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Person and its body as an object and subject of health care – solutions for education of healthcare students

1. Introduction

Theory about health nature, health maintenance, disease prevention, as well as theory about nature of diseases and their treatment are culturally determined. In this relation, Kleinman (1997) distinguishes three disease aspects: cultural representation of diseases in a given society, collective experience of the given society with a certain disease, and also experience of individual persons – members of the society with a given disease. The same author, as declared by Mares, claims in his approach to medical anthropology that the objective category „disease," after deeper examination, is not a biological entity, a category on its own, independent on culture but – as anthropological and ethnographic research shows – it is more likely a social construct (Mareš & Vachková, 2010). In other words, it is a socially/culturally constructed entity. A man who feels certain unpleasant symptoms constructs himself an idea of what his problem can be, and gives his disease a certain sense. Similarly, he approaches to his own healthy and sick body. He constructs a certain image of his body, takes a particular stand on it, has a certain attitude to it.

2. The attitude of a person to their body

The attitude of a person to their body is affected by a multitude of factors. First of all, it is age, gender, followed by personality factors, the influence of one´s upbringing and education, and socialisation and enculturation in general. It is in the family environment and school environment where we acquire and adopt schemas related to the self-concept of our own body and its perception on the cognitive, emotional and behavioural level.

Fox (1997) emphasized the influence of a physical self-concept on one´s behaviour and their feeling of well-being. The way a person perceives their body and the attitude to their body determines their physical self and also their attitude towards physical activity, sport, body weight, presentation of their personality and also their coping mechanism regarding, coping with difficult life events, such as serious illness, aging, etc. (Stackeová, 2006).

However, it is necessary to separate unconscious perception from semi-conscious perception of one's own body from conscious experiencing associated with their body image or physical self-concept. As Le Breton (2003) claims, the Westerners tend to notice their body only in unusual situations or during moments of crisis. For example, when tired, unable to accomplish something for whatever reason, usually associated with physical abilities, when feeling worn out (by age), when experiencing pain, when injured or ill.

An individual also notices their own body during moments of intimacy, tenderness, or with women also during their periods, pregnancy and delivery, in the postpartum period and while breastfeeding. These situations either place restrictions on the life of an individual, as claimed by Canguilhem and Leriche (Le Breton, 2003) or, conversely, they widen the scope of individual´s influence, which is less frequent. The "present versus non-present" body is the main axis which incorporates a person into the complexities of the world and forms the sine qua non (basic condition) for all social processes. Nevertheless, human consciousness only notices the body when it seizes to fulfil its usual functions, when the everyday routine disappears and the "silence of organs" is disrupted (Le Breton, 2003).

The perception of one's own body and problems associated with it is undoubtedly intensified in situations such as hospitalisation in a medical facility, when the person (and their body) is subjected to a series of diagnostic, therapeutic and nursing procedures.

Under normal circumstances we do not operate with a virtual "separation" of a person´s mind from the body. We perceive both as an inseparable whole. We even do not perceive, or should not perceive, the body in a purely biological sense. Even though the term "body" refers exclusively to human physicality, the human body is an unparalleled synthesis of biological, psychological, social, cultural and spiritual components, which only when integrated make a person unique in the sense of a distinct, one of a kind entity and value (Cichá, Dorková, & Tomanová, 2007). Such view of a person and their body is truly anthropological. In words of Mácha (2004), a person as an "integrum" is an implicit, ever present subject and object of anthropology

with their biological and social aspects and the basis for his/her reactions as a human being is a well balanced union of both of these aspects.

The basis of bio-psycho-social model in medicine, of which without any doubt the base is anthropological relationship towards a human being, is a systemic approach towards disease. This approach puts emphasis on the reciprocal relationship between body and psyche, as well as on disease examination on all levels (Bishop, 1998). Similarly it is reasoned by Mastiliaková (1999) who refers to our own experince showing clearly that our psyche and body are closely related. We contribute that all this takes place in a particular social context, in a certain social situation, which is another important, related factor. Every day, our ordinary experience leads us to awareness of this relationship. Generally we can say that narrowly specialized view of a human being always brings danger of ignorance of important sides of human personality that are closely related. Because of this risk, any of its spheres should not be examined totally isolated. If the character of work requires such a narrow specialization, consequent integration into an organic complex is necessary (Cichá, Goldmann, & FEDYN, 2007).

3. Reducing a person to a mere body

As stated, a person and their body constitute a compact unit which implies that reducing a person to a mere body is impossible. However, it does occur to a greater or lesser extent, especially during illness, injury, disability, and in old age. As stated by Le Breton (2003), an old person, in terms of general awareness, is often reduced to a mere body, especially in hospitals, long-term care facilities, hospices and other institutions. In most of these facilities we tend to approach an old person and their individuality as a damaged or broken body that requires feeding, washing. Simply requiring care in terms of basic needs, as if this "somebody" did not have any past, as if we were dealing with an anonymous individual. According to Le Breton (2003), aging in the Western concept is a gradual reduction of the body, a process that ultimately makes the individual dependent on their body.

An elderly person is also the most frequent recipient of medical care because the old age is accompanied by polymorbidity, i.e. frequent illnesses, hence more frequent hospitalisations (CDC, 2011). The elderly can be seen as a specific target group of health care recipients, similar to young children and pregnant women. The facts below need to be taken into account with respect to the age of a client (patient), their gender and especially the current situation the patient is in (their health status, possible pregnancy or the period after delivery, injury or illness). We need to consider the difficulties a patient

is experiencing, the diagnosis and therapy or diagnostic and therapeutic interventions, the ability to tolerate stress, adapt to changes, etc.

It is generally known that during the process of providing medical care it is essential to pay attention to the professional aspect of the medical (curative or nursing) procedure, i.e. its meticulous preparation, the execution of the task itself and nursing the client (patient) after the procedure (standard, safe procedure, lege artis procedure). We also need to pay attention to the perception results provided by the client (patient), his/her experiences, emotions and behaviour associated with handling unusual or stressful, so called stressogenic situations.

Generally, it is possible to claim that these situations include hospitalisation itself as the client (patient) is "extracted" from their social environment, from family or other emotionally significant bonds that play a part in forming one´s social network and in effect also one´s social support. Social support was one of the first factors identified as moderating the influence of unfavourable life situations, the emotional well-being and health of a person (Kebza, 2005).

4. Person and its body during hospitalization – from the patient's perspective and from the perspective of health professionals

As stated by Křivohlavý (2002), hospitalisation is a rather new kind of experience for patients. Many things change – not only in the patient (in their body – in a purely biological sense) but also in the patient´s psyche. The cited author compares a psychological status of a healthy and an ill person. In his conclusions Křivohlavý (2002) validates the hypothesis about stress and the fact that hospitalisation in a medical facility generates stress. Situations that are linked to direct acts of providing medical care, to procedures that the client (patient) is submitted to during hospitalisation are considered especially stressful.

Many of the procedures, whether medical (diagnostic or therapeutic) or nursing, relate to a certain disruption in integrity of the human body, to a lesser or larger invasion of intimacy. These are accompanied by unfamiliar or unpleasant sensations, sometimes even pain. Surgical procedures form a special "chapter", especially the ones performed under general anaesthesia. In these cases, the period before the surgery is typically accompanied by client's (patient's) anxiety or fear from the surgical procedure and the preceding preparations, uncertainty about the outcome of the procedure, fear of complications, etc. (Schmid, Wolf, Freudenmann, & Schönfeldt-Lecuona, 2009) Also indecision about whether to undergo the procedure at all is stressful. Anxieties, fear, indecision, feeling more or

less threatened usually also occur in the period after the procedure, and are further accompanied by pain or other unpleasant phenomena.

The fear of results of diagnostic tests, especially in situations when the main diagnosis is yet to be established, when a suspicion of an oncologic diagnosis was expressed, even when just feared by the patient though not supported by doctors, are significant from the client´s (patient´s) perspective regarding hospitalisation. Another affiliated, but still a very significant (and for many patients even the most significant) phenomenon is the client's (patient's) concern about the deficit in the area of self care (Orem, 1991), and consequently one´s partial or complete dependence on others, especially with regards to fulfilling basic physiological needs, namely those that invade one´s privacy and intimacy. Many clients (patients) fear being powerless about making decisions concerning themselves. In other words it is necessary to take other more or less negative consequences of hospitalisation into account, particularly the negative aspects of some medical and nursing procedures as they are being perceived and experienced by the client (patient).

In spite of being well aware of these generally applicable contexts that exist in the area of medical care, the medical personnel are more focused on professionalism of the procedure they perform. Feelings, experiences and emotions of the client (patient) are secondary and are not considered worth exploring in greater detail by many (Levinson, Gorawara-Bhat, & Lamb, 2000; Preston, Cheater, Baker, & Hearnshaw, 1999).

We can schematically notice the "action", i.e. the procedure being performed by a physician or a nurse, whereas from the patient's perspective the professional skills of the physician or nurse are naturally not the most important aspects. There are other, equally important, seemingly only appendant phenomena such as a degree of empathy, verbal and nonverbal communication of the medical worker with the client (patient) who is the main "protagonist" here, but also the attitude towards other patients, communication between medical personnel, the overall atmosphere that is omnipresent in such a workplace and to which patients are very sensitive. The outcome of the entire "action", in its all-encompassing complexity, is a logical "reaction", which is qualitatively and quantitatively influenced by the composite action of all the factors above. At the same time, it is necessary to consider their effect on the medical worker, understanding that behaviour of a client (patient) affects the professional´s behaviour further.

In reality, this model is similar to one described in connection with psychogenic pain (Knotek & Knotková, 1998). It encompasses the following six active subsystems: perception field, experience, cognitive processing,

affective and motivational processes, reaction and behaviour, and reaction and behaviour of others.

The reaction and behaviour of a patient are not only a consequence of the procedure itself or its nature, the level of difficulty, the degree of pain, etc. It is often a consequence of reactions and behaviour of the medical personnel. This makes the perception field of the patient more complex, affecting the quality and intensity of their experience, and how they cognitively process it. Naturally, it depends on how the results of perception and accompanying emotions affect reactions and behaviour of the client (patient). Undoubtedly, these reciprocally influence the medical personnel, their perception and assessment of the situation, and their future reactions and behaviour.

Differences in perception are to a certain degree determined by differences in cognitive categories that are related to the perception. Perception from the perspective of medical staff relates to professional categories, while the perspective of the client (patient) implies different cognitive categories. Perception from the perspective of a physician, a nurse, or nurse-midwife serves different purposes than perceptions of the client (patient).

A health care worker is routinely focused on searching for certain indicators that are relevant to execution of the procedure and their control. Whereas the client (patient) focuses on signs of a possible threat, especially the ones indicating possible pain. The primary difference is thus characterised by the differences and functionality of the perception processes and their focus in the health care worker and the client (patient).

In case of medical personnel there is no random or incidental perception of the patient's body. It is a pragmatically controlled process of observing certain phenomena related to the character of the provided medical procedure. Therefore, the scope of possible perception is somewhat limited. However, other bodily phenomena may enter the process by drawing sufficient attention to themselves by their "attractivity".

Patient´s perception can be considered far more variable and complex. It can shift from the position of perceiving "mere body" to the position of perceiving self as a whole, which encompasses the body. Put in other words, the patient could perceive the situation as something being out of order or that something is happening to his body or its part, or the same situation can be perceived as if something is happening to them as entity, possibly affecting their whole life. The patient could assess the situation as if their body or its parts were in danger, but also as if their entire life was at risk. It could be assumed that the patient and their body is more or less an object for physicians and other medical care providers. However, the patient approaches their body as a subject of medical care.

5. Conclusion – solutions for education of healthcare students

Bishop (1998) claims that medical personnel often display an impersonal attitude towards the patients. The patient is for various reasons placed into a position of an object, either because of conventions or necessity to be as emotionally disengaged as possible in such situations, or because of a belief that it might help calm down the situation. Let us mention a communication model that is illness-centred and in which the physician focuses on the illness, its symptoms and progression, while losing interest in the patient as a personality. On the opposite side there is a patient-centred approach, which recognizes that patient as a personality with its distinct needs and life history. Patient centeredness is ensured by the physician being actively interested in patient's perspective, even if the patient is unable to express it in words (Janečková, 2005). Such approaches can be applied to medical care in general, that is, in all situations in which medical personnel intervene in favour of the client (patient).

Patient's perspective is simply significant. Hahn and Gaines et al. (1995) coined the term "world of patienthood". This concept denotes patient's perspective of their illness, its beginning, progression, diagnosis, treatment and prognosis.

According to Cassell (2010), illness is personal and individual. It is related to personal characteristics of the sick individual and it is influenced by the particular individual suffering from the condition. Illness changes patients. It may affect their body, actions, thinking, behaviours, responses to others and to the world around them in general. These changes may occur even without the patient's awareness. In reverse, such changes also alter the illness. It is a "circular process". The actions of a health care worker must also be personal, should they act accordingly. The process of providing health care should be directed toward the patients, the symptoms of their illness, the effects of the illness, and sick persons as such. Therefore, a health care worker should get acquainted with the patient as with their illness. Their knowledge should provide them with skills to understand the sick person as an individual.

Galland (2012) believes that the importance of understanding the patient's experience and perception of an illness must not be underestimated. His extensive research on doctor-patient interactions indicates that physicians who fail to pay sufficient attention to their patients´ concerns, often miss important clinical signs. The conventional diagnostic paradigm, also called differential diagnosis, leads doctors to ignore or denigrate information which the patient might consider important, or which influences their individual prognosis. This ignorance not only

impairs the effectiveness of treatment, but it also generates growing dissatisfaction among patients.

In the context of patient's struggle with the disease, Křivohlavý (2002) brings up the cognitive model. This model is also applicable to coping with hospitalisation, diagnostic process, treatment and nursing during hospitalisation from patient's perspective. We could make another parallel and extend this model to hospitalisation of pregnant women and situations associated with the delivery, whether physiological or pathological, natural or surgical, and the postpartum period.

In pregnant women, we naturally expect self-perception to be significantly changed or rather continuously changing, simultaneously with altered perception and experience of their own "gravid body", and also altered perception and experiencing the unborn offspring. While in a pure biological sense the unborn child is a "mere" embryo or fetus, the view of the mother might be diametrically different. It is not necessarily positive in all women. In either case, various intensity and a various character of perception and experience in pregnant women in association with their pregnancy need to be taken into consideration. These effects are also not static. We can similarly approach women after child delivery.

It is very important how the client (patient) interprets their situation, how they adapt to it, how they copes with stressful situations associated with hospitalisation and medical care that is being provided during their hospitalisation. Thus, the emotional and behavioural strategies employed by the client (patient) while coping with these situations are equally important. This variety complicates the understanding of the clients (patients) by medical care providers, which also makes it difficult for them to respond adequately in given situations.

According to Mareš and Vachková (2009), such subjective information provided by a client (patient) is crucial for the work of professionals. It enables the understanding of client´s individual opinions, attitudes, fears, hopes, and why they cope with their illness in certain way. It serves for individualised education of the client, for guided involvement of the client in the diagnostic and therapeutic decisions, for winning the client over to voluntarily adhere to a long term treatment plan.

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Person and their body as an object and subject of health care – solutions for training of healthcare students

The text of this theoretical study acquainted with concept, of which the objective is to analyze the perception of client's (patient's) body, its condition, its changes and reactions, as an object of medical care. It is necessary to analyze the perception from the perspective of health care providers in direct relation to client's hospitalisation in medical facility, and in relation to medical and nursing interventions. Results of these analyses should be compared with evaluations obtained from the clients, who will also, at given points of time, provide their perception of self, his or her body, their experiencing and assessment of their health condition, and their experiencing and assessment of medical interventions received during the course of their hospitalisation. This will build a platform for creating more optimal concept of bio-psycho-social approach to the client for the benefit of increased professionalization of medical care. Teachers who educate students of health care disciplines must be aware of the above mentioned facts. Also theoretical and practical education of future health care professionals should take the above into account. Such education is also needed in relation to clinical professionals who directly affect not only patients but also the students during their clinical practice.