects of activity	State	Educational standards, standards of care	Financing	Government support programs for healthcare providers	The social image of the doctor in the media	Social factors of quality of life, ecology
	Medical institution	HR policy	Material base, internal routine	Employee incentive system	There is no sustainable mechanism of influence Partially through a patient information system	Profile medical care quality of equipment, etc.
	Doctor	Professional competencies	Activities of professional organizations	Personality features	Professional communication	Diagnostic thinking
	Patient	There is no sustainable mechanism of influence Partially verification through consultation of other specialists, the Internet	There is no sustainable mechanism of influence Partly through complaints about the quality of treatment	There is no sustainable mechanism of influence Partially through communication style complaints the doctor	The level of general culture, self-regulation of behavior	Features of health-saving behavior

This scheme shows that there is a high potential for organizational conflict in four areas of activity of a medical organization, three of which are associated with the lack of mechanisms for the patient's influence on the treatment process, and one with limited capabilities of a medical institution to influence patient behavior. The patient is a consumer of medical services, but he is deprived of the tools of a socially acceptable impact on the quality of medical care.

It should be noted that in the world healthcare practice, and in recent years in our country, patient organizations have appeared whose activities are aimed at protecting the rights of the patient and influencing the process of medical care. The patient's tool now is just complaints in the form of complaints. At the same time, it should be noted that the complaint is not the most effective conflict resolution tool for

the patient. It is included in the bureaucratic system and falls out of the system of therapeutic actions. In the area of responsibility "Motivation of the doctor's professional activity", presented in the diagram of N.F. Prokhorenko, the patient has no influence mechanisms at all: he cannot motivate the doctor in socially acceptable ways. Therefore, the arsenal of behavior in this area is the emotional and material manipulation of a doctor. Another potentially conflict zone is the practical lack of mechanisms for the influence of a medical institution on patient behavior. The medical institution can inform the patient, but does not have the resources to effectively monitor his behavior in the process of providing medical care.

Certain specific conflict zones may arise in the context of a particular medical care case. Any mechanism can be unbalanced - this is the employee incentive system, the features of professional communication, the formation of professional competencies, the state of the institution's material and technical base, the social image of the doctor in the media, the patient information system, etc. Analysis of the main mechanisms of effectiveness, their improvement and the prevention of imbalance is the basis for the prevention of organizational conflicts in the medical field.

Another important approach in the analysis of organizational medical conflicts may be the dispositional-structural approach of German medical psychologists. B. Dahme and colleagues propose their classification of conflicts in a hospital [11] (Table 2). Each of the six types of conflicts has its own objective and subjective reasons. For example, conflicts of type C and D are caused by contradictions in the needs of the patient and medical staff arising during hospitalization (Table 3).

The psychological approach to the analysis of the conflict potential of medical activity can be most fully revealed within the framework of the personality and role theory of conflict. In domestic literature, these issues are presented in the works of V.A. Tashlykova, L.P. Urvantseva, N.A. Magazanik [20-22]. Received V.A. Tashlykov data on the characteristics of perception in the process of treatment by a doctor and patients of each other allowed us to distinguish three main types of emotional-role interaction: leadership, partnership, leadership-partnership. Each form of contact has its own advantages depending on the medical motivation and activity of the patient. Depending on the degree of congruence of the emotional-role behavior of the doctor and the patient, as well as their mutual assessment of this behavior, contact options were identified: congruent, unstable congruent and incongruent.

Table 2.

Classification of conflicts in the hospital (according to V. Dahme, 1982)

	Doctor	Nurse	Patient
Doctor	Type of A	Type of B	Type of C
Nurse	Type of B	Type of D	Type of E
Patient	Type of C	Type of E	Type of P

Table 3.

Differences in the motivation of the patient and medical staff

Patient	Medical staff
The need to treat yourself as a person with a certain social status	The desire to complete this contact faster and move on to the next
Need for habitual behavior	The desire to achieve the same patient behavior corresponding to the role of the patient
Pursuit of peace and quiet	The need to observe the general hospital routine
Interest in your favorite activities	The desire to prevent unusual activities
Need for contacts with the outside world	The desire to limit the external contacts of the patient
The need for individual space	Striving for uniformity
Desire for emotional closeness with a doctor	The desire to maintain social distance
The desire for personalized treatment	Attitude to the patient as a “working episode”
The desire to quickly return to a healthy person's lifestyle	The desire to stay longer medical observation and the necessary restrictions

The personality-role analysis of medical conflicts allows you to identify the conflicting potential of subjects of medical interaction. The occurrence of conflict depends on the level of conflict of the medical worker and the patient. So, E.A. Karasev investigated the conflictogenic potential of the personality of medical workers using standard psychodiagnostic methods: tests by Thomas-Kilman and Spielberger-Hanin. He found that a very high degree of conflict is inherent in 8.5% of medical workers; high degree of conflict – 25%; pronounced degree – 58%; low degree conflicts – 8.5% [6]. A.V. Varlamov and V.V. Yakovlev, examining the conflictogenic potential of hospital patients, drew attention to the role of self-control (factor Q3 of the 16PF test): the higher self-control and the lower the conflict with surrounding people. The

authors consider maladaptiveness a direct personal predictor of the conflict (indicator of the AA Luscher test) [23]. A.A. Isaeva identifies five types of conflicting personalities that are most often found among patients in medical institutions: demonstrative, rigid, uncontrollable, over-punctual and unstable [24]. V.D. Chetverikov adds skeptic, rent, possessive and annoyingly demanding (viscous) types of patients [15].

The role-based approach to the analysis of the conflict potential of interaction is associated with the analysis of role-based projections in the field of medical communications. Such conflicts are often associated with a mismatch between the patient's expectations and reality: inadequate understanding of the proper behavior of medical personnel, procedures, sanitary and hygienic conditions in a hospital. On the part of the doctor, the conflict in communication with the patient may be due to the behavior, the appearance of the patient and the style of his communication. These characteristics may not coincide with the role play of the doctor and reduce his tolerance in interaction with the patient. In this connection, the stereotypes of the “lung” and “difficult” patient in general practitioners, studied by L.P. Urvantsev (Table 4) [25].

Table 4.

Generalized characteristics of stereotypes in the perception of general practitioners (according to L.P. Urvantsev)

“Easy” patient	“Difficult” patient
1. Dull	1. Doubtful
2. Unobtrusive	2. Obsessive
3. Modest, polite	3. Conflict, rude
4. Disciplined in treatment	4. Non-compliant
5. Trusting a doctor	5. Suspicious
6. Good-natured, friendly	6. Dull
7. Serious	7. Frivolous

In our study of reference images of a doctor and a patient, significant contradictions in the role expectations of communicants were recorded [26]. The most significant characteristics of the image of the ideal doctor in patients were emotionally empathic; Doctors have self-regulatory. The repetition of this experimental scheme at present (2018-2019) has shown the preservation of the main zones of contradictions. The study involved 30 primary care physicians and 62 patients from a multidisciplinary hospital. The age-demographic characteristics of the sample were aligned with the 1994 primary study. The main research method was the author's technique “Cascading Assessment of Personality Professional Skills” [27].

Table 5.

Rating of psychological skills identified in the study of the image of the “Ideal doctor” (1995-2019)

Characteristics	Expert Groups 1994		Expert Groups 2018-2019	
	patients	doctors	patients	doctors
1. Sensory-perceptual	4,2(5)	6,4 (4)	6,3 (3)	4,6 (4)
2. Memory-cognitive	6,5 (3)	7,2(3)	5,8 (4)	4,8 (3)
3. Communicative-technical	9,7 (2)	8,0 (2)	8,0 (1)	5,3 (2)
4. Self-regulatory	5,8 (4)	8,8(1)	4,1(5)	5,6 (1)
5. Emotional-empathetical	9,9(1)	5,6 (5)	7,6 (2)	2,2 (5)

In general, the experiment showed that the substantive content of the ideal of the doctor” has decreased. The range of estimates obtained in 1995 is much wider than the modern one. In 2019, the maximum rating of characteristics for a block of skills was only 7.6 points compared to 9.9 points (out of 10) in 1995. This may indicate that the tension of role-based projections to the personality of the doctor has decreased. Patients do not dream of a “super doctor”. Nevertheless, the rating of characteristics remained. For patients, the most significant characteristics of a doctor were communicative-technical and emotional-empathic characteristics. Their significance has changed somewhat: the patient of the 1995 model included more “sincerity” in the ideal of the doctor, while the modern patient considers the “communicative competence of the doctor” to be most important. At the same time, in the doctors' view, the “ideal” remained unchanged, although its substantial content decreased even more than in patients.

This direction of socio-psychological research, in our opinion, is of high relevance and a good prospect of practical application.

In general, analyzing the modern reality of medical communications and that the frequency and significance of medical conflicts is increasing. It is worth agreeing with the opinion of A.V. Kuznetsova, who talks about the total medicalization of society as a result of the spread of the influence of medicine on all new areas of public life [7]. This leads to an increase in the conflicting potential of medical activity and an increase in the relevance of its research.

The most promising psychological areas of study of the conflict potential of

communication in medicine, we consider the organizational, structural and personality-role approach. Recently, a fairly large number of works have been accumulated showing the effectiveness of these approaches in the study of conflicts. The continuation of this work and the accumulation of scientific data opens up new horizons for researchers of the conflicting potential of medical activity.

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