Clinical Medicine

Clinic: the art of balancing disease and subject

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Study conducted at Universidade Estadual de Campinas, Faculdade de Ciências Médicas, Department of Preventive and Social Medicine, Campinas, SP, Brazil

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The term "clinic" is derived from the Greek word *klinikos* with the component part "*klino*" or "*kline*", which means to lean or bed[1]. The image of the doctor leaning over the patient, examining it, is very familiar to most people. By extension, "clinic" could be understood as the practice of medicine at bedside. However, as we shall see, its scope is much broader.

According to the Aurélio Dictionary of Brazilian Portuguese[2], medicine is the "art or science to prevent, cure, or mitigate diseases". The Brazilian Dictionary of Medical Terms by Pinto[3] defines medicine as the "art of knowing diseases, disorders, and illnesses – etiology, pathogenesis, diagnosis, prognosis, therapy, prevention." These two definitions corroborate what Foucault pointed out in his book *The Birth of the Clinic*; i.e., that disease is the object of attention of medicine[4]. However, other authors highlight the relevance of including the patient and the collective as objects of interest. Cunha[5] understands Clinical Medicine as a "complex interaction or an encounter between two singular subjects: a professional and a patient, a staff and a patient, a team and a collective". Campos[6] proposes the expansion of Clinical Medicine, "from its biomedical nucleus to the social and subjective aspects of each subject, respecting the unique characteristic of each case". According to Foucault, clinical medicine was born in the 18th century, in the wake of modern science, when empiricism replaces metaphysics and philosophy. The observed fact became more important than the interpretation of disease. One of the cornerstones of this new science was the creation by Carl von Linné of a scientific nomenclature system to classify animals and plants[7]. Before Linné, Thomas Sydenham and Sauvages from Montpellier tried to classify diseases, the first through the description of diseases and the second according to class, order, and gender, following the same path of biologists' classification of animals and plants[8]. Medicine adopted this classificatory model used by biologists and started naming diseases according to the same hierarchical logic, which remains the basis of medicine to the present day[4,9]. Another advance that has contributed to a fundamental change in disease perception was the development of pathological anatomy, which allowed the correlation of signs and symptoms with changes in organs examined on the autopsy table or under the eye of the microscope[8]. These advances lead to the Clinic that prevails until today. According to Foucault, "an empirical process in which by looking at the patient we seek to discover the disease. The patient, in turn, is not involved in the disease rational, being regarded as an event outside of what he is experiencing. The paradoxical role of medicine is to neutralize the patient so that the optimal configuration of disease takes on a shape that is concrete, free, totalized, and open to the order of essences. Therefore, we are not speaking about discovering a truth still unknown, but about a particular way to sort the truth already acquired, hidden, already present in the patient's body. Anyone who wishes to understand the disease must subtract the individual and his unique qualities; if the course of disease is not interrupted or disturbed by the patient, the immutable laws that determine it can be rapidly discovered"[4]. It is an ontological model in which "disease is an instance located in the body, which can be conceptually separated from the affected person"[8]. Campos[10] recognizes an "anti-positivist dialectic of medicine that keeps the disease and discards any responsibility for the history of concrete subjects". According to Foucault[4], not even the fact of having an organ affected is necessary to define the disease. "The organs are solid supporters of the disease: they never constitute its indispensable conditions." Physical examination is nothing more than a method of investigating the concrete space of the body in order to establish the relationship between the phenomena, background, and disturbances observed to obtain a name: the name of the disease[11]. Ramos Jr.[12], in his treatise on *Semiotécnica da observação clínica* (semiotechnique clinical observation), confirms that diseases rather than patients are the object of investigation: "The history should be obtained according to the information and composition of symptoms, so that the rationale for the required, anatomical, functional, and etiologic diagnosis is possible. All information or expressions not related to the organ pathophysiology must be purged"[12].

The Clinic is based solely on the perceptual field, guided by the exercise of observation. According to Foucault, the physician's eye is able to achieve "the general form of any scientific finding": the patient is observed as if he was a planet or a laboratory experiment. The physician's eye is directed toward what is visible on the disease and occurs in the form of a "contact prior to any speech, free from the entanglements of language"[4]. The Clinic gives a new shape to things through the language of a "positive science". It is the concrete individual opening to the language of rationality. The clinical tool is the empiricism, which supplanted the philosophical and metaphysical posture of the Middle Ages, coinciding with the emergence of modern science, anchored in the essential skill of observing the evidence, the object that can be perceived. It is considered that Medicine became scientific when it became empirical, departing from theoretical and speculative Field. In the acclaimed *Cecil: Tratado de Medicina Interna*, Goldman and Ausiello insist on the relationship between medicine and modern science: "Medicine is a profession that incorporates science and scientific methods with the art of being a physician"[13]. In his speech at the first graduation class of the Faculty of Medicine and Surgery of São Paulo, Arnaldo Vieira de Carvalho makes clear the belief in the power of positive science, the path to the truth: "In addition to relieving the physical ailments of the patient, the doctor is also responsible to restore the broken society and for the huge and complete task of sanitizing and improving the environment in which both evolve! Improving and modifying the environment in which we live or intend to live is a great problem. For Metaphysica, he exceeds the limits of human strength, to be unenforceable and even unapproachable. For the real man of science, however, is not unenforceable or unapproachable. For you others, who are lovers of truth, my young colleagues, such a development will have especial charm, will be the beloved subject of reflection, and should be a point of honor to find a solution"[14]. Later in the text, he reduces the medical knowledge to the obedience of the laws of nature: "You are physicians – you can not see in men more than a set of cells, more than higher animals. You are biologists – you can not conceive in the manifestations of these animals nothing but the psychochemical manifestations of a cluster of protoplasm; you can not find in such phenomena more than the effects of the physics law, this unique and truthful science, which explains and clarifies everything without resorting to fantastic and absurd assumptions […] reduced the social improvement to a biological equation, no one other than the physician – always a supposed scientist/biologist, and not one of those storytellers focused on the life of animals – is more apt to provide the solution[14]". The modern, positive science is the paradigm of the Clinic[15], as it defines problems, legitimate methods, and models. A Clinic that has experienced and continues experiencing a process of consolidation and strengthening in which nature is forced to fit within the pre-established and relatively inflexible limits provided by the paradigm.

It must be recognized that this Clinic, essentially empirical, grounded in modern positive science, focused on signs and symptoms in the search for a name (the disease's name), was effective to respond to various challenges of the health-disease process. For example, saying that a patient with fever, productive cough, and pulmonary rales has pneumonia (disease's name) and prescribe antibiotics and observe the patient's recovery in order to resume his daily activities is to realize the power of this Clinic. On the other hand, it is weak to account for claims that do not meet anatomical, functional or etiological diagnoses.

Porter[16] agrees that despite the extremely positive results obtained by empirical Clinic, the society recognizes gaps in its effectiveness. "Never have people in the West lived so long, or been so healthy, and never have medical achievements been so great. Yet, paradoxically, rarely has medicine drawn such intense doubts and disapproval as today. No one could deny that the medical breakthroughs of the past 50 years – the culmination of a long tradition of scientific medicine – have saved more lives than those of any era since the dawn of medicine".

Starfield[17] recognizes differences in the demands presented to the specialist and primary care. According to the author, "Primary health care involves the management of patients who often have multiple diagnoses and confounding complaints, which can not be fitted into known diagnostic". In this level of care, the more 'rebel' demands not fitting the known diagnostic seem to emerge or manifest with greater freedom, challenging professionals from primary care units. In specialized care, the diagnostic process grounded in observation and pathophysiology predominates; therefore, demands that are not resolved by this process tend to be ignored[7].

Even when the medical discourse goes beyond the biological aspects and moves towards the psychological and social factors of health-disease process, these factors often only orbit the disease, following the logic highlighted by Foucault[4], Goldman, and Ausiello[13] argue that physicians must understand the individual as a person, "understand the social situation of the patient, family issues, financial concerns, and preferences for different types of care and outcomes", but they do not deviate from the history/physical examination model aimed at signs and symptoms that may define a disease; thus, the psychosocial aspects are related to patients who serve as "home" for diseases. Starfield[17] argues that "effective medical attention is not limited to the treatment of illness itself" and cites the context as a factor to be considered, but assigns to health services the primary task of investigating the "cause of illnesses and the management of diseases".

With the same desire to pursue a higher power from the Clinic, other initiatives were implemented, such as the humanization of medical practices; the person-centered medicine, considered "as a whole regarding emotional needs and existential issues"[18]; the Balint groups; and the Extended Clinical Care[10].

According to McWhinney and Freeman[19], "the person-centered clinical method provides a systematic and integrated approach to include the person and the disease". It is an alternative proposal to the family and community doctor, as in 35% to 50% of visits in this area it is not possible to establish a specific diagnosis of a disease. The solution of these cases lies in the belief that they could be "treated" by understanding the person and the context. These authors distinguish "disease" from "experience with the disease". The first would be a "pathological process that physicians use as an explanatory model of experience with the disease"; that is, "what the patient is *experiencing* when he goes to the doctor; the disease is what the patient *has* after visiting a doctor". This distinction means considering the disease both from the standpoint of meaning for the person's life and from the standpoint of pathology. The person-centered method is aimed at understanding the experience with the disease at all levels, from pathology to thoughts and feelings[19].

Ruben et al.[20] also use the English clearer distinction between illness and disease to defend the extended approach of the person. According to McWhinney and Freeman[19], illness corresponds to the experience with disease: "It is the unique and singular way in which a person is affected by the disease". Disease is a mental construct created to deal with the biological problems more easily. It is individual-independent and follows the logic of pathophysiological reasoning. Except when the disease is in its non-illness stage; i.e., it is asymptomatic or still unknown by the patient, coexisting with illness in the same person. These authors consider that an essential characteristic of family medicine is to incorporate the illness in the patient approach. Similarly to Starfield[17], others suggest that, for the specialist, one single Clinic would be enough for the disease, whereas the primary care professional, more specifically the family doctor, needs to include the illness or experience with the disease in his Clinic.

In its 2008 World Health Report "Primary Healthcare: Now More Than Ever", the World Health Organization emphasizes the importance of person-centered care and also points out differences between the problems addressed in primary and secondary levels, understanding as a more complex challenge the one imposed on primary care. This is because people must be understood holistically in their physical, emotional, and social development, and must be placed in a world with its own changeable characteristics in time[21]. Besides benefiting the patient, the person-centered strategy seems to increase health professional's satisfaction.

After noting the difficulty of doctors with the emotional problems of their patients, the psychiatrist/psychoanalyst Michael Balint organized seminars on "psychological problems in clinical medicine" and proposed the extended interview based in the ability of listening by the doctor, deeming it necessary to expand the limits of anamnesis[11]. In these lines, Cunha proposes a different clinical anamnesis "giving space to the ideas and words of the patient"[5] and Bedrikow argues that the dynamics of consultation "must be freed from the rigid rules of traditional anamnesis and open space to a less structured conversation"[1]. In such cases, the limits of the traditional clinical method connected to the modern scientific thinking are recognized, in which the patient in his doctor-patient relationship is led by the physician through a script able to reach the name of a disease. The authors mentioned above, following in the footsteps of Campos, understand that the patient, "free" to develop and convey ideas, may add different elements to the Clinic, with the possibility of bringing out other issues than his illness. The patient (under such conditions) is allowed to achieve higher coefficients of autonomy and initiative, with a more prominent role. This is the starting point of the Clinic of the Subject, thought by Campos, from Sartre's Existentialism – the subject responsible for the "construction of meaning or significance to things or phenomena" – and from Basaglia's "role of concrete subjects", for whom the objective of the work is the patient, the person, not the disease[10]. Also according to Campos, "the modern clinic reform should be based on a shift in the emphasis from disease and be focused on the concrete Subject; in this case, a subject carrying a disease"[10]. In his conception of Clinic, even transferring to the patient the role of the ontologized object of medicine, the disease continues to exist, "it is there in the body, all the time, making noise, breaking the silence of the organs. The disease is there, depending on doctors and medicine, it is true, but also independent of medicine; depending on people's will to live, for sure, but also independent of the Subject's will"[10]. At this point, Campos agrees with Foucault in recognizing that the Clinic provides always a disease which *inhabits* an individual. There would be no Clinic without disease, "otherwise it would not be Clinic, but sociology or existential philosophy"[10]. Here is the specificity of Campos; he does not propose to replace the disease by the patient, but to expand the object of knowledge and clinical intervention, including also the Subject and its Context, because "similar illness in terms of classification may occur differently depending on the history and subjective resources and materials of each Subject".

The Subject inclusion as the object of the Clinic challenges the paradigm of positive science, which draws on the regularity of diseases and has difficulty addressing the uniqueness of cases[22].

We could analyze the different clinical methods by placing these methods into two main streams: one focusing on disease – the Clinic described by Foucault, the Positive Science, the Official Clinic[10]; the Clinic of Treaties Medicine and Semiotechnique (Cecil, Ramos Jr.). And another focused on the meanings, emotions, and uniqueness of each person – the Clinic of the Subject (Basaglia and Campos)[10]; the Person-Centered Medicine (Brown, McWhinney, and Freeman); and the Listening Clinic of Psychological Problems (Balint). This separation follows the description of two school of thought made by Crooskshank: the natural/descriptive and the conventional/academic/ontological approach to medical knowledge, followed by the Ancient Greek schools of Cos and Cnidus, respectively. The natural approach is concerned with body and illness and describes the experience with the disease in all its dimensions, while the conventional approach is concerned with organs and diseases, seeking to classify and name the disease as an independent entity separate from the person. These are the two "doctrines that are endlessly repeated over the centuries"[19].

The modern Clinic born in the 18th century, described by Foucault, and taught in Western medical schools until the present day has a close relationship with the conventional/academic/ontological school of thought followed by the group of Cnidus who "understood diseases as entities independent of the patient, which needed to be classified and distinguished from each other, focusing its activity in the diagnosis […] medicine was taught and learned as a science"[23]. The Clinic of the Subject, person-centered, interested in meanings and affects has more identification with the school of Cos with its natural/descriptive approach, which "interpreted the disease within the specific and peculiar condition of each patient and the symptoms as independent of environmental and personal factors; the disease is an abstraction because the symptoms vary continuously in the course of a single disease, and the patient is the real problem of medicine [...] medicine should be taught and learned as an art to treat the sick human being"[23]. Crookshank[19] noted that "the best doctors at any time balanced the two methods". The idea that there is no single truth and that different methods can coexist, enhancing each other, should be one of the main strategies of health managers. In this sense, it seems to me very fortunate the preface of the Final Report of the Workshop on Primary Care of the City of Campinas when using the following sentence from the book by Marguerite Yourcenar *Memoirs of Hadrian:* "There is more than one truth. And all are important to the world. There is no harm in alternating"[24].

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