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Summary of the dissertation: ***"Communicative action and discursive approaches in doctor-patient relationship."***

The dissertation contains five chapters and presents the results of the following main research objective: to analyse, in a theoretical way, what are the chances of further developing the dialogical and partnership-based relation between doctor and patient in a discursive approach. The idea is to structure this relationship in such a way as to empower the patient as fully as possible (in view of the patient's rights, based on the modern principle of individual autonomy and self-determination); to design conditions favourable to his or her widest possible participation in the medical (clinical) decision-making process, while at the same time realistically defining the institutional framework and the constraints that are objective, or that result from the patient's state of health and will. It was not the aim of this thesis to present Habermas's theory apologetically and dogmatically, but rather to present systematically and as concisely as possible (a) communicative interaction as, on the one hand, an intersubjective relationship constantly and in various formulations (e.g. communicative interaction as, on the one hand, an intersubjective relationship constantly and in different formulas (e.g. dramaturgical) enabling human subjects to coordinate their various practices (which naturally also occurs in clinical contexts) and, on the other hand, as a mutual understanding and recognition of the meanings and senses of what people communicate to each other in speech acts (which also appears - or at least should appear - to be unfamiliar in clinical communication involving the patient, especially in the relationship between patient and doctor); b) a presentation of what the discourses (theoretical, practical in its various variants, explicative, applicative, etc.) are, what they consist of, what elementary rules they require, and how useful they are.). This presentation deliberately ignores the adaptation of discourse for legal contexts, which dominates the study of discourse in the format that J. Habermas developed for more than half a century on the basis of pioneering assumptions. The avoidance of legal contexts (with minor, justified exceptions) has made it possible to analyse the most practical (practicable) assumptions of discourses in the role of procedures useful for decision-making and resolution-seeking on medical grounds, which also require argumentative justification and consensual acceptance of decisions or solutions as 'valid', and to discourse reported with a 'claim to validity' (both in the epistemological sense on the grounds of theoretical discourses, and to validity and legitimacy on the grounds of practical discourses) (Chapters III, IV).

In addition to this central research focus, Chapter II presents the evolution of the scope, as well as the forms of patient participation in medical-clinical (and clinical-ethical) contexts involving the patient in various communicative interactions, up to deliberative models and their evaluation by J. Habermas. Chapter V, on the other hand, thoroughly (on the basis of the international as well as national literature on the subject and the relevant legal provisions and codes of medical ethics) proposes a narrower and broader formula of 'informed consent'. In the broader formula, informed consent is reflexively and discursively explained and is an integral part of the sum total of acts of acceptance at the level of clinical discourse involving all participants (entitled or authorized to such participation). However, the patient's informed consent can occur as a self-contained act, but this self-contained, isolated, communicative-discursive isolation can reduce it to a poorly reflexive, almost mechanical and resigned gesture of approval (or refusal). The analysis showed that the institution of 'informed consent is interpreted in an ambiguous manner under domestic law. At the same time, in the context of the patient's right to information, it is something inalienable, with great potential, the realization of which (as well as awareness - which was one of the aims of this work) deserves discursive support. In addition to the patient's consent as an element of consensual consent, it was considered how clinical decisions (with or without the patient's participation) - instead of producing and duly justifying new, universally accepted norms (which is essentially what practical discourse is called for, especially in adaptations to the context of legislation and jurisprudence) - apply already existing general legal norms, procedures, protocols, also ethical norms precisely where decisions are made regarding the state of health and the optimal treatment plan for a specific patient (specific case). This is because the discourse can serve the purpose of jointly (with the patient's participation) selecting, constructing and applying to the patient such a treatment scenario that it will be of optimal quality, taking into account purely biomedical priorities (medical experts increasingly reduce 'health' to biomedical categories) together with the priorities of the patient.