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Revealing the hidden vulnerabilities of psychiatrists: Insights from the Romanian health system. A sociological and empirical study

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Abstract
It is well known that the medical and sociological literature abounds in materials that present a whole series of categories of patients as being part of vulnerable population categories. Medical professionals, and doctors, in particular, are seen as parts of the therapeutic relationship holding power, also leading to an image of a 'privileged' social group. Although this idea is a predominant one within classical sociological theories, but also within the traditional image of the doctor, if we look in a certain context, such as the functional one of the Romanian health system, we can reveal another social image of today's psychiatrist. The present work wants to outline such a picture, starting from theoretical landmarks of medical sociology and observing a whole series of social realities identified through empirical research based on ethnographic evidence, but also on analyses of publicly available secondary data. The conceptualization of the vulnerability of psychiatrists will be highlighted within the complex interactions within the health system, which is in a problematic relationship with the entire social system. Finally, we want to undertake exploratory research on the specific vulnerabilities of psychiatrists (some vulnerabilities characterizing the entire professional body of doctors): complex clinical tasks, limited collaboration with other categories of doctors, limitation of resources specific to the profession (paraclinical and laboratory examinations), rigid control, extensive and overlapping of different control bodies, geographical isolation from other medical institutions and the emotional impact in the face of patients' suffering. The vulnerability of doctors overlaps, but also inverts, that of patients, accentuating a whole series of already existing problems. Defining the group of psychiatrists as a vulnerable social group generates the need to identify answers for a problem that we consider

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fundamental: difficulties arising in the complex of mental health care can lead to a real social problem.

Keywords: *vulnerability; mental health care; doctors; psychiatrists; social problem.*

Introduction

The purpose of this paper is to examine a series of vulnerabilities of psychiatrists, within their professional practice, the unveiling of an invisible side in a power complex with patients, taken for granted, both by researchers in the social fields and by society as a whole. The examination of vulnerability will be done by analyzing professional life within psychiatric hospital units. Sociology looks at vulnerability as a one-sided process within binary relationships such as the doctor-patient relationship. Because doctors are the ones who intervene in this relationship from a position of power, both through professional knowledge and membership in a whole range of social structures and agencies, it is the patients who seem to bear all the suffering and helplessness. Psychiatrists' vulnerability appears to be rarely discussed in studies of vulnerable groups.

The concept "vulnerable" finds many definitions in the sociological literature and involves various uses, with meanings that can change between them; most often referring to 'sensitive', 'hard to reach' or even 'hidden populations' individuals or groups. Vulnerability can be defined by several variables such as lack of autonomy and independence, bodily and psychological insecurity, marginalized or deviant status, and lack of recognition within society (Liamputtong, 2006). Vulnerability studies include emotionally overwhelming and socially taboo topics, such as those related to intimate experiences that can lead to discrediting and criminalization (Lee & Renzetti, 1990), such as death, pain, violence, AIDS, drug use, and homelessness. Vulnerable groups are exposed to discrimination, intolerant attitudes, and subordination. Very often, when we refer to vulnerable groups, we include people who have certain health-related conditions, such as those with terminal pathologies or those with mental disorders (Dickson-Swift, James, & Liamputtong, 2008). Patients are usually the first people we think of when we talk about vulnerable people in a medical context; doctors, seen as the upper pole of power within the therapeutic complex, are rarely characterized as a vulnerable group, but in certain circumstances, they can be recognized as vulnerable especially if the conditions that put them in such a position are revealed. The social context of Romania and the observation of the functioning of the local health care system, using empirical data and secondary data sets, can reveal a series of vulnerabilities of doctors that are almost always mixed with those of patients. Doctors' vulnerabilities span multiple social dimensions, from individual, and psychological ones to the much broader, institutional ones. We consider it important to modify our approach and leave classic conceptualizations; vulnerability can no longer be seen as belonging only to certain groups, marginalized and powerless, but can seriously affect even traditionally empowered populations. This aspect can become an easy one to perceive when we become aware of how such population groups interact and are influenced, especially in the healthcare sphere.

Professional autonomy of physicians

Professional autonomy of physicians can be described as a sociological concept that refers to the freedom and independence a physician has to exercise his own judgment and expertise in the treatment and care decisions of his patients. According to sociological theories, the professional autonomy of doctors is based on two key elements: professional expertise and social authority. Professional expertise refers to the specialized knowledge and skills that the physician possesses that enable him or her to make wise and well-informed medical decisions. Such expertise is obtained through long professional training and ensures that patients will receive quality care related to their needs. Social authority refers to the respect and trust society places on doctors because of their expertise. This authority is also derived from the public's perception of doctors as highly qualified professionals who can provide quality care and is also influenced by the institutional arrangements of the health system, such as the division of labor and the control of strategic uncertainty (Salvatore & al., 2018). Likewise, the professional autonomy of doctors can also be seen as a form of self-control. This means that the doctor can regulate his behavior and conform to ethical and professional standards without being influenced by external pressures or financial or political interests. In addition to these theoretical aspects, the professional autonomy of doctors can also be influenced by cultural, political, and economic factors, such as relationships with patients, the health system, or the pharmaceutical industry. In any case, it is an essential aspect of the medical profession that must be protected and promoted to ensure the best patient care. Several theorists and sociologists have analyzed the professional autonomy of doctors.

Classic works such as Eliot Freidson's „*Professionalism Reborn: Theory, Prophecy, and Policy*" scrutinize the concept of medical professionalism and the professional autonomy of physicians as fundamental to the functioning of the medical system (Parker & Freidson, 1995). Talcott Parsons, the author of social systems theory, analyzed the role of the doctor in society and the importance of professional autonomy from the perspective of the functioning of the social system (Parson, 1949). Bryan Turner, the author of "*Medical Power and Social Knowledge*", describes how physicians gain social authority and exercise power in the medical system (B. Turner, 1995). Even if we turn our attention to contemporary theories, the professional autonomy of doctors retains a central position. Michel Foucault, author of the theory of power and social control, analyzed the power relations between doctors and patients and the influence of the medical system on the body and health. "*Naissance de la clinique*", published in 1963, explores the transformations in the medical field in the 19th century and their impact on the relationship between doctors and patients. Foucault examines how medical power and authority evolved with the development of medical institutions and changes in the way illness was understood and managed. He emphasizes the importance of new medical practices, such as clinical analysis and direct observation of patients, instead of more traditional and abstract methods. Medical knowledge and power over individual health were consolidated in the hands of medical professionals, thereby promoting their authority; this medical authority is not only a matter of technical expertise but also involves an exercise of power and control over the individual's body and health (Poynter, 1964).

The decrease in the psychiatrist's autonomy can put him in a position of vulnerability, as it can affect his ability to exercise his professional expertise and protect his patients. In psychiatry, professional autonomy is essential to be able to provide

appropriate and effective treatment for patients, as the diagnosis and treatment of mental disorders are often complex and require individualized assessments and decisions.

In the context of psychiatry, a physician's professional autonomy may be limited by several factors, such as institutional rules and policies, government laws and regulations, pressure from health insurance, as well as the interventions of other mental health professionals, or the patient's family. These boundaries can influence medical decisions and lead to conflicts between psychiatrists and others involved in the patient's care. In addition, another threat to the psychiatrist's professional autonomy is stigmatization and discrimination against people with mental disorders, which can affect the psychiatrist's ability to exercise his expertise without prejudice or external influences. Professional autonomy is essential in psychiatry to ensure the best care for patients and to protect their rights and interests. Limiting this autonomy can have negative consequences for psychiatric practice and lead to the psychiatrist's vulnerability.

Decrease or lack of trust in doctors

Lack of trust in doctors can be described as a tendency in which people have a decreased level of confidence in the skills and judgment of doctors or the medical system in general. This trend can be caused by a variety of factors, such as negative personal experiences with doctors or the medical system in general, misinformation and mistrust of available medical information, high costs of medical care and limited access to quality medical services, perception of an increase in the financial interests of doctors and medical institutions, which could affect the treatment of patients.

In addition, the lack of trust in doctors can be influenced by socio-cultural factors, such as cultural views of authority and power in medicine or the relationships between patients and doctors within the medical system. Distrust of doctors can therefore be considered as a sociological concept as it is linked to wider cultural, economic, and political issues and impacts on patient-doctor relationships as well as the medical system in general. It is important to understand and address this issue to improve the quality of medical care and to ensure that patients have confidence in the medical services provided.

Sociological research has also addressed the phenomenon of lack of trust in doctors and the medical system. An example is the American sociologist Anselm Strauss, who researched the relationship between patients and doctors and developed the concept of "medical interaction", which refers to the communication and interaction between patients and doctors during medical care. Strauss identified several issues that can lead to a decrease in trust in doctors, such as the communication barrier, reduced humanization of doctors, and negative experiences with the medical system (Strauss, 2018). Eliot Freidson studied the medical profession and the power that doctors hold in the medical system; the aspect he considered central was the fact that doctors have strong control over patients and the medical system in general, which can lead to a decrease in trust in them if patients feel that they are not treated with respect or are not given appropriate care (Light, 2010). It is becoming increasingly urgent to address the negative effects of medical misinformation, especially in the context of new technologies and virtually unlimited access to information in the Internet age. Misinformation in the medical sphere is not a new topic; its contribution to decreased trust in doctors and the medical system in general appears in sociological research (Löwy, Pringle, Cassell, & Lowy, 2000).

Lack of trust in doctors can particularly affect the psychiatric profession, as psychiatrists are often involved in the treatment of mental disorders, which may be seen as more subjective or difficult to assess than other medical problems. Psychiatrists depend on

the trust of their patients to work effectively and establish a strong therapeutic relationship. If patients have a lack of trust in doctors, including psychiatrists, this can affect psychiatrists' ability to establish a positive relationship with their patients and provide them with the necessary care. In addition, a lack of trust in physicians can affect patients' access to psychiatric services, as well as the hiring and funding of mental health programs. These problems can make psychiatric work more difficult and less effective, which can lead to greater vulnerability for people with mental disorders. Therefore, psychiatrists must be aware of the impact of a lack of trust in physicians and try to establish trusting relationships with their patients through effective communication and transparency. It is also important that there be efforts to increase trust in the medical system and the psychiatric profession in general, by educating the public about the benefits and effectiveness of psychiatric treatments, and by improving access to psychiatric care.

Diminishing the doctor's authority

The decrease in the doctor's authority can be described in sociological terms. This can be analyzed from several perspectives, including that of changes in power relations and social expectations. In modern society, power and authority are increasingly distributed among different social groups, and patients want to be better informed and make more active decisions about their own health. This movement towards autonomous and informed patients has led to a change in the physician's role in the relationship with patients. In addition, the development of technology has led to an increase in access to medical information, which has allowed patients to improve their knowledge about health and disease. This allows them to take a more active role in making treatment decisions. The healthcare system has also undergone major changes in recent years, with a greater focus on efficiency and cost. These changes reduced the power of doctors regarding treatment decisions and shared them with other actors in the health system. As a consequence, we can say that the doctor's authority has decreased, and patients have become more informed and more active in the treatment process. This change reflects wider changes in modern society, which place greater emphasis on equality and individual rights.

Several sociologists have addressed this trend and have explored changes in the doctor-patient relationship. Anselm Strauss developed the theory of the "*active patient*"; starting from this conceptualization we find a whole list of works that emphasize the importance of the patient's involvement in the medical care process and decision-making (Grötken & Hokenbecker-Belke, 2012). Nikolas Rose introduces the concept of the "*informational patient*", who seeks and accesses information about his own health and treatments, and thus becomes more autonomous in his decisions (Rose, 1999). Bryan Turner has written about the "*medicalization of everyday life*" and how medicine and health are increasingly integrated into our lives, leading to a shift in the power and authority of the physician (B. S. Turner, 1997). Michel Foucault's approach to themes such as power, control, and discipline within the medical system has become a classic and is the starting point for many other directions of interpretation. The fundamental element remains that medicine has an important role in controlling society and that the doctor's power is based on his knowledge. Erving Goffman wrote about "*self-presentation*" and how patients and doctors present themselves to each other in medical interactions, highlighting that these interactions are influenced by social status and power in the doctor-

patient relationship. Starting from this principled approach we can reach much darker points of view in which health institutions operationalize totalitarian practices, contributing to the "mortification" of patients and nurses alike, in the service of the bureaucratic machine (B. S. Turner, 1997). Practically, the operation of the health system and hospitals, under the supervision of an ever-increasing number of regulatory and control institutions, with bureaucratic architecture unimaginable a few decades ago, leads to a severe diminution of the professional authority of the doctor but also other professionals.

The decline of physician authority is not unique to psychiatry but is a trend seen in many areas of medicine and the health care system in general. However, it can be argued that psychiatrists are more vulnerable than other doctors to this tendency, for several reasons. The stigma of mental disorders exists, is recognized, and exceeds the intensity of that felt in the case of other illnesses. People's reactions continue to include a strong stigma associated with mental health problems, causing many individuals to avoid seeking help or be reluctant to seek treatment. This can make the doctor-patient relationship more difficult and reduce trust in psychiatrists. The psychiatrist is closely related to the entire stigmatization process of the psychiatric patient. The relationships between stigma and the psychiatric profession are so closely connected that members of the professional body can simultaneously be stigmatizers, recipients of stigma, and powerful agents of de-stigmatization (Schulze, 2007). Mental health professionals, as targets of stigma, can be seen as clinicians adding additional occupational stressors through the role of stigma as an occupational stressor in psychiatry. The complexity of psychiatric diagnosis and treatment is another factor that can promote the diminution of the psychiatrist's authority. Mental disorders are often more difficult to diagnose and treat than other medical conditions, which can make psychiatrists feel less secure in their authority and lead to increased uncertainty. Although psychiatric diagnosis has followed a path of standardization through the construction of operational scales and diagnostic criteria included in diagnostic and treatment manuals, uncertainty continues to be present; the perception by patients of such a positioning inevitably leads to a reduction in the axis of power within the therapeutic relationship and a diminution of authority. Recently, the literature in the field of medical sociology has introduced calls for medical uncertainty to be better understood (Hatch, 2017) and for doctors to move into a therapeutic space of "shades of grey" and change their professional culture to embrace uncertainty (Simpkin & Schwartzstein, 2016). Psychiatry's role in the development and application of treatments is somewhat similar to that of other branches of medicine, however, many treatments for mental disorders are developed and applied in a more unclear and perceived way than treatments for other medical conditions, which can lead to greater uncertainty and an increase in controversy. All these aspects can make psychiatrists feel vulnerable in front of patients and the health system in general. However, it is important to recognize that diminishing the doctor's authority can also have positive effects, such as encouraging patients to be more informed and make more active decisions about their own health.

Institutional complexity in medical care

Institutional complexity in healthcare systems is a concept studied by medical sociology. It refers to the number of institutions and organizations involved in the provision of health services and how they are interconnected and coordinated. In general, the more institutions and organizations involved in the provision of health services, the greater the institutional complexity. This complexity can lead to problems of coordination,

communication, and collaboration between different organizations and can affect the quality and efficiency of health services. Medical sociologists study institutional complexity in healthcare systems to better understand how it affects the delivery of health services and to identify ways in which it can be reduced or managed more effectively. Within the system of institutions dealing with mental health care, 'planned spontaneous complexity' was chosen as an overarching theme to characterize the new knowledge and practice that was developed. We are in a situation where the space in which the medical act takes place is shifting and non-medical professions are being introduced that have enabled community practices thus, the whole framework is being reshaped and new knowledge is emerging about service users as people and professionals as skilled professionals. The challenge remains for managers to trust their colleagues and not impose rigid rules, schematized methods, and repeated controls (Topor & Matscheck, 2021).

Institutional complexity in health care systems has led to different sociological conceptualizations that describe the dynamics within the social system of both patients and physicians. Anselm Strauss, who studied how patients and their families navigate the healthcare system, developed the concept of the "suffering line" to describe their experience. The patient trajectory refers to the sequence of events and turning points that occur during treatment. Once a trajectory is initiated, there may be intermittent and alternating phases, acute, stable or unstable, ascending or descending. In its purest forms, a patient's trajectory does not have a set course, as it is shaped and managed by continuous interactions of the actors concerned (Pescosolido, 2013). The doctor's trajectory follows that of the patient; the doctor accompanies the patient, accompanies and supports him within the increasingly complex institutional health system; the difficulties felt by the doctor can lead to even greater suffering for him by superimposing a moral vulnerability that arises from his assumption of the role of caring and protecting health. In the classical literature of sociology, we can find references regarding the modulation of social interactions as a result of the complicated structuring of the health system. Talcott Parsons examined how different medical and social institutions interact in the provision of health services. Eliot Freidson analyzed the role of medical professionals in healthcare systems and explored how they establish their position within healthcare institutions. John G. Bruhn, who developed the concept of the "health system" to describe the set of institutions and organizations involved in the provision of health services and analyzed their interaction, also observed that increasing institutional complexity accentuates the difficulties regarding access to healthcare and, inherently, there is an erosion of public trust in the medical professions (Cano & Bruhn, 2004).

Increasing institutional complexity can affect psychiatrists as well as other healthcare providers. Psychiatrists must navigate multiple levels of institutions and organizations to provide mental health services to their patients, including hospitals, clinics, private practice offices, government agencies, and professional associations. This complexity can affect the availability and accessibility of mental health services, as well as communication and coordination between different organizations. It can also increase the administrative burden and reduce the time available to provide effective mental health services to patients. However, psychiatrists are usually trained to deal with institutional complexity through their medical training and learning of the health system. Overall, psychiatrists may be vulnerable to increasing institutional complexity, but they can develop the necessary skills to cope with this and provide high-quality mental health services to their patients. For the real situation in the Romanian health system, we should

interrogate the level of functionality of all the structures involved, not just the medical ones; the care of psychiatric patients involves the interconnection with the social assistance system whose real representation within our social system remains deeply limited.

Inconsistency and ambiguity of laws

Legal systems governing health systems have been analyzed by medical sociology; it focuses on the study of health systems and the social processes that influence health and disease. The legal framework and its functioning are difficult aspects to integrate into a unitary sociological concept; we must understand that medical sociology covers a wide range of topics and issues, and theoretical and methodological development continues to evolve. Thus, several sociological concepts are used to analyze issues related to health and the care system. These include the concepts of social health inequality, medicalization, the stigma of mental illness and other mental health problems, the patient-centered approach, and more. It is important to note that these concepts are not independent and can be interconnected in a complex web of theories and models. Medical sociology allows for an interdisciplinary approach and can collaborate with other disciplines such as medical anthropology, medical psychology, history of medicine, and others.

In medical sociology, several researchers and theorists have studied the problems of inconsistency and ambiguity in the laws that govern medical practice, and psychiatric practice in particular. The critical theory of power and discourse, developed by Michel Foucault, has also been applied to the medical system. In his book "*Madness and Civilization: A History of Insanity in the Age of Reason*", Foucault examines how psychiatric practice has evolved. This medical practice is considered to have been used as an instrument of power by society and governments (Wilder, Foucault, Howard, & Pepitone, 1972). This particular action of a medical procedure cannot take place without a legislative construct imposed by the state and society. Even the stigmatization phenomenon developed by Erving Goffman within the theory of "*social identities*" does not intervene in a social vacuum but within a structure in which laws intervene decisively. In his work "*Stigma: Notes on the Management of Spoiled Identity*", Goffman examines how people suffering from mental health problems are stigmatized and marginalized by society. The dividing line between normality and stigmatization is not as deep as a look at the problems of people with deformities, colostomies, homosexuals, prostitutes, "junkies" and social minorities might lead us to believe. Three categories of stigmatized individuals are examined: those with physical deformities, those with mental disorders, those in prison, those with addictions, alcoholism, etc., and those with tribal stigmas, including race, religion, and nationality. It is concluded that the phenomenon of stigmatization is universal (Goffman, 1974). The physician is not exempt from inclusion in such a process, both directly and by association with his patients, and the legal framework that seeks to bring about a social order appears to be a distinct and broad one for each of these categories. Even if the initial objective is a salutary one, to protect suffering people and reduce negative conditions, the legal construction becomes broad and must be used by the medical professional who is based on a completely different professional training. It becomes obvious that medicine thus joins the social institutions of control even if it did not set out to do so at the primary level. Irving Zola's "*Medicine as an Institution of Social Control*" addressed issues related to the medicalization of society and mental health; at the same time, it analyzes how medical practice can be used as a tool of social control and

how it can affect people with mental health problems (Zola, 1971). Formal social control through laws has a growing impact in today's society.

The analysis of the legal framework that acts in medicine is a difficult undertaking to realize and conceptualize; even if it can easily pass into the sphere of perceptions of the members of a professional body, the enormous number of changes that the main law governing health in Romania (Law No. 95 of 2006, on health reform) has undergone remains an objective aspect and easy to prove. The inconsistency and ambiguity of laws governing psychiatric practice can lead to a vulnerability of psychiatrists. Psychiatric practice is subject to strong social control through a series of laws and regulations, which can be quite complex and difficult to interpret. Furthermore, legislation in this area may vary from one country to another or even within different states of the same country. In such situations, psychiatrists may be exposed to vulnerabilities such as malpractice lawsuits, disciplinary investigations, or even court actions due to differing interpretations of the law. In addition, the inconsistency and ambiguity of laws can make psychiatrists feel uncertain about the decisions they have to make, which can lead to delays in providing treatment or decisions that may be less beneficial to patients. Psychiatrists must be well-informed and have a clear understanding of the laws and regulations that govern their practice. In addition, they should have access to appropriate resources, such as consultation with specialized lawyers, to ensure that their practice is by legal and ethical standards. Training in the medical profession, however, contains few elements of a legal nature and this kind of support during the practice of the profession remains insignificant for the local system.

Emotional and psychological experiences

Psychiatrists' emotional and psychological experiences of their patients' suffering have been tracked and analyzed in sociological research on mental health. Sociologists interested in this topic have studied how psychiatrists feel and manage emotions during interactions with their patients, how these can influence the quality of care, and how the negative effects of stress on the professional health of psychiatrists could be prevented. For example, some sociologists have investigated the phenomenon of "burnout" in psychiatrists and analyzed how this condition can affect their ability to provide quality care to patients. There is more and more evidence that shows a loss of control on the part of psychiatrists regarding the defining parameters of their medical practice, an increase in demands related to productivity, and an emphasis on the administrative burden associated with professional activity that contributes to the emergence of burnout syndrome. Compared to other medical specialties, psychiatrists tend to under-report symptoms related to burnout, and there is a need to understand what are the protective factors and what are those that promote the onset of this suffering. As more psychiatrists begin to work in large systems of care, the shortage of psychiatrists becomes increasingly present, and practicing clinicians will have to meet "unpaid obligations" to provide services to a number more patients while using the same or even fewer resources. This unbalanced balance can increase the occurrence of burnout syndrome and will urgently need to be corrected (Roberts, Hales, & Yudofsky, 2019).

Other researchers have studied the role of empathy in the psychiatrist-patient relationship and analyzed how psychiatrists can develop and maintain an empathetic attitude toward their patients despite the difficulties and stress associated with the profession. Breaking empathy can result in the loss of the therapeutic relationship. The

intensity of the therapeutic process and the activation of both patient and therapist in response to traumatic reports can produce unique countertransference reactions (or empathic tensions) (*Ment. Heal. Consequences Torture*, 2001). Sociological research in the field of mental health has investigated the emotional and psychological experiences of psychiatrists concerning the suffering of their patients and has contributed to the development of strategies to prevent the negative effects of occupational stress and to improve the quality of care provided by psychiatrists to their patients.

American anthropologist and psychiatrist Arthur Kleinman wrote about the interaction between the emotional experiences of patients and psychiatrists and how this can affect the quality of medical care. He introduced the concept of "*suffering representations*" to describe how patients and mental health professionals interpret and respond to symptoms and behaviors related to mental health problems. The perspective is much closer to the sociological one and is based on ethnographic explorations. In the face of suffering, we do not only have an individual response of the person experiencing the trauma, but there is a relationship between collective and individual memory, alternative public spheres are created for the articulation and narration of the experience, the voice of the individuals facing the tragedy and the meaning of healing and return are recovered to everyday life are interconnected. Ethnographic essays often poetically address issues of social trauma and the remaking of everyday life through a uniquely anthropological perspective that explores how violence "works on lives and interconnections to tear apart communities" (Aprahamian et al., 2002). This is a welcome contribution to a field dominated by psychologists and psychiatrists whose focus is on documenting, and diagnosing PTSD. The anthropological approach brings into focus the issues of cultural representations, collective experience, and critiques of the construction of knowledge based on the appropriation of social suffering, it also highlights the consequences of social suffering on everyday life, the effects of collective violence and social trauma on the individual and the "*construction*" of suffering social. From this angle, the psychiatrist cannot be a character excluded from suffering, when exposed to the trauma of mental illness. Psychiatrists' emotional experiences and other mental health issues have been noted since the classical period of sociological conceptualizations. In the book "*Patients and Healers in the Context of Culture*" the relationship between cultural factors and psychiatric experiences was explored, trying to obtain an image from the perspective of the professional as an actor deeply involved in experiencing suffering (Kleinman, 1980). American sociologist Charles L. Bosk wrote about the emotional experiences of psychiatrists and the effects of professional stress on them in his book, "*Forgive and Remember: Managing Medical Failure*". He used case studies to show how doctors tend to hide their emotions and blame themselves when their patients suffer or die. Perhaps the most important aspect is the fact that in medical education, technical norms are subordinated to moral ones (Bosk, 2003). American sociologist Allan V. Horwitz wrote about the history of psychiatry and the evolution of the diagnosis and treatment of mental illness in his 2002 book, "*Creating Mental Illness*". He examined how social and cultural factors influenced the development of psychiatry and how mental health professionals interpreted and treated psychiatric symptoms. Conceptions of psychiatric distress as a disease may be reexamined. The author argues that this notion fits only a small number of serious psychological conditions and that most conditions considered mental illnesses are cultural constructs, normal reactions to stressful social circumstances, or simply forms of deviant behavior. Framing mental illness as a disease benefits various interest groups, including mental health researchers and clinicians, prescription drug manufacturers, and

mental health advocacy groups, all of which promote disease-based models (Wirth-Cauchon & Horwitz, 2002). The cultural determinism of mental illness brings the physician into the circle of suffering related to interaction with mental illness.

Psychiatrists can become vulnerable in managing their patients' suffering and mental disorders for several reasons. Physicians' empathy and emotional commitment can be brought to the fore. Psychiatrists are often exposed to the painful stories of their patients and can develop a strong emotional bond with them. This connection can lead to a strong emotional commitment and can cause the psychiatrist to become too involved in the patient's problems, which can lead to emotional exhaustion. Psychiatrists often face stressful and difficult situations, such as aggressive or suicidal patients, or the pressure of dealing with a heavy workload; all these aspects outline an independent entity: professional stress. This stress can be overwhelming and lead to physical and psychological exhaustion. Psychiatrists are exposed to the traumatic life histories of their patients and may witness traumatic events during treatment. Exposure to trauma can lead to the development of post-traumatic stress disorder or other mental health problems. Psychiatrists who prescribe drugs may be exposed to their side effects, manifested by patients, such as fatigue, irritability, feelings of loss of control, influencing other somatic treatments, or different aspects of daily life. All of this loops back to the mental health care professional.

To manage these risks, psychiatrists must pay close attention to their own mental health and take steps to protect themselves against occupational stress and burnout. These measures may include personal therapy, regular exercise, a balanced work schedule, and other forms of self-care. It can also be beneficial to have a support network, such as work colleagues or support groups for mental health professionals.

The risk of physical and emotional violence

These forms of abuse can occur in the practice of psychiatry, as patients who come to a psychiatrist often have severe mental health problems or a history of trauma or abuse. This can lead to aggressive or defensive behaviors on the part of patients, and psychiatrists can be exposed to these behaviors. In medical sociology studies, violence against psychiatrists has been conceptualized as a form of abuse of power over a vulnerable group, in this case, patients with mental health problems. These studies examine the risk factors that may contribute to violence during psychiatric consultations and how it affects both patients and psychiatrists. How psychiatrists constitute a vulnerable group from the perspective of abuse is still insufficiently investigated. Medical sociology studies also examine how these incidents of violence affect the relationship between psychiatrists and patients and how these incidents are reported and managed within the health system. Studies show that patients who exhibit violent behaviors are less likely to receive appropriate medical care due to stigma and fear of retaliation. Physical and emotional violence are important issues that arise during the practice of the psychiatric profession, and medical sociology studies are important to understand these issues and to develop strategies to prevent and manage violence within the health system.

Several important sociological works address violence against psychiatrists and dealing with patients with mental health problems. "*Violence in Mental Health Settings: Causes, Consequences, Management*" focuses on violence within the mental health system and examines the factors that contribute to it, such as overcrowding, underfunding, and a lack of training and support for medical staff. The paper also offers suggestions for

improving the management of violence within the health system. Therapists, nurses, social workers, and counselors in hospitals and other inpatient and community settings will find violence in mental health settings a source of vital insights and ideas for future policy (Richter & Whittington, 2006).

"*The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention*" by Sameena Mulla examines sexual violence against women and how medical intervention can perpetuate this violence. The author also explores the impact on medical staff providing care to victims of sexual assault (Whiteoak, 2015). Observations can be extrapolated to other forms of abuse or represent starting points for further observations.

Violence against psychiatrists is a real problem that needs a systematic approach and can be linked to the stigmatization of people with mental health problems and problems in the mental health system; the stigma likely extends to the professional group that provides care for these types of patients. The papers also highlight the importance of understanding social context and inequalities for addressing mental health issues and improving medical interventions. Psychiatrists, in many cases, can be considered a vulnerable group due to the violence and other forms of abuse they are subjected to during the exercise of their profession. First, psychiatrists face an increased risk of violence from patients with mental health problems, who may exhibit aggressive and unpredictable behaviors. In addition, psychiatrists may be exposed to violence and abuse from other people, such as family members of patients, employees of health institutions, or even co-workers. Psychiatrists can also be subjected to verbal and emotional abuse from patients or their families. This exposure to violence and other forms of abuse can have a significant impact on psychiatrists, including physically and psychologically. There can be effects of post-traumatic stress, anxiety, depression, burnout, and even increased risk of suicide. In addition, psychiatrists also face other problems and vulnerabilities while practicing their profession, such as overwork, the pressure of time and limited resources, administrative and financial demands, and others. Psychiatrists must have adequate support and protection to deal with these issues and to protect their health and well-being while fulfilling their important role in caring for people with mental health problems.

Marginalization within the medical system.

The marginalization of psychiatrists can be examined from several perspectives, including the interrelationships with other medical specialties, authorities, and patients. For example, it is possible to analyze how certain specialties, such as family medicine or neurology, are more valued compared to psychiatry within the health system, or how government authorities and other institutions influence the funding and distribution of psychiatric services.

"The Social Transformation of American Medicine" by Paul Starr examines the historical evolution of the American healthcare system, including the marginalization of psychiatrists compared to other medical specialties. At the same time, we find the idea that liberal-minded people approved the wide extension of medical authority in the regulation of social life (Starr, 1982). Regulation not only intervenes in social structuring but inherently pushes several social groups towards certain distinct areas of society. The Rise and Fall of the Biopsychosocial Model: Reconciling Art and Science in Psychiatry by S. Nassir Ghaemi discusses how psychiatry has been marginalized in comparison to other medical specialties by the very model it has adopted, and the author argues that an approach A more holistic approach to mental health is needed to address the complexity

of psychiatric issues. The biopsychosocial model was developed in the 20th century as an outgrowth of psychosomatic medicine and is seen as an antidote to the constraints of the medical model of psychiatry. In evaluating the biopsychosocial model, Ghaemi provides a philosophically grounded assessment of the concept of mental illness and the relationship between evidence-based medicine and psychiatry. He argues that the conceptual core of psychiatry is eclecticism, which in the face of too much freedom paradoxically leads many of its followers to enforce their own dogmas. A new paradigm of medical humanism and method-based psychiatry that is consistent with modern science while incorporating humanistic aspects of the art of medicine appears to be desirable (Feisthamel, 2011). An evolution of psychiatry towards less eclectic models presupposes an acceptance of the social construction of mental illness; relying on the methods used implies a closeness to the treated individual, a humanization, or even a socialization of psychiatry. In this way, one could hope for a reduction in the marginalization of the profession and also of individuals suffering from mental disorders.

"*Madness in Civilization: A Cultural History of Insanity*" by Andrew Scull examines the historical evolution of the concept of mental health and psychiatry within Western society and discusses the issues of stigmatization and marginalization of patients with mental health problems. Madness has often been posited as the antithesis of civilization; a "*madman*" was essentially outside the civilized world. And yet "*madmen*" are always with us, and in many ways, their condition is as elusive today as it was in the ancient world. As such, the problem of insanity and its ineffective remedies have been infiltrating our civilization for centuries (Carey, 2022). The relegation of people suffering from mental illness and those who intervene in the management of these illnesses to a peripheral area of society is not a new process but rather one that is perpetuated; man continues to manifest a fractured and fragmented relationship with mental illness through deep cultural springs.

"*The Divided Self: An Existential Study in Sanity and Madness*" by R.D. Laing is considered one of the most influential works in the field of existential psychiatry. Laing argues that mental health problems are often related to social and cultural trauma and criticizes traditional psychiatry for its medicalized and pharmacological approach. Psychiatry might be, and some psychiatrists are, on the side of transcendence, genuine freedom, and true human growth. Laing's perception comes to reinforce opinions that are quite widespread socially and that confirms an attitude of marginalization of many aspects related to the field of mental illness; psychiatry can so easily be a technique of brainwashing, of inducing behavior that is adjusted, through (preferably) some form of harmless "torture". In the best places, where straitjackets are abolished, doors are unlocked, lobotomies are largely abandoned, and they can be replaced by more subtle tranquilizers that place bars and locked doors inside the patient. That is why I would like to point out that our "normal", "adjusted" state is too often an abdication of ecstasy, a betrayal of our true potential, so many of us are too successful in acquiring a false self to adapt to false realities (Laing, 1966). Such a conceptualization of the psychiatric world explains the broad phenomenon of social exclusion and marginalization, both as a result of a modification of the self through the action of the social and cultural framework and an impairment of the individual's identity in the eyes of extended social groups.

Psychiatrists can be considered a vulnerable group from the perspective of marginalization for several reasons. The first reason would be stigmatization. Mental health, and by extension psychiatry, are often taboo or stigmatized topics in many

cultures. This can lead to the marginalization of psychiatrists, who may be perceived as *'different'* or *'strange'* by colleagues, patients, or others in society. Discrimination can be an independent phenomenon for the social group of psychiatrists. In many countries, psychiatrists' salaries and benefits are lower than those of other medical specialties. Psychiatrists may also be discriminated against in terms of promotion and access to leadership positions within medical institutions. The lack of resources within the institutions in which they operate may represent an additional factor. Mental health services are often underfunded and undervalued compared to other health services and may be placed outside the healthcare system as a whole. This can lead to a lack of resources and equipment for psychiatrists, as well as a lack of support and ongoing training within medical institutions. The history of psychiatry is marked by controversial practices and abuses, such as involuntary treatments and incarceration of patients in psychiatric institutions. These practices can lead to a negative image of psychiatry in society and contribute to the marginalization of psychiatrists. All this can lead to a marginalization of psychiatrists and an underestimation of the importance of mental health services within the health system.

Results and discussion

The present work contributes to the contemporary discussion about the vulnerability of medical professionals and, among them, that of psychiatrists in the context of their activity in the Romanian social and medical system. If we look at the vulnerability of psychiatrists from the perspective of marginalization, disadvantages and social inequalities, poverty, and social problems we could say that doctors cannot be attributed to a vulnerable group. If we refer to the professional stress and exhaustion of medical professionals, to the presence of various symptoms, or to the emotional distancing that becomes a constituent part of the burnout syndrome, we can conclude that we are facing a vulnerable group. Through a deeper approach, which takes into account the structural and functional contexts of the social system in which psychiatrists work, a large number of defining conditions of vulnerable groups can be identified. How doctors were viewed until now, starting from the distribution of power within the therapeutic relationship, seems to be no longer up-to-date, nor does it manage to faithfully describe the positioning in the social system; maybe the time has come to move away from a classical conceptualization. The traditional image of the patient belonging to vulnerable groups may retain its relevance, but that of the doctor seems to be drawn with new touches; perhaps these are still quite pale, and the new identity remains hidden from the viewer. It is precisely this last feature that raises even more the problem of belonging to a vulnerable group.

The approach taken was to examine, in an exploratory way, a series of invisible (or ignored) vulnerabilities of a professional group, which is considered to be strong and resourceful (especially by being attached to the wider group of doctors). The more specific we become in observing some characteristics of psychiatrists that hardly describe other professional categories (doctors from surgical specialties or highly technological ones such as medical imaging) we can reveal a much clearer picture of a distinct group of doctors, with a high chance of being reunited within a vulnerable social group. As a rule, vulnerability is attributed to patients (especially those suffering from mental illness or those considered at the end of evolution for a somatic illness, the terminal ones). The process is also a very easy one to go through if we look at the patient as a passive beneficiary of services and specialized medical help, and deficient in terms of understanding and knowledge about the disease. Even that last statement has become

intensely questionable in today's information and internet age. Despite the policy of neoliberal choice and investing patients with the power to choose and decide about therapeutic intervention, their resources remain limited, they experience physical and emotional suffering and a large part of them are dependent on social assistance services. If we refer to traditional, binary sociological approaches to understanding power relations, doctors oppose patients through the power brought by professional knowledge, the power of decision and action; referring to these premises they should not suffer and could not be considered vulnerable. Understanding the professional and social context can dramatically change this view.

A first criticism of classical sociological approaches regarding vulnerability refers to the implicit definition of certain groups as vulnerable; here we have the clear case of the patient group. In this way, we only narrow our observational field and ignore "hidden" vulnerable groups. Only if we keep our senses sharp and use the sociological imagination properly do we manage to notice inappropriate professional practices and harmful interactions between various components of the health system or the social system as a whole. The limits of the determinants that enter together in the construction of the vulnerability of the psychiatric profession are quite imprecise, it is difficult to draw clear demarcations; the qualitative, ethnographic information manages to bring several negative conditions into the visibility area. It is increasingly difficult to see doctors positioning themselves in an emotionally neutral zone when dealing with the suffering of the psychiatric patient, and the difficulties that must be overcome to find therapeutic solutions (including for somatic diseases) in a deficient medical system for countless reasons. Many situations can be identified (probably most non-medical or outside psychiatry proper) in which doctors lose their power or are dominated by feelings and cognitions from this sphere; other times they cannot manifest the action that defines their professional role and face a lack of resources. The results are also counted in terms of suffering, with the difference that, compared to their patients, these experiences also take other forms: existential and moral. It is precisely this type of suffering that seems to be invisible, ignored, and perhaps even denied at the level of society.

Another distinct approach concerns the abandonment of paternalism when analyzing professional groups of physicians; this kind of one-sided perspective excludes precisely the social and systemic context in which the professional life of doctors is carried out. At this moment, we are experiencing complex changes in everything that constitutes the health system; we have a mix of non-medical influences and decisions that are conceptualized differently and override the physician's paternalism. Whether we are talking about the management of medical institutions (based on economic principles of profitability or according to the regulation of the distribution of funds) or whether we are talking about the marketing of medicine, the doctor's influence in clearly tracing the path of a patient is becoming less and less. These new premises are found in the restriction of the doctor's autonomy and the feeling of the numerous pressures from the administrative, regulatory, and control institutions. External constraints are not only restrictive (such as lack of funds or limiting therapeutic protocols) but can also be contradictory. The direct conditions of practice in the workplace are little or not at all within the direct control of the professional so the choice of appropriate treatment strategies for patients cannot reach high heights. From this moment we can identify a new vulnerability, the legal one; improper working conditions can lead to errors and medical negligence circumscribed to the phenomenon of malpractice. Vulnerability is accentuated by adding the moral one;

elementary professional training involves the well-being of the patient and not the deterioration of his health.

Physician vulnerability does not limit its ill effects to the physician as an individual or to his professional group. Even the psychiatric patient, belonging a priori to a vulnerable group, suffers. When the physician experiences vulnerability, it is expected that the patient will benefit from less attention and poor care through the actions of those factors that cause vulnerability to the physician. The therapeutic relationship becomes damaged, and dysfunctional, characterized by low trust between the two parties. Complaints by disgruntled patients and their actions before the courts are seen as unfair by the medical professional group; understanding professional contexts can give them justice even if the harm to patients is as real as possible. The evolution of today's society can lead to an aggravating route of vulnerability; social programmatic actions aimed to reduce the vulnerabilities of the patient group end up creating a new vulnerable group, that of psychiatrists. Patient suffering can be exacerbated by the feedback loops of defensive medicine stemming precisely from litigious risk. Doctors are concerned with protecting themselves from possible sanctions and, implicitly, reduce the time and actions allocated to direct patient care. The circle closes and all this negative conditioning can be accelerated. The way to a real social problem seems open.

Professional autonomy of doctors

The professional autonomy of doctors represents a fundamental element of carrying out a specific activity and can be seen as a reflection of the sum of the patient's rights arising from traditional ethical principles. The decision to admit a patient is formal, according to specific medical provisions, under the direct influence of the medical decision. The practical experience, revealed by the doctors' statements, identifies situations where there is pressure from some state power institutions for the hospitalization of certain social categories of patients. Some particular groups of patients can be identified for whom hospitalization in the psychiatric hospital can be seen as a translation of social control to the medical profession and the transformation of the psychiatrist into an agent of this type of control. Hospitalization of alcohol-intoxicated patients can be analyzed medically from several points of view; acute intoxication would fall within the scope of medical competence of other medical specialties and it would be correct to be treated in multidisciplinary centers and not in mono-disciplinary centers (as psychiatric hospitals are organized domestically), with limited resources. Compliance with the specific legislation for the situation in which the patient cannot express his consent or when it is not valid and which aims precisely to protect the patient is difficult to achieve. The situation does not seem to be a limited one but a genuine practice in our society that puts pressure on a professional group not only through medical responsibility but also through the transfer of power that would be the prerogative of the state. The medical liability and the risk perceived by the doctor for the occurrence of litigious situations or even malpractice reach high levels both through the impossibility of being able to correctly assess the risk of severe complications of alcohol consumption and which are treated in multidisciplinary teams (for example acute pancreatitis, aspiration syndrome, and even delirium) as well as by how patients and families will later interpret the "restriction" of individual freedom by the doctor's "decision". In a situation where this decision is not one under the principle of professional autonomy, it becomes a determining factor for negative perceptions and even suffering for the doctor.

The state's attempt to protect individuals from the violent potential of the psychiatric patient, based on utilitarian principles, can interfere with precisely the individualistic,

humanitarian principles that protect the individual (even the doctor, not only the patient). At the center of this conflict is the psychiatrist, in a moral, functional medical, and civil dilemma, without the state developing the resources necessary to protect a profession that intervenes in the case of genuine social problems. Things become much more complicated in the case of patients who, in the context of mental illness or not, carry out actions punishable by criminal law. Doctors describe an inadequacy of the state to ensure care in a continuous form of psychiatric patients leading to the maintenance of a responsibility on the psychiatrist who provides the initial intervention; the doctor cannot ensure the real discharge of responsibility representing another facet of a real professional autonomy. Examples include various categories of patients for whom the state's care chains remain dysfunctional: patients with chronic, degenerative diseases, such as dementia, for whom the medical network does not provide adequate services. In reality, healthcare structures take over roles from the social assistance sphere. The physician is placed in the position of continuing care, sometimes exceeding the bounds of medical rigor, unable to refer patients and families to an appropriate support network. The creation of a forced framework for practicing the profession is called for, under the pressure of families and civil society, prolonging admissions, and maintaining enormous periods of hospitalization for some patients in health facilities whose role is different. The inability of the state to ensure functional evaluation structures and intra-community care leads to a professional paradigm that forces the psychiatrist to a series of behaviors in which his decision ends up with a reduced degree of autonomy.

Decrease or lack of trust in doctors. Diminishing the doctor's authority

In the professional relationship between doctor and patient, authority is transferred from the patient to the doctor, by his role as a specialist, professional, the one who, following his training and skills, decides sovereignly on the diagnosis and solutions resulting from the problem raised by the patient. He, in the absence of specialized training, turns to professional judgment, inhibits his own options, and leaves himself to the decision of the professional, because he cannot identify by himself what are his own needs and what are the solutions can cover the needs resulting from loss of health. Authority cannot be understood without taking into account professional autonomy, and therefore the statements of doctors are difficult to be strictly framed in a certain theme; they cover multiple topics and their presentation in a specific section is only to reveal hidden vulnerabilities in an organized way. The authority ultimately represents a form of power with which the doctor is endowed not only as a result of his specific training but also as a result of some formal rules of the state included in a series of legal norms. As a functional result, the reduction of authority also leads to a decrease in professional autonomy; this mechanism may be an easily noticed one in certain situations while, in others, it is a subtle result. Observations from qualitative evidence can reveal such mechanisms that can lead to the vulnerability perspective we investigate in this paper. The psychiatrist intervenes in situations considered risky through a specific measure, that of non-voluntary hospitalization. The state gives authority to the physician to decide (for a certain time, subject to further confirmation by a judicial procedure) to limit individual liberties to some extent to prevent potentially harmful acts. The problem arises in the situation of an imprecise regulation that makes the doctor vulnerable to patients, families, and society as a whole. Whatever decision he makes, there is a degree of risk for it to be considered inappropriate and the return to the legal provision, through its ambiguity, does not offer support to the professional activity. The law should contain objective elements that can be

easily proven so that the doctor's authority, conferred by the state, is a solid one. The chosen statement focuses on the use in the legislation of words that are interpretable or whose functional definition is extremely difficult, leading to a vulnerability of the one entitled to make decisions based on this regulation. When the psychiatrist is faced with such a situation (the decision to admit a patient without obtaining his consent) he should be able to focus on the patient's risks and needs and not on his own. If the harmful risk for the patient is not perceived by the doctor as "imminent enough", he can decide not to admit the patient, but he has no control over the subsequent conduct of the patient and his family (initiation and adherence to treatment, supervision, return to a psychiatric service in certain conditions); the occurrence of an undesirable event in the following period will result in the questioning of the responsibility of the doctor who is now unable to objectively justify the decision.

The operating rules of the health system not only limit the doctor's autonomy but also destroy his authority by imposing rules that are distant from the medical ones and concern economic aspects, many of them. The inclusion in certain diagnostic groups to report some indicators or for inclusion in certain rigors of prescribing the compensated medication are just a few examples. Health economics appears to be a rigid and complex functional center (prescribing rigors, case complexity calculations, insurance carrier prescribing protocols, and more) while violence risk assessment remains in a fluid and imperfect regulatory framework. The state imposes a thick regulatory framework to control the spending of public funds, but the regulation of how the psychiatrist exercises his role as an agent of social control transferred by the state remains deficient.

Also interesting is the perception that doctors have regarding interaction with state "force" institutions that conceptually have a direct role of control, an authority that departs even from the statutory roles of these institutions (such as the police). The physician's fundamental role is directed toward the recovery and maintenance of health and not toward a form of citizen control; the latter is a derivative role and a surrender of state authority to a professional group that finds itself unsupported in a role for which it has not prepared. The comparison used by the doctor below is highly suggestive; the mental disorganization specific to schizophrenia is translated into the disorganization of the state regarding the functioning of all parties involved in decisions related to the freedoms of people, citizens (psychiatric patients continuing to remain citizens of the same state even after the installation of a mental pathology).

Emotional and psychological experiences. Experiencing discrimination and stigma

Stigma is a well-documented barrier to health-seeking behavior, engagement in care, and adherence to treatment in a range of health conditions globally. Existing stigma frameworks typically focus on a single health condition in isolation and often focus on the psychological pathways that occur among individuals. This trend has encouraged a separate approach to health stigma research, focusing on individuals, preventing both comparisons between stigmatized conditions and research on innovations to reduce health stigma and improve health outcomes (Stangl et al., 2019). The inclusion of doctors and their understanding, as experiences and perceptions, within the chains and social reactions related to stigmatization and the experience of discrimination becomes more and more necessary. Stigma can affect different patient groups and the degree of stigma can vary according to society, culture, and individual perceptions. However, patients with mental disorders are often among the most stigmatized in various communities. Several socially manifested reasons lead to this result. We can talk about a lack of understanding and acceptance of psychiatric suffering; many people do not fully understand mental disorders

and, due to lack of knowledge, may perpetuate negative stereotypes and fears about these conditions. The psychiatric patient and his entire social context (including the doctor) are pushed into a shadow area of social perception, into a hidden part, apparently in a similar way to other vulnerable populations. The process perpetuates itself over time and we can speak of a historical stigmatization. The process must be seen as a legacy of our social development and the evolution of social institutions. In the past, people with mental disorders were often marginalized, isolated, or even locked up in institutions. Even today, there are traces of this history in the way mental disorders are perceived. Perhaps more than ever we are faced with a situation of media stigmatization, with unsuspected influences in the context of new technologies and the speed with which "information" circulates today. Misrepresentation of mental disorders in the media can contribute to the perpetuation of stereotypes and stigma. Often, characters with mental problems are presented in an exaggerated or distorted way. Both large types of news that roll repetitively in the domestic media can have such an effect, regardless of the stated objective of the authors. If the news views the psychiatric care environment as a prison and the doctor's intervention as a limitation of individual rights, in the end, the image of the doctor-patient complex is not a positive one. The second hypothesis concerns the social impact of the deviant actions of a psychiatric patient (from acts of violence to suicide); in this case, the image seems all the more negative, and the medical profession is blamed for its far too little preventive actions and unable to limit the mobility of the patient with mental suffering. Under the rule of utilitarian interests, individual rights are neglected, omitted, or even denied, for which society seems to campaign outside of such events. Again, the doctor and the patient are held accountable for their actions amid a long-term inert society. Primary experiences of any human being are primed; in the case of mental disorders, we can talk about fearing unpredictability. Some mental disorders can be associated with unpredictable or unusual behavior, which can generate fear and rejection from others (including other individuals in medical or caring professions). All this social reaction becomes a reverberating, amplified one, including through reactions of self-stigmatization. People with mental disorders can internalize stigma and experience self-stigma, that is, they can internalize and accept the negative stereotypes that circulate about these conditions. To what extent such a mechanism is also valid in the case of psychiatrists becomes a legitimate question that can be empirically validated.

Inter-sectionality in sociology is no longer a new approach but even a mandatory one; natural social evolution has led to a multidimensional approach to all aspects of human life. Manifestations of stigmatization can no longer be understood without addressing the entire social context, the extended social group in which the patient lives with his doctor and his family. Intersectional stigma is a concept that emerged to characterize the convergence of multiple stigmatized identities within a person or group and to address their joint effects on health and well-being. While investigating the intersections of race, class, and gender serves as a historical and theoretical foundation for intersectional stigma, there is little consensus about how best to characterize and analyze intersectional stigma or how to design interventions to address this complex phenomenon (Turan et al., 2019).

The psychiatrist seems to go beyond his traditional professional setting, the one for which he has formally trained; medical care becomes one accompanied by one with a clear role to reduce discrimination. This participatory role leads to an experience of discrimination and stigmatization on the part of the doctor and to an experience of the

doctor's vulnerability, normal if we look at the therapeutic relationship created as a natural transition between people. The manifestation is all the more severe as society's reaction also includes other categories of doctors who, more or less voluntarily, accentuate the circuits of stigma. The following passage is relevant in revealing the reaction among GPs and positioning them at the base of the care system; the damage at the level of primary medicine leads to negative damage from the foundation of the psychiatric patient care process, which concerns prevention. The refusal to identify the individual with a psychiatric condition as a result of potential (real) discriminatory situations in general social circuits is strong evidence of the intensity and depth of the stigmatization process in psychiatry.

Marginalization within the medical and social system

The private life of the psychiatrist cannot be seen as completely separate, independent, from the professional life. The gross time spent at work does not produce a strictly proportional influence on the individual but one, probably much more important; therefore, the working conditions are an important determinant of the quality of life even of the psychiatrist. His exposure to inhumane conditions transposes him not only to an attachment to the vulnerable group he cares for but include him, through the hours lived in this environment, within a marginalized population.

Even though many of the shortcomings have been remedied in the last two decades, the general (unsatisfactory) aspect remains, most likely the result of a broad, socially-ranking attitude towards the management of mental disorders. Society seems to oscillate between utilitarian needs (patients must be "locked up" to be protected) and humanistic needs, which concern the individual rights of a person. Society is prepared to intervene in the sick to a similar extent as the health system is prepared and willing to assist these citizens: staff training, infrastructure, availability of resources, continuity of care, the existence of support networks, and a clear legislative framework do not seem to have reached the desired or claimed standards. The psychiatrist remains at the center of the care process, burdened with the greatest responsibility, under unsuspected societal pressures, and constantly in a moral dilemma stemming from his professional status and role. Seen this way, its vulnerabilities are revealed and become question marks addressed to the wider, societal framework.

The treatment of difficult cases, of those that may be the subject of the press or may constitute criminal investigation files regarding the ill-treatment of minors, are a suggestive example of how the group of psychiatrists is positioned. The cases of children with disabilities return to the attention of the media or to that of some public authorities without being able to find solid, consistent, and systemic solutions. In the example selected and presented below is the case of a child with serious psychiatric problems; the described dilemma concerns, on the one hand, the fear of escalating a psychiatric treatment (which could raise the issue of a form of drug containment) and the inability felt by the doctor due to the lack of institutional means to provide adequate support (psycho-medical treatments, of support for the family or the possibility to provide an appropriate environment for this child in care centers). Belonging to an organized form of representation, also felt as a negative condition through precisely its lack of a form of social inclusion, can also lead to the idea of a form of marginalization within the social system.

The feeling of deep fear felt by the author of the comment starts from a highly publicized case that was finalized in favor of the doctor after many years of legal instruments in the criminal sphere: "The neuropsychiatrist Ramona Gheorghe was arrested

as part of the case opened by the prosecutors for several employees of the "Sfânta Maria" Social Services Complex, which targets alleged acts of mistreatment of the minor, abuse of office and embezzlement. Given that the doctor Ramona Gheorghe was the only psychiatric specialist employed in the social centers in Sector 1, and this one on a part-time basis, the children had no one to prescribe the necessary medication for their ailments." (HotNews.ro, 2016). The fear regarding the criminal investigation and even the risk regarding the doctor's imprisonment (even temporary) seems to be as justified as possible; attaching the image of the doctor who cares for children with such problems to that of a criminal becomes a real one. Through the small number of specialists who care for such patients, through the direct conditions of practice made available by the medical and social protection institutional environment, and by pushing responsibility to the exclusive responsibility of the doctor, we find a form of marginalization within the entire social system that becomes inert to real problems and focus on subjective situations, explained by individualistic ethical principles and moral principles that seem to be attributed only to the medical profession, and members of society, in general, seem to be exempted or these principles are ignored in public messages. Problems regarding the coverage of doctors according to the real needs of society cannot fall to the responsibility of the professional group and, even more, cannot be the individual responsibility of the doctor who nevertheless provides such services. The situation is neither new nor hidden from the public or the authorities; it appears in the media, with some cyclicality, on the occasion of a case that becomes mediatized. An example is the case of children with attention disorders, a pathology with increasing prevalence: "*Things are even more disastrous regarding the Directorates of Social Assistance and Child Protection in Bucharest, which have an acute shortage of pediatric psychiatrists to treat institutionalized children. The situation in Sector 1 is as eloquent as possible: Dr. Ramona Gheorghe, the doctor prosecuted in a case for ill-treatment of minors, employed part-time within DGASPC Sector 1, had to monitor over two hundred minors monthly*." (Bogdan, 2016). The real possibility of adequately treating such a large number of patients is clearly limited by the very fundamental characteristics of any human being: it cannot be ubiquitous and thus cannot simultaneously care for such a large number of suffering children. The cry for help also reveals a series of moral vulnerabilities deriving from the professional practice itself: exceeding certain doses existing in the basic norms of the profession or existing in the approval and marketing documents of medicines, interfering with the prescription of another colleague, exceeding of skills through intervention in the case of another specialty (in Romania we have two distinct specialties, psychiatry and pediatric psychiatry). The medical intervention becomes one without a solid positive impact, it seems to be only one to temporize the situation until the family or the protection institution requests a new consultation (emergency or not); it is the moment when another colleague, possibly from a related specialty (that of adults because pediatric psychiatry is very little represented), is put in a situation of probably higher vulnerability (the inability of the system to intervene adequately becomes more and more visible, from one medical intervention to another and the concrete problem can trigger the entire media reaction or specific to some regulatory and control institutions). The helplessness of the specialist can also be seen as a reduction of power within social relations, a reduction of professional autonomy, and the lack of convergent reaction of society and public institutions leading the profession and patients into a shadow cone, into an unseen part of society, towards a periphery of the social field.

Authors contributions

R.M.D. was involved in research design, the literature review, data collection, analysis and interpretation, and drafting conclusions. A.N.D. was involved in the literature review, data analysis and interpretation, and drafting of conclusions.

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References:

Aprahamian, S., Das, V., Kleinman, A., Lock, M., Ramphele, M., & Reynolds, P. (2002). Remaking a World: Violence, Social Suffering, and Recovery. *Anthropologica*, *44*(2). https://doi.org/10.2307/25606091

Bogdan, S. (2016, November). De ce in Romania nu are cine sa-ti trateze copilul, daca sufera de ADHD. *Www.Vice.Com*. Retrieved from https://www.vice.com/ro/article/wn597b/tratament-pentru-adhd-in-romania

Bosk, C. L. (2003). *Forgive and Remember: Managing Medical Failure*. Chicago: The University of Chicago Press.

Cano, C. R., & Bruhn, J. G. (2004). Trust and the Health of Organizations. *The Academy of Management Review*, *29*(2). https://doi.org/10.2307/20159039

Carey, J. (2022). Madness in Civilization: A Cultural History of Insanity. In *Sunday Best*. https://doi.org/10.12987/yale/9780300266689.003.0004

Dickson-Swift, V., James, E. L., & Liamputtong, P. (2008). *Undertaking sensitive research in the health and social sciences: Managing boundaries, emotions and risks. Undertaking Sensitive Research in the Health and Social Sciences: Managing Boundaries, Emotions and Risks*. https://doi.org/10.1017/CBO9780511545481

Feisthamel, K. P. (2011). The Rise and Fall of the Biopsychosocial Model: Reconciling Art & Science in Psychiatry. *American Journal of Psychotherapy*, *65*(1). https://doi.org/10.1176/appi.psychotherapy.2011.65.1.96

Goffman, E. (1974). Stigma; Notes on the management of spoiled identity. *JASON ARONSON, NEW YORK, N.Y., (147 p.) $US 7.50*. https://doi.org/10.2307/2575995

Grötken, K., & Hokenbecker-Belke, E. (2012). The Trajectory Model. *Student Nurse Journey*.

Hatch, S. (2017). Uncertainty in medicine. *BMJ*, *357*. https://doi.org/10.1136/BMJ.J2180

HotNews.ro. (2016, July). Sase copii de la centrul "Sfantul Nicolae" din Bucuresti, ramasi fara medicatie psihiatrica, au intrat in sevraj/ Medicul psihiatru angajat a fost arestat preventiv saptamana trecuta. *Www.Hotnews.Ro*. Retrieved from https://www.hotnews.ro/stiri-esential-21144170-sase-copii-centrul-sfantul-nicolae-din-bucuresti-ramasi-fara-medicatie-psihiatrica-intrat-sevraj-medicul-psihiatru-angajat-fost-arestat-preventiv-saptamana-trecuta.htm

Kleinman, A. (1980). *Patients and Healers in the Context of Culture*. *Patients and Healers in the Context of Culture*. https://doi.org/10.1525/9780520340848

Laing, R. D. (1966). The Divided Self: An Existential Study in Sanity and Madness. *Medical Journal of Australia*, *1*(6). https://doi.org/10.5694/j.1326-5377.1966.tb19657.x

Lee, R. M., & Renzetti, C. M. (1990). The Problems of Researching Sensitive Topics: An Overview and Introduction. *American Behavioral Scientist*, *33*(5). https://doi.org/10.1177/0002764290033005002

Liamputtong, P. (2006). Researching the Vulnerable : A Guide to Sensitive Research Methods, 1–256.

Light, D. W. (2010). Health-care professions, markets, and countervailing powers. In *Handbook of Medical Sociology, Sixth Edition*. https://doi.org/10.2307/j.ctv16h2n9s.19

Löwy, I., Pringle, R., Cassell, J., & Lowy, I. (2000). Sex and Medicine: Gender, Power and Authority in the Medical Profession. *Revue Française de Sociologie*, *41*(1). https://doi.org/10.2307/3322668

Parker, C., & Freidson, E. (1995). Professionalism Reborn: Theory, Prophecy and Policy. *Contemporary Sociology*, *24*(4). https://doi.org/10.2307/2077679

Parson, T. (1949). Professions and Social Structure. In Talcott Parson (Ed.), *Essays in Sociological Theory: Pure and Applied.* (pp. 185–199). Glencoe (IL): Free Press.

Pescosolido, B. A. (2013). Patient Trajectories. In *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*. https://doi.org/10.1002/9781118410868.wbehibs282

Poynter, F. N. L. (1964). Book Review: Naissance de la clinique: Une archéologie du regard médical. *History of Science*, *3*(1). https://doi.org/10.1177/007327536400300114

Richter, D., & Whittington, R. (2006). *Violence in mental health settings: Causes, consequences, management*. *Violence in Mental Health Settings: Causes, Consequences, Management*. https://doi.org/10.1007/978-0-387-33965-8

Roberts, L. W., Hales, R. E., & Yudofsky, S. C. (2019). *The American Psychiatric Association Publishing Textbook of Psychiatry*. *The American Psychiatric Association Publishing Textbook of Psychiatry*. https://doi.org/10.1176/appi.books.9781615372980

Rose, N. (1999). *Powers of Freedom*. *Powers of Freedom*. https://doi.org/10.1017/cbo9780511488856

Salvatore, D., Numerato, D. & Fattore, G. Physicians' professional autonomy and their organizational identification with their hospital. *BMC Health Serv Res* **18**, 775 (2018). https://doi.org/10.1186/s12913-018-3582-z

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. In *International Review of Psychiatry* (Vol. 19). https://doi.org/10.1080/09540260701278929

Simpkin, A. L., & Schwartzstein, R. M. (2016). Tolerating Uncertainty — The Next Medical Revolution? *New England Journal of Medicine*, *375*(18). https://doi.org/10.1056/nejmp1606402

Stangl, A. L., Earnshaw, V. A., Logie, C. H., Van Brakel, W., Simbayi, L. C., Barré, I., & Dovidio, J. F. (2019). The Health Stigma and Discrimination Framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine*, *17*(1). https://doi.org/10.1186/s12916-019-1271-3

Starr, P. (1982). *The Social Transformation of American Medicine: The Rise Of A Sovereign Profession And The Making Of A Vast Industry*. New York: Basic Books.

Strauss, A. L. (2018). *Professions, work and careers*. *Professions, Work and Careers*. https://doi.org/10.4324/9781351307963

The Mental Health Consequences of Torture. (2001). *The Mental Health Consequences of Torture*. https://doi.org/10.1007/978-1-4615-1295-0

Topor, A., & Matscheck, D. (2021). Diversity, complexity and ordinality: Mental health services outside the institutions—service users' and professionals' experience-based practices and knowledges, and new public management. *International Journal of Environmental Research and Public Health*, *18*(13). https://doi.org/10.3390/ijerph18137075

Turan, J. M., Elafros, M. A., Logie, C. H., Banik, S., Turan, B., Crockett, K. B., … Murray, S. M. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Medicine*, *17*(1). https://doi.org/10.1186/s12916-018-1246-9

Turner, B. (1995). *Medical Power and Social Knowledge* (2nd ed.). London: Sage Publications UK.

Turner, B. S. (1997). From governmentality to risk: Some reflections on Foucault's contribution to medical sociology. *Foucault, Health and Medicine*.

Whiteoak, A. E. (2015). The violence of care: rape victims, forensic nurses, and sexual assault intervention. *Journal of Gender Studies*, *24*(5). https://doi.org/10.1080/09589236.2015.1073961

Wilder, W. D., Foucault, M., Howard, R., & Pepitone, A. (1972). Madness and Civilisation: A History of Insanity in the Age of Reason. *Man*, *7*(1). https://doi.org/10.2307/2799941

Wirth-Cauchon, J., & Horwitz, A. V. (2002). Creating Mental Illness. *Contemporary Sociology*, *31*(6). https://doi.org/10.2307/3089999

Zola, I. K. (1971). MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL* Irving Kenneth Zola. *Sociological Review*, *20*(November).

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