Doctors, the Social-Weavers

Knowledge and Knowledge-Making in Polish Primary Care

Hubert Wierciński

ABSTRACT

This paper explores the problem of knowledge and knowledge-making among Polish primary care doctors. Following Kirsten Hasstrup and Tim Ingold, I argue that doctors are skilful social-weavers capable of exploring and reconciling various orders of knowledge. Thus, through a diverse set of knowledgeable yarns – originating from professional and state regimes, and embedded in today's social relationships and economies – doctors are involved in the art of weaving a fabric composed of many, it would seem, contradictory orders of knowledge. The fabric in question is one in a constant state of reworking – although it is one that establishes a meaningful and knowledgeable environment in which the doctors can perform.

KEYWORDS

knowledge-making, medical anthropology, primary care, professional culture, Poland

Anthropologists and social scientists have successfully investigated biomedical cultures for a long time now (Doroszewska and Sadowska 2013; Hahn and Kleinman 1983; Nowakowski 2014; Rhodes 1996). Despite their achievements, however, the foundations of knowledge in Central-Eastern European biomedical culture(s) are still obtuse in many ways. Some researchers have pointed to local economies and political reshuffles, particularly the transition and accession to the EU (Bazylevych and Hrešanová 2011; Włodarczyk 2001). Others have explored the notion of standardisation, establishing relations of power and ways of acting within the biomedical environment (Bludau 2014; Laviolette 2009).

Yet doctors, as Eliane Riska and Aurelija Novelskaite (2011), and Stefan Timmermans and Hyeyoung Oh (2010) point out, act in a system of logics constituting their working background. First, they acknowledge a body of biomedical knowledge and follow a professional ethos visibly affected by the standardisation of medical practice (Cambrosio et al. 2006; Timmermans and Berg 1997; Włodarczyk

This article is available open access under a CC BY-ND 4.0 license as part of Berghahn Open Anthro, a subscribe-to-open model for APC-free open access made possible by the journal's subscribers.

and Badora-Musiał 2017). Secondly, they determine their position in relation to the state's policies, which lay the foundations of medical practice. Finally, doctors are embedded in the frameworks of markets and informal economies.

This article nevertheless considers the division of the doctors' world into logics to be a simplification. The logic-division does not provide answers for the complexity of the practitioners' knowledge, failing to account for what emerges at the boundaries of the elements composing medicine's social realities. It is likely that doctors' knowledge resembles a patchwork fabric, made of densely tangled yarns. The art of weaving, and thus the art of medicine, then becomes an act of continuous social creation rather than working in ready-made logics. Consequently, I consider doctors' knowledge to be a product of social influences, rooted in a variety of interactive social backgrounds.

This article thus enquires into the roles of knowledgeable yarns – along with the ways of using them – in the process of making medical care a system that is meaningful to a section of its users – the doctors. Using data from my investigation into Polish primary care – *Podstawowa Opieka Zdrowotna (POZ)* – I first demonstrate the yarns of the professional face of the doctors' knowledge. At this point I analyse the impact of biomedical and state influences on the practitioners. Next, I move to doctors' social engagements. Finally, following Brian McKenna (2010, 2012), I disclose a split in primary care, which – I argue – has its roots in the non-cohesive elements composing the practitioners' knowledge.

The Research

This ethnographic study among doctors anchors itself in seventeen POZ clinics between 2014 and 2020 – non-public¹ medical companies, albeit ones providing patients with state-funded public services contracted to the *Narodowy Fundusz Zdrowia (NFZ, National Health Fund)*. Ten of them are in Warsaw and Białystok, and seven in small towns and rural locations spread across Mazowsze and Podlasie. With the exception of one of the bigger clinics in Warsaw and two in Białystok, the clinics are run by partnerships of several doctors. These surgeries serve populations of up to six thousand patients, with doctors sharing their medical and administrative duties among themselves. The larger clinics handle higher numbers of patients and have their own supervisory boards chaired by a doctor with a full-time managerial position.

These clinics are diverse working environments, shaped by their regional demography and available human resources (Czachowski 2002; 2005; Holecki et al. 2013; Włodarczyk 2000; Partyka et al. 2017). The doctors occupy different social and economic positions. Before taking up positions in POZ, many of them worked in hospitals and some of them completed postgraduate management studies. The younger ones, however, in most cases have neither worked in hospitals, nor do they have any postgraduate diplomas. As a result, the ‘capital’ is in the hands of the older practitioners, while most younger doctors work as salaried employees.

I conducted forty-seven interviews with doctors, along with a number of unregistered conversations summarised in the fieldnotes. The project was divided into five series of fieldwork research, each lasting for about two months. Four of these series ended up with a thorough analysis of collected data – its selection according to the topics that emerged during the fieldwork – and its subsequent interpretation. The fifth part, dedicated to the impact of Covid-19 on POZ is currently underway. Therefore, I will not deal here with the issue of the pandemic, however, the evidence suggests that it has both a ground-shaking and stimulating influence on doctors, who have begun remodelling their practice of everyday medicine as a result of these unusual times.

The perspective of employment has led me to the discovery of an open world of practices reproduced by the generations of practitioners who ‘dwell’ in their professional ‘land-and-task-spaces’ (Ingold 2000). Although the registered interviews were undeniably informative, the body of informal conversations has proved to be equally valuable. Most of those took place while the doctors were engaging in trivial activities, such as gardening or socializing. The very foundations of these encounters gave me an insight into the doctors’ ordinary business of life, and thus exposed me to plenty of experiences, practices and obscured reflections. Their essence emerged in the form of lines, ‘the paths of growth and movement’, as Tim Ingold named them (2016: 5). Although ephemeral and non-graphic, these lines, knotted, yet opening possibilities, were the paths of life along which the knowledge and awareness I was curious about were constructed. After spending some time with doctors in their gardens or in their home comforts, I consider my research to be existential in nature; the study signals the importance of considering any medical practice in relation to the loose ends of everyday life.

Researchers involved in hospital ethnography agree that clinical settings require remodelling of ethnographic methods (Long et al.

2008). As Gitte Wind suggests (2008), participant observation in particular should be rethought, as it might be impossible to apply it in its original form in restrictive clinical realities. However, seven patients accepted my presence during their encounters with the practitioner. These observed encounters, though obviously not fully participant, yet unearthing the lines of practices and meaningful interactions, exposed to me the complexity of knowledge exchanges, many of them being outside any specific pattern of medicalised relations. This convinced me that it is key to consider the clinics as places where a doctor's knowledge is built through an accumulation of multiple social relations, enriched and informed by the practitioner's professional background and experience.

Finally, after having studied a number of legal acts, I took part in a series of gatherings of Porozumienie Zielonogórskie (Zielona Góra Agreement) – an association of healthcare employers representing the interests of some POZ doctors. I was invited there by two informants, who introduced me to the organisation's principles. During the gatherings, physicians, activists and other actors discussed the challenges related to politics, as well as the legal, medical and practical issues affecting POZ. During these intensive exchanges of ideas and stories from everyday work, a body of knowledge was born. Thus, Porozumienie is in fact itself a knowledgeable background, exposing doctors to a variety of opportunities.

The Conditions for POZ

Since the 1990s, the Polish healthcare sector has suffered from underfunding and frustrating disorganisation (Piątkowski 2015; Watson 2103). In 1997, the government attempted to reshape Poland's faltering healthcare. Since then, the healthcare budget has consisted of the common insurance contributions that were brought in to underwrite the system. Between 1997 and 2003, healthcare insurance (a component of social insurance) was managed by sixteen regional *Kasy Chorych* (health-insurance funds), which were the paymasters responsible for contracting medical services. In 2004 the *Kasy* were replaced by *Narodowy Fundusz Zdrowia*, which is now the sole institution contracting medical services.

After 1997, practitioners were encouraged to create private partnerships (non-public healthcare providers) based on contracts currently signed with the NFZ (Partyka et al. 2017). The value of a contract

results from the number of patients registered to a surgery, multiplied by the capitation rate linked to each patient. Surgeries must cover all their own costs from budgets made up of the above-mentioned contributions. The remainder of the money is for the doctors' income. In some clinics, self-employed doctors with independent medical practices issue a monthly invoice to the clinic for their services; in others, the final income is divided between the doctors according to internal regulations outlined in a particular partnership's agreement.

In 2017, doctors' duties were significantly expanded. Currently, patients registered with a clinic are in the care of teams composed of doctors, nurses and midwives. Doctors now act as coordinators of these teams; they are responsible for managing diagnostic processes and circulation of information about patients. This reform was designed predominately to increase the efficiency of primary care and strengthen its position in the healthcare system. Practitioners, generally perceived as accessible and competent, as studies have shown (CBOS 2017; 2018), have been entrusted with new duties, along with the competence allowing them to take over some of the prerogatives previously assigned to the less accessible secondary care system.

Consequently, many practitioners are now fluent in more than medicine; they have become guides to patients, managers and employers. Sławomir Czachowski pointed out (2002, 2005) that POZ doctors work in complex environments, but are also involved in the co-creation of these environments. Hence, they participate in a variety of knowledge-making activities. They follow both their profession and the state policies, but are equally involved in diverse relationships with patients and other social actors. This bestows upon them the role of social-weavers, who, using knowledgeable yarns of various logics, actively manufacture networks of ideas and relationships, ensuring patchwork backgrounds for their every-day practices.

The Questions of Knowledge(s)

Michael Herzfeld (2001) distinguishes two major epistemological areas, namely the paradigmatic background of anthropology and the local epistemologies. The epistemologies that the researchers discover are, however, historical, ethical and methodological interplays between people sharing experiences, which anthropologists then shape into paradigmatic theories. Johannes Fabian (2012) goes even deeper. Anthropology, he writes, resembles a 'gargantuan costume

party' (2012: 440) of epistemological ideas and ideas about epistemology. As Fabian concludes, the critical approach inherited from the reflexive shift disturbs the ball, prompting two questions – 'knowledge of what?', and 'whose knowledge?' Consequently, the following article is – best expressed in Clifford Geertz's terms (1973) – a thick description of my knowledge of local to primary care conditions formulating a doctor's knowledge.

I appreciate Fabian's idea of knowledge as an activity opposed to ignorance. The doctors were certainly not ignorant. This required significant effort in forming a background to their knowledge-making activities. Knowledge is, however, also a possession that belongs to those who actively create and utilise it – precisely as the doctors did during encounters with patients, and when gathering together to discuss professional matters.

The knowledge I am concerned with is never given in advance. Instead, it is constantly emerging from the relations doctors have with their patients, other doctors and institutions. The doctor's knowledge is an unfinished project of possession, practice and interpretation of stimuli from social as well as professional milieux. Consequently, to be a primary care doctor means to specifically know and work through certain skills. This, as Ingold argues (2000, 2016), engages people in (re)creating their occupations. That way, they draw lines of actions, along which their knowledge and experiences emerge. Knowledge is established in the process of linking those various lines, thus introducing a sense of composition and opening a perspective on a volume of knowledge coming from a variety of sources. To illustrate this, Ingold (2016: 64) describes the fabric of a Navajo blanket: in the looms, he argues, two 'threads' meet, yet the visible lines are never a simple composition of 'traces', but a system of complex differences creating a positive sense of the lines' continuity and a recognition of their different 'traces'. That observation is crucial to understand how doctors compose their every-day fabric.

This moves the discussion to Kirsten Hastrup (2018) and the process of 'knowing' constituting a sense of personhood and a comprehension of locality. The doctor's knowledge is thus much about developing an interactive 'enskillment' – as Hastrup argues (2018), the enskillment is an act of arriving at a knowledge and interpretation of socially significant acts, actors and actions. In this process, she argues, the skill of 'forecasting' is crucial, as, it can be supposed, it gives doctors the art of common-sense observation and the anticipation of steps fundamental to their professional self-awareness and practices. Thus,

knowing is an ability to act in response to the past and perceived emerging future conditions. Knowledge-making is therefore an act of expansion and mastering incoming challenges. As a result, I consider doctors' knowledge-making to be an act of weaving requiring the skills they have gained during their academic training, in practice, and from social entanglements exposing them to the complexity of real life in clinics. Consequently, the doctors navigating a path between the aforementioned logics – now crucial for Central-Eastern European healthcare systems – are then within the continual transformation of their profession (Timmermans and Oh 2010).

The Yarn of Profession

After a day spent in the clinic, we were discussing with Kristin the events that had happened that day. At a certain point, she said: 'I've been thinking about your questions on my medicine and I might have some answers for you'. She started with this strong declaration:

I worked in the hospital for about twelve years. I consider this a success. There has always been a certain assumption that those working there were decisive and educated. It is there, where patients come and doctors ought to figure them out and treat them. (interview 1)

In such a way, she embeds her knowledge in the yarn of her professional background, which, according to her words, was itself a knowledgeable and simultaneously knowledge-making system. That unique disposition, as Hastrup would name it (2018), enskilled Kristin and endowed her with a certain skill for forecasting. This became clear to me, after Kristin made some comments on her job in POZ:

Who was ill today? I would have to think who really was. Renewals, check-ups, but first you should have this treatment set. Later, there is usually just a continuation. But, there are hard cases, and if not my normal experience from the hospital ... Doctors with less experience would simply either not even notice or simply let them pass by, because they wouldn't have this habit or awareness of what they are actually missing. Or they would have had just enough intuition to send the patient to hospital with hope that somebody there would do something more accurate. (interview 1)

Then, the doctors' knowledge is specifically rational and grounded in their practical experiences, allowing them – in a certain manner – to efficiently and accurately forecast possible scenarios for the patient's body (Hahn and Kleinman 1983; Rhodes 1996). Individuals

possessing such skills and knowledge – as Kristin and others have signalled – were a certain elite, respected by the doctors’ community and patients alike. Following Pierre Bourdieu (1990), they owned a capital, allowing them to weave facts and interpretations and, therefore, manage to suppress the stress of dealing with a range of cases, especially as the latter in the explicitly individualistic practice of POZ might be a significant problem. This is Ann speaking:

The stress here is something massive. In hospitals, teams take decisions and can be controlled at a certain level by others. Here you are responsible for your decisions and this is certainly stressful – when you are alone in the office and you have to take some decisions. This is a big responsibility. (interview 17)

A doctor’s working environment, as I have observed in the clinics – especially the encounters with their patients – urges them to confront tens of admissions daily. Consequently, doctors ought to be ready to employ, intuitively, multiple learned patterns – usually labelled ‘standards’ for certain conditions. I have witnessed examples of the latter when doctors almost on the spot adopted specific paths of knowledge and related actions.

As Riska and Novelskaite have shown (2011), the logic of profession is the space in which the doctors’ knowledge is manufactured and disseminated across the professional milieu. This logic brings to local biomedical cultures a straightforward style based on a certain standardisation of knowledge and a unique type of objectivity. Cambrosio et al. consider it:

... consistently results in the production of entities and protocols (both tacit and explicit) that combine biology and pathology in novel ways and that are most often produced through concentrated programmes of collective actions. These actions themselves incorporate unprecedented levels of reflexivity, in the sense that biomedical practitioners in their debates and discussions take into account the conventional dimension of their endeavours. (2006: 190)

Although to some extent reflexive – as they must be when confronted with the research breakthroughs and dynamic policies of care – standards brought to doctors a sense of pride (Włodarczyk and Badora-Musiał 2017: 45–47). To be a good doctor – I was told – meant to follow the array of paradigms and solutions for healthcare. Margaret encapsulated this well:

I was commuting to the provincial hospital and doing night shifts. That cost me a lot of mental effort because I had to constantly switch between

oral and intravenous drugs. I had to deal with infants coming from the ward upstairs. Thus, yeah, that was an effort, but it was very educative, 'cause I had to get myself together (interview 30).

The standards – as Stefan Timmermans and Marc Berg would say (1997) – lie at the heart of medical practice, aiming temporally and spatially comparable actions towards patients. Indisputably, they are skills constituting a good part of medicine, while also setting confusing borders of a doctor's practice. I have discussed this issue with practitioners, who usually referred to it as Beth did:

For example, a patient with atrial fibrillation comes. You make a diagnosis and there is a precise standard for further actions. You don't attempt to stabilize the rhythm and take this patient back to his regular rhythm. Your job is to accurately diagnose him and transfer him to the emergency room. Otherwise you aren't following a cardiac standard. (interview 20)

Although informants often had the qualifications necessary for undertaking further action (including an appropriate specialisation, although one not recognised by NFZ for practice in POZ), the power of standards and the regulatory contracts with the NFZ restricted them from doing anything more than just following the rules. However, in my time in small rural clinics, I've found some interesting exceptions, proving that standards and contracts are not the sole motivations for doctors' actions. In rural areas lacking access to secondary care, the doctors – occasionally, and unofficially – deviated from the abovementioned provisions, knowing that some of their patients would have little chance for accessing help in distant secondary care. John says: 'I do this for my patients. I do this for Mr X, as he can't go there, he has no money, he will never be admitted to a surgeon. . . . I am a small-scale surgeon, a small-scale gynaecologist, a small-scale ophthalmologist, a small-scale dermatologist' (interview 31).

Thus, 'a provincial medicine' – as John interestingly named it – could be seen as a medical practice, in the skilful sense, actively responding to local circumstances, and thus making use of a doctor's knowledge, even though it is not recognised by the standards. Along with basic surgery, some forms of cardiology treatments were the most common off-protocol actions – hardly surprising, as such medical conditions, according to *Główny Urząd Statystyczny* (Statistics Poland, GUS),² are some of the most common reasons for death or permanent damage to health for Polish society.

A doctor's knowledge then appears to be operational – it is composed of clear directives and factual knowledge ready to be turned

into meaningful actions. It also brings to doctors a sense of emancipation. I assume this phenomenon has its roots in practitioners' education – especially in the first years of their practice – which are usually devoted to completing specialisations. At this time, they are heavily exposed to professional discourses – mainly brought to them by their supervisors – and learn to undertake complex actions that bring them a certain sense of elitism. Thus, from the outset of their career, they should be able to withstand the thoroughness of the training and the harsh conditions that come with the job.

Additionally, as Byron Good has suggested (1994), doctors are influenced by internal authoritative bodies charged with establishing a body of objectified knowledge and directives for medical treatment. Unfortunately, my attempts to establish meaningful contact with these organisations were dashed. I was thus reminded how hermetically sealed biomedical environments can be. That said, after a discourse analysis, I made some discoveries within the *Naczelna Izba Lekarska* (Supreme Medical Chamber), and *Ogólnopolski Związek Zawodowy Lekarzy* (Doctor's Trade Union of Poland, OZZL) – both organisations releasing frequently bold narratives on the medical profession and its substantial backgrounds. Consequently, doctors appeared to take the form of bodiless working minds, almost devoid of uncertainty and emotion, and thus able to see things with crystal clarity. Nevertheless, as I have earlier pointed out, they experienced moments of indecision or uncertainty. Practitioners shared a basic human need to talk to others – about their patients, and job routines. In POZ, which declares itself to be embedded in community matters – and so different from other contemporary medical practices – such reflective moments were a part of the job. One of my informants accurately asked: 'after all, how long can you stay focused and infallible when dealing with thousands of people?' (interview 7).

Disciplined Yarn: The Power of the State

Pavel Osinsky and Charles W. Mueller reflect on (2004) the surprisingly undervalued positions of skilled professionals in post-socialist realities. As they revealed, professional attributes, supposedly emancipating and market-valuable, are suppressed by a state wishing to preserve its authority.

These comments have value when applied to the study of doctors' knowledge foundations – there are other rigid sectors of influence

which significantly contribute to POZ knowledge frameworks. The institutional culture of the state has its own standards, usually visible as acts and documents having their own specific logics. Matthew Hull suggests (2012) that documents themselves are social actors, disseminating patterns of values and ideas, and thus establishing dispositions of knowledge for vast social environments. Eventually, this becomes the state – with the help of its institutions and a body of documentation made up of legal acts and contracts – dictating who can be a doctor, and how they can do it. Therefore, growing bureaucratisation in the healthcare system exposes practitioners to the influence of actors using knowledge other than medical, yet equally important in the provision of care.

This returns us to a discussion about ‘standards’, although the standards I am currently concerned with were designed in the minds of officials rather than opinion-forming biomedical institutions. Consequently, practitioners were left with the impression that they have been performing artificially narrowed duties, bestowed upon them by NFZ and the Ministry of Health in rigid contracts. As a result, the contracts have turned out to be not only agreements between parties engaged in providing care, but also bureaucratic interpretations of medicine itself. Doctors have had to accept these standards, including administratively established diagnostic and treatment procedures, thereby absorbing into their milieu yet another highly standardised model of knowledge. Prescribing medication well illustrate this point. In general, medication is a sensitive issue, as much of it is partially or fully ‘refundable’ – covered by the state. I was told that even the same substances, manufactured by different companies or with differing dosages, could be prescribed for different conditions and refunded at varying levels. This system impacted on the cost of medication and, for many patients, the cost of their treatment. Thus, every time the list was updated, doctors began binding administrative requirements, while using their creativity to figure out what would both benefit patients and comply with NFZ demands.

Not surprisingly informants have complained about bureaucratisation distracting them from performing their duties. Investigating documentation became a pressing part of doctors’ jobs, turning them – according to informants – into clerks, rather than doctors providing care. Indeed, after Jakub asked me to join him while he was filling in the paperwork blanks after a day in the clinic, I was amazed with the number of documents and the complexity of the software he had to deal with. The efforts he made and the time he required for

after-hours paperwork opened my eyes to the levels of bureaucratisation surrounding the doctors – things initially alien to them, but now standard practice. Not surprisingly, their instinct was to resist this situation, while accepting that knowledge – and its associated skills – although not resulting from a doctors’ education, were necessary to run or work in clinics.

Another striking point – this time observed in rural clinic – was the challenges posed by the software and its use. The software, according to respondents and based on my close examination, was far from user-friendly. Unnecessary brackets, small fonts and pop-up windows, made it difficult to use for the dynamics of a medical practice. Often, it left practitioners confused and overly focused on form filling, limiting time for listening to patients. All these reporting actions had to be completed under strict time pressures during the day – or after-hours. In particular, older doctors, often the only practitioners keen to work in the countryside, had difficulties in working in a digital environment. Instead, they simply performed their medical duties, and in so doing, they introduced strategies of resistance into their work routines. This is John speaking:

This looks well from the point of view of officials. But, really, only try to do this – and I ask: when?! Later, there are those reports and settlements. Yep, I do all of this, I check all those bilirubin values and so on, however I don’t give NFZ any reports, ‘cause they make me sick. (interview 31)

The Yarns of Market and Community

Entrepreneurship fosters deeper relations of affinity, while also giving the chance for diverse behaviour within communities. However, entrepreneurship as it is practised today operates in a somewhat narrower sense, focussing on the exploitation of opportunities designed to expand individual or shareholder wealth, rather than acting in the interests of communities. Such approaches have had a great influence on Central-Eastern European healthcare systems since the early 90s. Therefore, it now appears that the reconstruction of Polish primary care was – contrary to the Alma Ata and ‘Ljubljana Charter’ declarations (Janes et al. 2006) – ultimately focused on economic and legal aspects, with only a secondary role in community matters.

How, therefore, is it possible to distinguish entrepreneurship in POZ? I suggest that these points have two, differently weighted,

areas of knowledge. The first, characteristic of the vast majority of informants, reveals doctors' attachments to liberal values establishing a category of knowledge I term 'market knowledge'. The second approach concerns the mostly informal attitudes and actions of doctors who have a sense of the pro-community aspects of their work. This approach, however, was rarely used by informants to fulfil roles characteristic of social entrepreneurs (Farmer and Kilpatrick 2009). Instead, their actions were limited to occasional activities, or to non-medical relationships with patients based on the exchange of knowledge and, sometimes, favours. The latter do not fit neatly into any of the previously mentioned yarns – but, nonetheless, they contribute to the variety and depth of a doctor's knowledge and actions. Thus, I consider them as constituting another framework; one which I term 'the social yarn', involving a doctor's knowledge of, and their attachment to, their local community.

After 1997, running one's own business – or working in one – became the way to become a knowledgeable POZ doctor. This new form of practice, as the doctors told me, was welcomed by the majority of the medical community, which since the early 90s had been ready to absorb the novelties of the transformation. The market economy then brought doctors another enskillment: the recognition of economic possibilities, which led practitioners to develop a new awareness of the system itself – the result being fresh inputs to their knowledge backgrounds, coupled with innovations in their professional lives. Founding a POZ clinic, or even working in one enriched them with new visions of medicine. The doctors gained access to trainings – like coaching sessions and management studies – giving them the opportunity to implement innovations into their practices. However, practitioners began to discover the reality of POZ costs, and they were forced to control spending, as their clinics worked in much the same way as other businesses.

Although presenting difficulties such as limited budgets, and bureaucratisation, entrepreneurship has offered doctors a body of knowledge and skills they did not previously have. Evidently, becoming a doctor-businessperson in a non-public surgery was a revolution. This is Henry speaking:

It is just as in every other business, but, as the owner and the employer, I have certain duties. I must keep an eye on my nurses, I have to follow labour laws, and besides, like every employer, I must take care of health and safety issues. In the big surgeries there was a director and deputy, taking care of everything. And here, I am a director and deputy, I am the owner, stock manager, hauler, literally everybody. (interview 36)

Although generally positive for both doctors and patients, such reorientations pose threats to the philosophical foundations of medical practice (McKenna 2012, 2010; Stone 1997). An example comes from the way in which the majority of practitioners expressed their perspectives on healthcare in a neoliberal logic. With few exceptions, they talked about a ‘healthcare market’ rather than a welfare system, and postulated co-payments for consultations. Doctors rarely treated patients who were uninsured. They justified this by citing possible difficulties in recovering costs from NFZ, or via concern about the potential consequences of treating patients without the right to state-refunded healthcare. Finally, as the doctors had to cover all their costs from the money originating from contracts, they referred patients for examinations – for which they had to pay – only in ‘justified situations’ (the doctors’ term). Such was the case even when faced with charges of parsimony – this was especially the case in rural areas or neighbourhoods, where rumours more easily circulate. Such unique financial conditioning also encouraged doctors to segregate patients according to their economic potential. George had this to say:

The more I work, the less I have. I have a capitation rate, not a task rate. So, even if I have many admissions and I refer patients for examinations, this does not increase my salary, because I have a rigid contract. There are some loss-making groups, like children under one year. Those who have such children are very loss-making. They used to say: if you want to make some money on POZ, well, you better take some conscript eighteen year olds – they should be healthy. (interview 25)

How, then, have the doctors fulfilled their pro-community duties? Where should we begin a search for doctors’ socially grounded knowledge?

I have collected much subtle evidence to show that the silent agent determining the intensity and depth of relations in POZ is time. Time is the agent powering doctors’ actions and turning their knowledge into a practice of selfless care. I would argue for at least two distinctive time frames in primary care. The first is a standardised period deemed sufficient for a single consultation. Doctors use this measure – usually referred as ‘ten minutes’ – to depict intensive interactions with patients which, however, fail to allow the establishing of meaningful contact with patients and their bodies. Yet, as many patients have been registered in individual clinics for years, there is a second frame – a longer-term perspective through which doctors look to build up patient histories, composed of conditions and physical-mental changes, along with family and personal situations and

environments. Therefore, this is a fitting time axis, along which the depth and quality of relationships are born, before settling into a process of mutual cooperation between patients and doctors. Eventually, this cooperation produces a socially instilled type of knowledge that is, as informants argued, the essence of primary care practice. Here is Lucy speaking:

They have been coming for the last decade. I know those patients, sure. I know for instance, that a granddaughter was pregnant, when a patient comes, so I ask, well – a boy or a girl? So, there is a clear relationship with peoples' lives, I am not purely concerned about clinical facts, nor on the interview, or on pains. This is very much all connected, patients often want to tell me something about their lives, this is all simply intertwined. (interview 29)

Doctors, as I observed, were capable of navigating through and switching between medical and non-medical orders of knowledge; a situation that created uniquely professionals, with a still quite strong attachment to – it appears – the ordinary world. Therefore, to a certain extent, they were, as Sue Kilpatrick concludes, 'boundary crossers', who:

live in the rural community and are employed in the health system, and so are able to use the lens of a community member to analyse and lead actions to build and use community capacity for health development. They can do so because they operate in, and across, two or more social fields, including health. (Kilpatrick et al. 2009: 286)

Some of the doctors were indeed engaged in community matters, although not as influential social entrepreneurs. Generally, doctors working in Warsaw, along with some from Białystok, revealed very few, if any, community entanglements. Additionally, in big cities local healthcare is enriched by the private sector, based on voluntary insurance contributions, company healthcare plans, and pay-per visit appointments. Consequently, particularly in Warsaw, hardly any of the informants worked solely in one place and displayed much attachment to any single clinic or its patients. Therefore, they never had the chance (nor even the will) to establish relationships emerging over longer period of time.

In contrast to urban regions, the majority of clinics in rural areas and small-town locations are family- or friend-run surgeries, with the medical staff occupying full-time positions in a single place. Here, the patients and their families have often been with their physician for a long period of time. In this setting, POZ clinics played a major role in communities – such roles often reaching beyond the scope of contracted duties.

Anthropologists recognise humans as storytellers. Storytelling is an activity; it brings to life a sense of dynamism, which, as Cheryl Mattingly (1998) and Arthur Kleinman (1988) showed, is fundamental to any form of care provision. Narrative research in medical anthropology usually focusses on patients as storytellers. Yet, there are also medical professionals out there, who, besides story-tellers, are story-listeners. This conclusion draws attention back to the doctors' knowledge entanglements. I consider POZ doctors to be not only skilful professionals, but also good listeners to people's stories, which they sometimes make use of in order to help patients. Therefore, the art of empathetic listening seems to be crucial to primary care. Indeed, as Mattingly writes (1998), listening to an individual's traumatic story is already a socially anchored form of care involving psychologically positive relationships of trust and commitment. I have spoken to doctors who have claimed to have entered into such relationships. John tells it this way:

The rural doctor was like a priest – you could have a word with him. The older people still do this. I have a patient abused by her daughter-in-law. Nobody knows, but I know. She comes to me and doesn't want to leave, cries, wants to talk. Do you think this consultation lasts ten minutes? No. It lasts for half an hour. (interview 31)

Yet, despite being so pivotal, the art of story-sharing and story-listening is invisible in the concept of logics proposed by Riska and Novleskaite (2011), as well as in Timmermans and Oh's study (2010) on transformations of the medical profession. It is hard to find the space for such knowledge-making relationships and practices within professional and state logics, nor can space be found for them in the logics of market and informal economies. Despite this, as I have discovered, it is out there – a rich, hidden landscape of trust and cooperation, a place of knowledge-making and knowledge-exchange, a space for personal attachments right at the heart of a supposedly standardised doctor's practice. Here, the doctors' professional skills and authority, along with their unique relationships with patients and other social actors, are mixed into the fabric of professional, market-grounded and pro-social primary care. It was here where the doctors – usually via repeated admissions – assumed the roles of boundary-crossers: professionals with market orientations; attentive listeners, trustees and knowledgeable people primed for requests for medical and personal care. It is also here where the primary of primary care was born and skilfully practised over a long-time axis, recognised by both doctors and patients.

Patching the Fabric?

Brian McKenna (2012, 2010) critiques the neoliberal economy, having – in his words – a devastating impact on healthcare. He reveals the notorious issues of costs and budgets as having clear impacts on quality of care. The intrusion of market values led to a narrowing of the general concept of medicine – a familiar perception among so many of my informants, with their attachments to liberal values, and their eyes on their budgets. The rejection of pro-social principles in primary care, accompanied by a drift towards ‘capitalist medical care’ (McKenna, 2012: 266), are indeed true – I have found a strong body of evidence in support of this thesis. However, I am far from declaring ‘the death of primary care’ (McKenna, 2012: 67) – a system now allegedly turned into ‘a commercialised, profit-motivated, market-based battlefield’ (McKenna, 2012: 267). I am also not convinced about putting doctors into the somewhat odd division of slaves and free people: ‘Slave doctors are those who dutifully marched to the orders of bean counters and bureaucrats, practicing “cookbook” medicine, seeing 40 patients a day, Eisenberg said. Free doctors placed peoples’ humanity front and center’ (McKenna 2010: 7).

Consequently, all the doctors I met during my research would be considered slaves – many of them saw ever more patients daily, had to follow state standards, and few of them were much concerned about such issues as ‘peoples’ humanity’. They simply worked – after all, what else could they do in the clinics? Yet, despite some deficiencies in McKenna’s critique, I consider his notion of a ‘clash of civilisations’ (2012) as being, overall, productive. Indeed, from the outset of my research, I was amazed by so many contrasting orders in a single area of social activity. Do the discussed yarns compose a tight fabric, or are they so tangled up that the fabric lacks any cohesiveness? Although at first glance what we see is quite regular, a deeper investigation finds it plagued by internal cracks and collisions between the yarns. The doctors must cope with dramatically differing values, needs, strategies and, ultimately, knowledges. And yet, it works – POZ is the successful branch of the Polish healthcare system, lacking financial problems, having its own standards, and remaining accessible to patients (Włodarczyk 2000; Czachowski 2002; 2005).

Nevertheless, for many it was impossible to maintain deep contacts with patients, while operating within institutional regimes encapsulated in legislation and contracts. These documents were in fact testimonies of bureaucratic power that visibly limited doctors’ actions

and their chances for a meaningful relationship with their protégés. These agreements defined precisely all the doctors' duties, and even listed the diagnostic examinations doctors could use in their practice. Consequently, their knowledge of patients was significantly limited, and in many cases, it relied only on data coming from secondary care sources. It requires pointing out that there is no system efficiently collecting either the disparate items of knowledge attached to patients, or their test results: still the most common flows between primary and secondary care are those of the patients themselves. It is not surprising then, that much of a doctor's efforts are concentrated not on treating people, but rather on clarifying their situation. This is Kristin speaking:

A patient comes and has – for instance Accard from neurologists and Polocard from a cardiologist. The next consultations will be another half a year at the earliest. So, they come to me. And I say: well, these medicines are the same. Somebody isn't paying attention there, they just give their own treatment. So, presumably, I have to keep an eye on that. (interview 1)

This example, along with so many similar signals from other doctors, reveals something deeper: even the yarn of the doctor's profession can be surprisingly tangled, as there is no efficient system of communication between doctors working in different sectors of healthcare. POZ was initially designed to coordinate all incoming knowledge, however, without efficient tools, doctors were unable to achieve this aim. Consequently, many of them had the impression of their work being the art of finding a way through a thicket, the challenge of combining contradicting information, while meeting the vast demands and broad expectations of the system. In such a way, the act of inventing and weaving a socially meaningful fabric was their actual job routine.

Similar observations may be made about doctors' market entanglements. Practitioners ought to balance their spending in much the same way as every other entrepreneur. Consequently, they had to be cautious about referring patients for further examinations, as these were chargeable to the budgets. This often led to accusations towards doctors of parsimony. Therefore, doctors' knowledge frameworks are exposed to social criticism. Along with professional values, they must meet state demands and standards, while committing themselves to the even higher expectations from local communities. Additionally, doctors must constantly work out how to deal with other social actors and institutions, along with the possible legal and financial consequences

awaiting errors. The primary care knowledge is therefore characterised by the significant sense of insecurity resulting from the burden of playing so many roles at once. How hard it was to be a professional doctor with eyes and ears open to patients' problems and stories. How hard it was to be a well-oriented business person; how hard to be a skilled bureaucrat, competent in meeting institutional demands.

Primary care is far from being a battlefield exclusively concerned with neoliberal influences. Instead, I would rather consider it to be a doctor's struggle to make their knowledge as cohesive as possible, and to be ready to deal with the incoming problems. The lines of knowledge in primary care are then marked with internal contradictions. It is worth pointing out, however, that the doctors were very much aware of the situation described. In many ways they were eager to deal with such things, as dealing with difficulties was – as there were told in the first years of their training – the sole aim of medical practice. And so, there are doctors who, instead of being surgeons skilled in the art of sewing, are weavers trying to go about their work in any meaningful way possible, thus bringing essential life to the lines, threads and traces composing it. Consequently, there is something fundamentally unique about POZ practitioners: from the very beginning, they have been ready to play more roles and fulfil more functions than doctors usually have to. Working, learning, absorbing, helping and earning – truly, despite some obvious conflicts, they are enskilled social-weavers, capable of re-inventing and reviving the fabric of their own worlds.

◆

Hubert Wierciński University of Warsaw.
E-mail: hubertwier@gmail.com
ORCID: 0000-0002-9535-4180

◆

Notes

1. Non-public medical companies can be run by entrepreneurs, partnerships/companies, medical universities, foundations, labour unions, and so on. In 2011, they were transformed into 'medical entities' (*podmioty lecznicze*), a category that may include also state institutions. In the article I employ the 'non-public' label, as all investigated surgeries were run by individuals or partnerships/companies set up by doctors. Two such surgeries were co-run also by persons having no medical background.
2. https://bip.stat.gov.pl/files/gfx/bip/pl/zamowieniapubliczne/426/248/1/81_gp_rrl_2015_monografia_kardiologiczna.pdf (accessed 29 January 2021).

References

- Bazylevych, M. and E. Hrešanová (2011), 'Introduction: Health and Care Work in Post-Socialist Eastern Europe and the Former Soviet Union', *Anthropology of East Europe Review* 29, no. 1: 1–7.
- Bludau, H. (2014), 'The Power of Protocol: Professional Identity Development and Governmentality in Post-socialist Healthcare', *Czech Sociological Review* 50, no. 6: 875–896.
- Bourdieu, P. (1990), *Homo Academicus* (Stanford: Stanford University Press).
- Cambrosio, A. et al., (2006), 'Regulatory Objectivity and the Generation and Management of Evidence in Medicine', *Social Science & Medicine* 63: 189–199.
- CBOS (Centrum Badania Opinii Społecznej) (2017) 'Lekarze Podstawowej Opieki Zdrowotnej i ich Kompetencje' [Primary care doctors and their competences], https://www.cbos.pl/SPISKOM.POL/2017/K_161_17.PDF (accessed 29 January 2021).
- CBOS (Centrum Badania Opinii Społecznej) (2018) 'Opinie na Temat Funkcjonowania Opieki Zdrowotnej' [Opinions on the functioning of the healthcare system], https://www.cbos.pl/SPISKOM.POL/2018/K_089_18.PDF (accessed 29 January 2021).
- Czachowski, S. (2002), *Środowiskowe Uwarunkowania Praktyki Lekarza Rodzinnego* [Socio-environmental conditions in the practice of a family doctor] (Toruń: Wydawnictwo Naukowe Uniwersytetu Mikołaja Kopernika).
- Czachowski S. (2005), *Rola lekarza rodzinnego w praktyce medycznej* [The role of a family doctor in medical practice] (Toruń: Wydawnictwo Naukowe Uniwersytetu Mikołaja Kopernika).
- Doroszewska, A. and A. Sadowska (2013), 'Mosty Zamiast Murów – Socjologia Medycyny Przykładem Udana (?) Interdyscyplinarnej Współpracy' [Bridges not walls – medical sociology as an example of successful (?) interdisciplinary cooperation], *Nauka i Szkolnictwo Wyższe* 1, no. 41: 57–68.
- Fabian, J. (2012), 'Cultural Anthropology and the Question of Knowledge', *Journal of the Royal Anthropological Institute* 18: 439–453.
- Farmer J. and S. Kilpatrick (2009), 'Are Rural Health Professionals Also Social Entrepreneurs?', *Social Science & Medicine* 69, no. 11: 1651–1658.
- Geertz, C. (1973), *The Interpretation of Cultures* (New York: Basic Books).
- Good, B. J. (1994), *Medicine, Rationality and Experience: An Anthropological Perspective* (Cambridge: Cambridge University Press).
- Hahn, R. and A. Kleinman (1983), 'Biomedical Practice and Anthropological Theory: Frameworks and Directions', *Annual Review of Anthropology* 12: 305–333.
- Hastrup, K. (2018), 'Muscular Consciousness. Knowledge-Making in an Arctic Environment', in T. Rakowski and H. Patzer (eds), *Pre-Textual Ethnographies* (Oxon: Sean Kingston Publishing), 116–137.
- Herzfeld M. (2001), *Anthropology: Theoretical Practice in Culture and Society* (Malden, Oxford: Blackwell Publishing).
- Holecki T. et al. (2013), 'Kształtowanie Wizerunku Placówki Podstawowej Opieki Zdrowotnej w Kontekście Roli Lekarza Rodzinnego' [Shaping the image of primary healthcare centres in relation to the role of a family doctor], *Studia Ekonomiczne/ Uniwersytet Ekonomiczny w Katowicach* 157: 149–156.

- Hull, M. S. (2012), 'Documents and Bureaucracy', *Annual Review of Anthropology* 41: 251–267.
- Ingold, T. (2000), *The Perception of the Environment: Essays in Livelihood, Dwelling and Skill* (London: Routledge).
- Ingold, T. (2016), *Lines* (London and New York: Routledge).
- Janes C. R. et al. (2006), 'Poor Medicine for Poor People? Assessing the Impact of Neoliberal Reform on Health Care Equity in a Post-Socialist Context', *Global Public Health* 1, no. 1: 5–30.
- Kilpatrick S. et al. (2009), 'Boundary Crossers, Communities, and Health: Exploring the Role of Rural Health Professionals', *Health & Place* 15, no. 1: 284–290.
- Kleinman, A. (1988), *The Illness Narratives: Suffering, Healing & the Human Condition* (New York: Basic Books).
- Laviolette, P. (2009), 'The Death of the Clinic', in P. Vannini (ed), *Material Culture in Everyday Life* (New York: Peter Lang) 211–27.
- Long, D. et al. (2008), 'When the Field is a Ward or Clinic: Hospital Ethnography', *Anthropology & Medicine* 15, no. 2: 71–78.
- Mattingly, C. (1998), *Healing Dramas and Clinical Plots: The Narrative Structure of Experience* (Cambridge: Cambridge University Press).
- McKenna, B. (2010), 'Take Back Medical Education – The "Primary Care" Shuffle', *Medical Anthropology* 29, no. 1: 6–14.
- McKenna, B. (2012), 'The Clash of Medical Civilizations: Experiencing "Primary Care" in Neoliberal Culture', *Journal of Medical Humanities* 33, no. 4: 255–272.
- Nowakowski, M. (2014), 'Wiedza Medyczna Jako Przedmiot Badań w Ramach Socjologii Medycyny i Socjologii Wiedzy' [Medical knowledge as a subject of research in medical sociology and sociology of knowledge], *Konteksty Społeczne* 4, no. 2: 45–57.
- Osinsky, P. and C. W. Mueller (2004), 'Professional Commitment of Russian Provincial Specialists', *Work and Occupation* 31, no. 2: 193–224.
- Partyka, O., et al. (2017), 'Podstawowa Opieka Zdrowotna w Systemie Ochrony Zdrowia i Kształcenie Lekarzy Rodzinnych w Polsce. Co warto wiedzieć z historii?' [Primary healthcare in the healthcare system and education of family practitioners in Poland. What is worth knowing from history?], *Zdrowie Publiczne i Zarządzanie* 15, no. 4: 366–373.
- Piątkowski, W. (2015), 'Dysfunkcjonalność Systemu Opieki Zdrowotnej w Polskiej Socjologii Medycyny: Zarys Problematyki' [The dysfunctions of the healthcare system in Polish sociology of medicine: An overview], in A. Ostrowska and M. Skrzypek (eds), *Socjologia Medycyny w Polsce z Perspektywy Półwiecza: Nurty Badawcze, Najważniejsze Osiągnięcia, Perspektywy Rozwoju* [50 years of sociology of medicine in Poland: Research trends, achievements, prospects] (Warszawa: Wydawnictwo IFIS PAN), 67–104.
- Riska, E. and A. Novelskaite A (2011), 'Professionalism and Medical Work in a Post-Soviet Society: Between Four Logics', *Anthropology of East Europe Review* 29, no. 1: 82–93.
- Rhodes, L. A. (1996), 'Studying Biomedicine as a Cultural System', in C. F. Sargent and T. M. Johnson (eds), *Medical Anthropology: A Handbook of Theory and Method. Revised edition* (London: Greenwood Publishing Group), 165–180.
- Stone, D. A. (1997), 'The Doctor as Businessman: The Changing Politics of a Cultural Icon', *Journal of Health Politics, Policy and Law* 22, no. 2: 533–556.

- Timmermans, S. and M. Berg (1997), 'Standardization in Action: Achieving Local Universality through Medical Protocols', *Social Studies of Science* 27: 273–305.
- Timmermans, S. and H. Oh (2010), 'The Continued Social Transformation of the Medical Profession', *Journal of Health and Social Behavior* 51(S): 94–106.
- Watson, P. (2013), 'Catastrophic Citizenship and Discourses of Disguise: Aspects of Health Care Change in Poland', in P. Watson (ed.), *Health Care Reform and Globalisation: The US, China and Europe in Comparative Perspective* (Abingdon: Routledge), 118–139.
- Wind, G. (2008), 'Negotiated Interactive Observation: Doing Fieldwork in Hospital Settings', *Anthropology & Medicine* 15, no. 2: 79–89.
- Włodarczyk, C. (2000), 'Podstawowa Opieka Zdrowotna Jako Kategoria Polityki Zdrowotnej' [Primary care as a health policy category], in A. Czupryna, S. Poździej, A. Ryś, C. W. Włodarczyk (eds), *Zdrowie Publiczne. Wybrane Zagadnienia, t. I* [Public health. Selected issues, vol. I], (Kraków: Vesalius), 213–228.
- Włodarczyk, C. (2001), *Reformy zdrowotne: Uniwersalny Kłopot* [Healthcare reforms: A universal dilemma] (Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego).
- Włodarczyk, C. and K. Badora-Musiał (2017), 'Trwałość Niektórych Wyobrażeń: Niespełnione Obietnice Profesjonalizmu' [The continuity of certain images: unfulfilled promises of professionalism], *Problemy Polityki Społecznej* 36: 43–62.