

## **Social medicalization (II): Biomedical limits and proposals for primary care clinic**

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### **ABSTRACT**

Social medicalization diminishes or even destroys the population's autonomy regarding disease and healthcare and generates an endless demand on health services. It consists on an important challenge the SUS (Unified Health System). This article discusses the limits of biomedical knowledge and practices in relation to their contribution to the promotion of users' autonomy and proposes some guidelines for handling these limits. It comes to the conclusion that intervention technologies, biomedical knowledge and its cognitive procedures contribute very little to patients' autonomy. The article suggests a shift of the biomedical knowledge's meanings, focused on the healing function of health professionals. This shift should be regarded as a mission to rebuild autonomy, prevent and heal the lived sicknesses, beside the ones that are diagnosed. It defends a reorganization of primary care biomedical clinic's values and goals, such as the diagnosis' relativity, the end of disease and risk ontology, the end of the control obsession, the fight against biomedical dogmatism, and giving priority to therapeutics.

**KEYWORDS:** Social medicalization, Epistemology, Family health program, Primary care, Clinical medicine, Clinical competence.

### **Introduction**

The increasing social medicalization reality, along with the multiple crisis of health care, according to Luz (1997), have pointed out the need of a re-discussion and development of the medicalization theme, its consequences and handling in the public health services (Health Centers and Family Health Program –FHP). Medicalization is generally understood as a process of progressive expansion of the biomedicine intervention field through the redefinition of human behavior and experiences as if they were medicine matters.

According to Illich (1975), the expansion the scientific medicine or biomedicine, the

counterpart of social medicalization, creates a modern counterproductive phenomenon of the industrialized societies in which the usage of social and technological tools result in opposite effects to its purpose. As an example, there are health institutions that produce diseases, medicine that produces iatrogenies.

The consequences of health institutions counter-productivity actions and the illician thesis that they get apart from social and cultural conditions that allow the positive synergy among autonomous actions (carried out by the subject or impairs in an autochthonous social environment) as well as the heteronomous actions in health (carried out and controlled by institutionalized professional agents – specialists) highlight the importance of the medicalization theme and the autonomy-heteronomy issue. These were recently discussed by Nogueira (2003) and mean a relevant challenge to the Unified Health System (SUS)

Social medicalization is associated to what Illich (op. cit.) calls cultural iatrogeny which means a diffuse and surreptitious way of iatrogeny in biomedicine: the loss of cultural potential to handle the majority of pain situations, sickness and suffer. His most important proposal consists in improve, reinvent and/or ransom people's autonomy in health-disease as a way to restore the equilibrium between autonomous and heteronomous actions. This refers to the role that care, related to institutional health, performs in this process.

According to Tesser (2005), social medicalization can be considered a successful result of scientific efforts in health that tried to monopolize an epistemological legitimacy in the Occident. Using Fluck's (1986) epistemological concept, Tesser interprets social medicalization as the successful result of the socialization of this medicine to great population and little modern contingents which implicates in an epistemicide of knowledge and non-scientific, popular or traditional practices. These different forms of knowledge were, until recently, important resources of technical and cultural ballast to autonomous actions in health-disease; this ballast is under an extinction or intense transformation process. Adopting the perspective of Boaventura Santos (2000, 2004), the author proposes to consider biomedicine as indispensable and necessary and, simultaneously, inadequate and dangerous. One of its dangers is that of its acting in the process of medicalization and cultural iatrogeny mentioned by Illich.

From the perspective of developing practical action strategies to SUS, this proposition demands clarity and understanding about the power of basic care medicalization action, as well as over the *modus operandi* of the physicians performance and their knowledge over the users cultural health which is build up in each user-service or physician-patient interaction. As a consequence, health care strategies and orientation to health centers, which have the characteristic of being "unmedicalized" and/or reducers of medicalization, become valuable and relatively scarce.

The importance of this theme is highlighted when we take into consideration the current moment of SUS which invests in the enlargement and re-orientation of health centers through the PSF strategy. Having an easy access to Brazilian homes, PSF offers two things: a chance to rebuild autonomy and/or, simultaneously, a new and powerful medicalization force.

Thus, it seems to be necessary to question the contemporaneous biomedic knowledge/practice (clinic-epidemiologic<sup>1</sup>) in order to view the possibilities and challenges of this medicine in which its relationship with the increasing (or not) of subjects in health-disease autonomy is concerned.

These are justifications for the two purposes of this article: 1) to reflect about biomedicine in terms of its limits to the promotion and reconstruction of autonomous action; 2) to sketch some directives to the medic clinic practice about health care in health centers as well as in PSF. These issues are: which is the level of adequacy or inadequacy of biomedical knowledge/practice to ransom autonomous action? How is this *modus operandi* of biomedical action in its medicalized sense (inadequate)? Aiming the transformation or minimization of this sense, which strategies can be proposed to handle the problem in the basic care clinic?

The first purpose is approached through an essay that discusses some characteristics of the biomedical knowledge and technologies for prevention and healing, as well as of the cognitive movements usually carried out by medicine professionals in their daily work of health care within health centers. The interaction physician-patient is used as a focus reference for the analysis that follows (which, by hypothesis, can be adapted to other health professional actions considering the necessary corrections).

The second purpose – the third question – is developed through considerations based on a master study and professional and institutional experiences from the author as a general practitioner and sanitariat, which are discussed as a contribution to the structure of technical-philosophic directives to handle medicalization in the micro-social level of basic health services – obviously without the intention to deplete the theme.

### **Biomedicine and autonomy**

The interactive processes between health professionals and patients are always under multiple nature tensions, whose general results have been highly medicalized. Besides cultural factors, service management and graduation and (de)formation of physicians, the thesis defended here is that the current statements and technologies in biomedicine – its working and usage - tend to put pressure on the physician-patient interaction towards a reinforcement of medicalization; that means, they have an “intrinsic” medicalized power as to say.

In this topic, it is sketched a critic view about the biomedic knowledge (clinic-epidemiologic),

aiming a sizing of limits and challenges of the clinic-epidemiologic knowledge in which its relationship with patients increasing (or not) autonomy or users is concerned; that means, detailing some “internal” aspects of this medicalized force. The current clinic-epidemiologic knowledge, the medical institution and the biomedicine practice are inextricably overlapped. That is why these terms are used in their colloquial sense, without the pretension for a rigorous conceptualization, unnecessary for the aims of such a discussion.

By means of analysis, the biomedic statements and practices can be divided into two great areas: prevention and therapeutics. Even though they are linked by the same physio-pathologic knowledge, it is common that some prevention occur without a treatment both in the statement and biomedical practice or that the treatment occurs without prevention being mentioned. These two great areas are approached in the sequence.

### **Prevention**

Part of the biomedicine prevention is concerned with hygiene notions or infectious and parasitic diseases. Here, biomedicine contributes to the subjects’ autonomy enriching their view with explanations about what it considers as a pathogenesis of microorganisms and the importance of prophylactic hygiene. Even though these hygiene notions are not exclusive of this knowledge, nothing would imply a doubt in what the relationship of this part of biomedicine with the autonomous action phenomena is concerned. This is also worth to personal and sanitary cares in the sense of blocking means of transmission and contamination through water, residues, dejects, animals, etc.

Another great part of this preventive area is about the specific prophylaxis through immunization. This is a noble parcel of this medicine due to its investments for diseases considered as infectious, as well as some conquests attributed to vaccines development. This parcel and practice is responsible by part of the legitimacy and success of scientific medicine in its fight against this type of disease and it is, at a first sight, ambiguous in which its contribution to the increasing of autonomous action is concerned.

If, on one hand, these correlated statements and technologies allow the existence and life of many people who could be condemned to suffering, sequelae or even premature death, on the other hand, they expose people to a strict dependency of the medical institution (through public health), as the subject has to submit him/herself to technically determined procedures. The benefits of Bioscience immunization are anticipated and there is no discussion with the user-mothers of SUS if they should or not take their children to get a vaccine; if not to comment about their obstinacy in order to enframe them. In this sense, the biomedical knowledge does not add to subjects’ autonomy as all the power, knowledge and decision capacity are disconnected from them. The citizens must only accept what is

prescribed or sometimes imposed to them.

We can try to explain people the reasons why they should adopt what is already accepted, but it would not even get close to the statements universe, uncertainties, scientific polemics, risks, statistics, political pressures and circumstances that guide these decisions. The expansion of autonomy can contribute very little, although it is possible to diminish certain morbidities and mortalities and then, prevent diseases and their complications enabling the possibility of saving lives what is , definitely, not trivial.

Another part of prevention techniques and statements is associated to attitudes, habits, life styles, physical activities, etc or to the so called “hygiene-dietetic orientations”. It is not necessary to detail this universe completely, but some considerations about an aspect that permeates the biomedical knowledge are important. It is the medicine search for an objective and universal knowledge, in which it is supposed to be a separation between the cognoscent being and the already known one. The scientific medical knowledge has divorced from the life and cultural, personal and social perception of men. It acquired a technical, esoteric and positive characteristic, a knowledge which is said by a third person and that created, as a consequence, an abyss between what the patient and physician know or can possibly know. Santos (1982) discuss about an epistemological secession between the scientific knowledge and the common sense, having called it as a “first epistemological rupture”. Institutionalized as science, politically and socially triumphant, the medical knowledge is always that of someone else, with specific characteristics. It is knowledge about diseases or probabilities and risk of diseases in the body (or mind). Besides that, it is a knowledge that is beyond the professional itself who seems to command it, rooted in the “Science” institution. This knowledge condensed, amazingly, its validity and power over an institution represented by another transcendent one which is disconnected, distant and inaccessible to the sick person.

With its object of attention reduced from the sick person to the sick body (or mind), a body that possesses a disease(s) and its risks, the clinic-epidemiologic knowledge does not know the health and life of its patients, who are gradually transformed into measurements and quantifier tools while image patterns register, in terms of physiologic constants and variables, functional dynamics and risk factors established by statistical patterns (Luz, 1996).

These assertions are used to contextualize, theoretically and assess about biomedicine prophylactic statements: it created an almost insurmountable moat between the subject and the knowledge about his/her own health-disease, between the physician and the individual knowledge which, in practice, guide people and gain meaning and differentiated values to each subject according to his/her own personal, social, cultural and economical characteristics. A “second epistemological rupture”, proposed by Santos (1982) as a necessary one, seems to be extremely hard to happen in the

health area and, even when it is searched for, it does not seem to arrive satisfactorily – if not under the form of medicalization and its generalized dependency.

Thus, the prophylactic biomedical knowledge disconnect itself from the existential perspective of the sick person, without a vital meaning to the patient or a value-based review process in the sense of opening increasing possibilities, action and responsabilisation toward itself, the ones who are near and their health problems. As a consequence, much preventive knowledge established by this medicine acquires the characteristic of prescriptions that are not integrated to the universe experienced by the subject. They have a monastic, aseptic, little convincing and operationally feasible tone due to a rigid and restrictive characteristic: do not drink, do not smoke, do not use drugs, sleep well, eat moderately and not excessively, eat more vegetables, restrict sugar, salt and fat and practice exercises regularly, do not get stressed, etc.

Besides that, the prophylaxis situation gets worse due to the philosophical and value-based confusion in which this knowledge exists: it is deprived of its own philosophical space (as the rest of biomedicine as a whole, due to its adherence to the positivist scientific model which transformed this space into a methodological debate). Thus, it is hard to combine a proposal of the revalorization of the health issue (life) that is able to articulate the accumulated prophylactic knowledge by the biomedicine with the symbolic and cultural universe of patients.

Perhaps, only the symbolic and ideological world of the biomedical institution is able to get it as this is a space in which everything is summarized to the fight against pathological entities – and its risks – always lurked and ready to attack. This world has lived, recently, an obsession by prevention, by the “healthy life style” which expanded to society as a whole and to the media, called as a modern *higiomania (hygio-mania)* by Nogueira (2003).

As a consequence, these statements are disconnected within these massive techniques, values and ideologies and reinforce institutional dependence, pharmaceuticals specialized consumerism services, the depreciation of autonomy and other types of knowledge and sick person’s own values and even other diverse philosophical or cultural references. The results from such a professional practice are that such types of knowledge tend to minimize what subsists of autonomy in the subjects.

### **The therapeutics**

About the therapeutic side of the biomedical knowledge, the diagnosis is a central category. If it allows the doctor to conclude about what is going on, to propose and carry out therapeutic actions, it allows the patient an inter-relationship with this biomedic knowledge and its interpretation to the disease experienced context. It is in the diagnosis direction that the cognitive operations flux is guided

in biomedicine. These cognitive operations are retaken, in the sequence, for a discussion of their relationship with the patients' autonomy.

The patient and his/her history, within biomedical approach, are metamorphosed in clinic history and physical exams data. These allow the generation of syndromic, psycho-pathologic, functional-anatomic and/or etiologic diagnosis hypothesis that guide, according to the case, the mobilization of quite interventionist diagnostic techniques whose purpose is to build up a diagnosis: the medical literature of the situation that operates or tries to operate the identification of one or more pathologies in the body or mind of the patient.

The diagnostic(s) determine the interpretive context that the clinic-epidemiologic knowledge provides to the health professional who can, then, offer it to the patient (if that happens) as an explanation to the situation and the therapeutics as well. When this process lingers on, he refers to it as a "disease", that means, an entity that possesses a supposed autonomous existence and disconnected from the patient, despite being installed in his body and which has to be explained to the patient (generally, only named) and elected as the target and object of his attention, as an enemy to be fought and won.

It is worth point out that, about this medicine "theory of diseases" and from the current imagination in the medicalized world that diseases are seen as "things" associated to "lesions" to be investigated inside the physical body and corrected with some concrete intervention (Camargo Jr., 1993). It is unnecessary to mention that, even in specialized environments, the diseases' conventional and constructive way is extremely hard to be noticed, as one of the effects of scientific data construction is the deletion of vestiges of its own construction which grants it the appearance of pure objectivity (Latour, 2000a, b; Latour & Woolgar, 1997)<sup>2</sup>.

Through a knowledge and interpretation, it resulted in a movement of focusing the attention over the disease as a distinct and disconnected entity from the subject. It resulted in a specific perspective shift which set aside the subject's life and his sickness despite his existence conditions (social, economical, emotional, environmental, spiritual) and presented the physio-pathologic categories, etiologic and risk factors with which the biomedicine works with (Gonçalves, 1994).

At first this knowledge works in a self-referenced way. Thus, it ignores other perspectives or factors that are not those with which it works. In case the professional conceives or notes some distinct

relationship, in general, he won't be able to contrast it with the clinic-epidemiologic knowledge nor with the respective therapeutics pointed out through the diagnostic.

For instance, an infection is an infection, no matter the fact that it has been caused or involved in some emotional, existential or environmental disorder. In general, some "psy" diagnostic may be established, but then it reminds of the psyche-soma dichotomy. It is, very often, impossible: an "otitis" in a nursing due to the "cold wind" is only an "otitis". A correctly investigated and well chemically controlled "blood hypertension" with years of evolution is a "hypertension", no matter if it started specifically with the loss of a loved being or if such a pain remains for decades up to the point of initiating cathartics weeping in relation to the second question about the theme. Even though some late measures can be taken about the "emotional" problem (psychotropic? psychotherapy?), high blood pressure will only be treated independently while it remains high, in parallel to other interventions for "other" diagnostics. Such examples demonstrate these dichotomies and limits are also inscribed in this type of knowledge.

Having the diagnostic done, the patient is "invited" to accept the technical interpretation of the professional. Even though there are some relevant cultural differences, as most of the times it occurs in Brazil, there is a certain level of success in the appropriation of the biomedical interpretation by the patient.

Yet the medical knowledge points out to deep causes in the patient's life, as it commonly occurs in chronic diseases, this, while a subject, practically does not appear: he is the carrier of genetic, behavior risks, etc, all the things concerned with his lived life, but that comes to be strange within the biomedical isolation and objectiveness. Besides that, even if the diagnoses are syndromic or only descriptive, they cause the symptoms' objectiveness. These will, supposedly, receive a local intervention (specifically directed), which will have to deviate attention from the subjects, according to the way previously mentioned.

The diagnostic follows the therapeutic. The biomedical therapeutic intervention can be summarized into three great groups for discussion:

- 1) Fight and eliminates etiology if possible. It is common in the so called infectious and parasitic diseases, in which an agent, a parasite or a microorganism is identified as being the only cause of the disease. This kind of acting reproduces and reinforces an already operated movement by the diagnostic act. It is relatively poor from the increasing autonomy point of view no matter saving

lives, which is not trivial. This is one of the few areas of biomedicine in which physicians speak about healing without causing a malaise and in which its efficiency, in the severe cases particularly, is practically unquestioned by people.

2) The intervention in the psycho-pathogenic mechanism or in its expression for its control: it is used in all the non-infectious and chronic diseases in which nobody knows “only-one cause”. It happens most of the times, especially in chronic ones. This kind of therapeutics is the great bulk of biomedical therapeutics knowledge and it is involved in deep identity transformations, in the practices and representations about health-disease of these patients considered as incurable.

3) The fight against the symptoms is a third proposition of therapeutic action that needs to be mentioned, not by some own specificity, but by its economical and cultural power, its social dissemination and ideological expansion in the biomedical environment and among the population. In fact, this kind of intervention would belong to the former type, as it is concerned with intervention in the semiogenic mechanism to control the expression of subjacent psycho-pathogenic processes which are, most of the times, unknown. But the cultural, symbolic and emotional power (commercial and industrial as well) imposes the fact they have to be categorized aside.

The link between the symptoms fight and medical knowledge is ambiguous. It occurs due to the ethic duty of sedating pain and relieving suffering as a general rule and mock in the medicine doctrine. However, it mixes itself with the professional comfortable attitude and with the impotence of the biomedical knowledge when it is confronted with complains and sufferings not framed in the nosological board. Without being able to make sense or a satisfactory interpretation to sickness and complains, remaining descriptive diagnostics, the physician has to appeal to vague notions of somatizations, functional and/or psychological disorders to which the proximity of biomedicine is little. Such symptoms are, probably, most of what is reported by patients. That is why there are symptom inhibitions, highly medicalized and with an almost irresistible appeal. On the other hand, even when it is possible to define some diagnostics, the therapeutics is restricted, many times, to the fight against symptoms.

These three kinds of interventions are carried out by there types of technologies: pharmacologic, hygiene-dietetic (already mentioned) and surgical. These technologies, in any of the therapeutic types of intervention, present problems of diagnostic act about their relationship with the autonomous action. In general, they reinforce the heteronomy, focusing attention in the pathology or symptom which will receive (idealistically) a specific treatment (Sayd, 1998).

Through these two categorizations (intervention types and technologies) associated to the previous considerations about the diagnostic moment in biomedicine, it is possible to notice some little contribution of the clinic-epidemiologic knowledge for the increasing of the autonomous action. Summarizing these considerations, it is possible to say that the biomedicine conceptual structures and its socio-cognitive practices, synergistically with other not analyzed forces, impose limits and problems in relation to the challenge of re-structuring the autonomous action and thus contribute, in an important way, to medicalization.

Using the technology types proposed by Merhy (1997a, b) and Merhy & Chakkour (1997), it is possible to say that the “hard” side of the biomedicine knowledge (while a soft-hard technology) goes beyond and predominates excessively over its “light” side. The clinic-epidemiologic paradigm largely dominates the conceptual, symbolic, and practice universe of professionals and biomedical institutions. It shows itself to be little permeable to its “light” pole and to the emphasized aggregation of other “light” knowledge (as those of “psy” type) which enable a better intermediation in the interactions between professionals and patients, especially in what the restructure of autonomy is concerned.

The knowledge generated in biomedicine enlarges the heteronomy capacity of material intervention in the body and in the conceived and known physio-pathologic mechanism. It converges technically, philosophically and politically with the social medicalization, *hygio-mania* and domination, but it is still inadequate when it is a matter of considering it as a technology which promotes autonomy. It is highlighted the importance of this knowledge and its techniques which are valuable in cases when severe sickness, emergence situations, politraumas, fractures, advanced stages of instability and organic collapse require some kind of interventions in which they are efficient and able to save lives. It is only important to recognize that the situations in which it occurs represent a small amount of the general health problems and of those which end up at health centers or PSF.

### **Suggestion to approach the problem**

Having discarded naive illusions about the power of biomedical knowledge and tradition as emancipatory<sup>3</sup> tools to basic health care (clinics), it is discussed in the sequence, some strategies that are suggested to face the problem, from institutions everyday practice point of view. The suggestions are focused in a typical moment of attention to the biomedical health: the medical appointment.

It is important to clarify that the suggestions only make sense when inserted in a group of institutional, multi-professional and management activities and efforts that are coherent with the unmedicalized “philosophic practice” which is suggested ahead. The dilemmas of medicalization should be approached in the following actions: beyond-medical-appointment, intersectorials, group, educative, politics, sanitary, along with cultural, political, educational institutions, etc. These actions, though not the skopos of the article, are essential to avoid an uncontrolled medicalization which the medical appointments offer usually creates.

Nevertheless, even in a contrary institutional environment, these suggestions intend to add to the improvement of what happens during a medical appointment and also guide local managers into the discussion and evaluation of the clinic which is practiced in their services.

It is defended the urgent need of building up criteria and knowledge for the recognition, increasing and dissemination of innovations on the medical practice towards a broader clinic (Campos, 1992, 1997a, b; Cunha, 2004); something similar to a “deconstruction” of the hegemonic clinic and the creation of new modes and approaches to health problems (technically diagnosed or not).

The summarized suggestions that follow are based more into practical experiences than into literature, though some of them are, former orientations of the good clinic which are forgotten, nowadays, or restricted to the discourse. It is important to remind that they are only effective if admitted as a group as they are all interdependent.

1. The first one is the selection of the medicalization theme as the object of attention in everyday clinic. As a self-analysis and self-improvement tool, the issue of autonomy-heteronomy is a powerful analyzer of medical care everyday practices (Campos, 1992). In this sense, two basic components are always focused every time someone searches for help in a health service.

The first component involves the wish to recognize and legitimize sickness and impotence faced the experienced situation. It is then presented the expectation of a compassionate and solidare attention as well as an answer from the therapist who is able to interpret the sickness and also provide a treatment. There is also, and usually, a strong projection of power over the professional as well as in the examinations and drugs used. This first component involves a certain passivity which increases the more medicalized the patient is. Both the complete satisfaction as well as total frustration from this expectancy creates a tendency to repeat this movement for the next medical appointment,

examination or with another specialist. This is the field, internal to the user, in which dependency, medicalization and heteronomy increases.

On the other hand, there is a second component in the search for health care: it involves initiative, hope and wish to find a healer who indicates what the problems are and what to do to heal or make them better. There is openness, even though hid, to an encounter whose mainly result is the way to healing, freedom and health. If explored, this side can become a source of unsuspectable capacities and engagement into actions that generate more autonomy, participation and responsibility, revealing an innovation and resistance potential.

In order to carry out an “unmedicalized” health care (which promotes autonomy), the professional shall satisfy, up to a great extent, the first comment mentioned above. But, simultaneously, he shall offer action perspectives, interpretation for its problems, ways to maintain hope, therapeutics that can be the possibility of a movement towards solidarity and sustainability, responsabilisation and live learning, which means, the ransom of autonomy.

Within this double necessary movement of recognition of his momentary impotence situation in which health-disease is concerned – which allows to establish this link - and of an invitation/offering to a new movement towards autonomy, the professional challenge will be that of stimulating the user to the second component, searching for a more efficient and appropriate, sustainable, viable therapeutics able to be accessed and developed.

2. A crucial issue to the success of these efforts is the decisive idea that is up to the professional, as an indispensable item to fulfill the “healing relationship”, to offer the patient an interpretation of his disease that makes sense to him in order to try to reorganize the patient’s representations, fears, anxieties and wishes. This, usually, involves dialogue and explanation about causes, treatments and prognostics. Such an interpretation may be temporary, partial or it can be postponed to a subsequent meeting. What counts is that it needs to be approached and personalized, even though it means an increase in ignorance and difficulties of dialogue due to communicative or language blocks or cultural otherness. To accept this healing to function either totally and emotionally or permanently and repetitively, in each meeting (and then build up a *symbolic efficiency* according to Lévy-Strauss, 1975), it takes a meaningful unmedicalizing power, since it is followed by the other proposed suggestions.

3. In a medicalized environment, there is a complex paranoia, a constant fight against severe diseases and their risks which, on their turn, add to medicalization. It is suggested that physicians do not slide to the compulsion for establishing a diagnosis (having it done when possible), considering risks and benefits of therapeutic, economic and social nature prioritizing, at first, the therapeutic consequences. It is essential to any clinic to learn what Kloetzel (1980, 1999) called “*demora permitida*” (*allowed delay*), even though it is not easy to be learned. It becomes possible and easier in an environment that allows a longitudinal follow up of patients (within time), which is allowed through the PSF and is one of the most fundamental changes implemented by this strategy.<sup>4</sup>

The biomedical tradition works as if it had accurate diagnostics. The scientific technology will enable an efficient treatment of diseases and, consequently, of patients. This is a necessary presupposition, though not enough and many times imperfect in both its parts. Therefore and at the same time, it is necessary to focus the patients’ treatment. It is important to develop emotional, cognitive and technological abilities to approach the experienced diseases without the compulsion to enclosed diagnostics or without keeping a great level of diagnostic uncertainty, which is quite common with an emotional tranquility. This, in fact, improves self-critics, diagnostic competence and intuition; being this last one of a great importance to the clinic practices.

4. When diagnostics are given, it is necessary to focus on words. Particularly, one must not shut patients’ destinies down with names of diseases and their unhealing or lack of control feature since both are related to scientific medicine patterns and whose power of prediction about patients’ private life can vary a lot. Diagnoses are similar to a static picture while life is in a complex and endless movement or can, eventually, enter in it. Thus, it is important to take care instead of depriving the patient from the knowledge and medical statements about his/her situation. Biomedicine is a limited and restricted knowledge. The complexity of diseases, the multiple dimensions involved (social, emotional, environmental, existential, cultural, etc), the human’s nature amazing healing capacity and transformation demand that one must not summarize all the interpretative possibilities to biomedical diagnostics and the therapeutic potentialities to the scientifically current treatments. This directive is associated to the process of absolutization of personal and scientific limits, which are always hard to be accepted; thus, creating “mislead” in patients, as well as bilateral frustrations and symbolic iatrogenies. This absolutization is also related to an epistemological arrogance inherited from Science, according to which valid knowledge is restricted to those that already scientifically validated (Tesser, 2004).

5. In this sense, another challenge consists in not to succumb to the tendency of building up and fixing the myth of the disease entity that the patient holds, neither to the patient nor to the professional. That means, try to *disontologize* the disease and the suffering, giving them back to the patient, sharing his/her anguish and searching for appropriate therapeutics for the situation. It requires a deep cultural change in the physician imagination which has not started yet and will be endless. This is a necessary and viable change if we ransom the character who does not have a place in the “diseases theory”: the sick patient. In biomedicine, patients and their lives orbit around diseases. The necessary Copernican revolution within this medicine implied making the diseases orbit around patients and their lives. This, in the specialized environment of the scientific knowledge construction is not even conceived. But, in the clinic practice, it is made easier and it may happen with a simple but deep focus change which, little by little, alters all the cognitive process of clinic logic (Tesser, 2004).

The end of an appointment may not be just a prescription, the requirement of an examination or referral, but the beginning of a new dialogue basis centered in the patient’s situation and suffering, his psycho-existential conditions and, mainly, his therapeutic challenges and other interpretation possibilities. During this investigation and intervention, both the healer and the patient can enable a clinic improvement and a progressive autonomy.

6. Another challenge for the biomedical clinic is the ransom or reconstruction of former technical-ethic generic directives which offer safe orientation and hardly ever pursue a practical consequence in professional behavior. One could be "*primum non nocere*", "first, not being harmful". Every intervention, in which the relationship therapeutic risk/benefit is doubted, should be avoided at first. Another aspect is the sense of protection the professional has in relation to the patient: protect him, through biomedicine, from the imminent health dangers or harm that might be threatening him either with risk of life, complication or an important sequelae, for instance. It is also important to mention the protection against dangers into which biomedicine can be transformed when used carelessly, that means, only conventional technical criteria, disconnected from the user’s life (what has already been called as quaternary prevention).

7. Another mission of the professional is to demystify the powerful and controlling action of the chemotherapics, especially the symptomatic ones that attract and enchant with its momentary potentiality to relieve symptoms. This can be done by talking to the patient and explaining him about the other side of the situation: transitory effects, contrary effects, possible rebound effects; the possibility of the symptomatic intervenes in semiogenic mechanism only, etc.

Taking the reflections already mentioned into consideration, we can say that all the symptomatic chemicals have to be avoided, at first, by several reasons. Every symptom is, by hypothesis, an alarm signal of a subjacent, known or, most of the times, unknown process. To turn this alarm off is not advisable, besides being not only alienating but also a stimulus to consumption, to the dependency of drugs and to the search of a chemical management to any sensation or pain. We can notice stylistic and cultural limits of biomedicine which, many times, is obliged to intervene chemically to relieve symptoms. However, this is greatly softened by: 1) means of a good relationship healer-patient and by fulfilling the healing relationship which maximizes well-oriented non-chemotherapeutic measures and 2) through several therapeutic resources from other medical fields or even popular or homemade therapies. Once they frequently refer to the therapeutics and the patient's care to his own life, such alternatives make the questioning about his problems ("Why" and "How") easier through the search for solutions, understandings and autonomously management preventions.

If symptomatic chemicals are used, it has to be done during a strictly necessary time in order to achieve their purpose: rapid and momentary relief of symptoms and always with the necessary orientations about drug characteristics, its power of action and possible side effects. It is recommended to face the symptomatic the way it is, that means, as only a momentary relief that enables not only the search and practice of other movements with a more effective therapeutic action over the problem itself but also the patient's ability to administer it autonomously.

8. It is also important to mention two typical physicians' characteristics which are highly problematic in basic care. The first one is the biomedical authoritarianism derived, up to a great extent, from the intra-hospital learning and its authoritarian tradition, which will hardly be fought against in professional environments. Particularly, in health centers, it presents disastrous consequences such as the promotion and negotiation of therapeutics, the legitimization of the healing relationship and the adherence from patients which are brought into question at every moment (Cunha, 2004).

Associated to this biomedical, relational and emotional, idiosyncrasy there is the obsession of controlling. Both are learned, in school hospitals, by similarity before any kind of reflection and totally immune to a rational approach. According to Lacey (1998), control is a scientific value of first order. It is deeply rooted in the structure of scientific knowledge and, especially, in medic knowledge. Diluted in physician cognitive processes, controlling, understood as a value, mixes intrinsically with authoritarianism creating relationships and medicalizing difficulties of a great proportion in basic care clinics. The suggestions for this problem go through long term learning – emotional, cognitive and rational – about the (official) healer's increasing responsibilities without the illusion of obtaining

control with what can be called *curanderia* (folk healing) – that counterbalances the inner authoritarianism and arrogance of physicians. The continuous care environment of a group of patients, provided by PSF, seems to be the fastest way to treat these medicalizing idiosyncrasies in the professional graduation and in permanent education as well.

9. The practice of these suggestions implies a continuous search for therapeutics that improve the clinic and symbolic efficacy, besides the patient's autonomy always taking into consideration shared evaluations of risk-benefit therapeutics. That means to nurture an eternal search for interpretations and therapeutics which, at first, do not need to respect any medical logic (Cunha, 2004; Tesser, 2004).

According to Almeida (1996), the therapeutics is the greatest provider of feedback, a real retrofitting to the medical theories and practices. Nevertheless, the biomedical therapeutics and its feedback are “tied” by the scientific methodology of clinic essays which monopolized the legitimacy to say what “really” happens or not as a direct result of health treatments (Tesser, 2004). The therapeutics “imposes, obliges, constrains the thought and action in the search for a purpose; it is genetically theological” (Almeida, 1996, p.174). For this author, the search premises for a therapeutic result affect the doctrines frontiers. The nature of the therapeutic field not only allows but also requests eclecticism, an excluded category from the scientific medicine. “In this perspective, eclecticism would mean a medical determination to a broad capacitation or, simply, to admit a multiplicity of therapeutic resources and medicines whose access is the right of the patient” (Almeida, 1996, p.168).

To improve biomedical care and open the way to recognition, research and use of other therapeutics and medical rationalities, it is crucial to bring out this re-valorization of therapeutics which requires an eclecticism that causes empiricism to emerge. Then, it is possible to open way for a clinics reconstruction and open basic care to the enriching and broadening of health practices, biomedical ones or not. As a consequence, there is a possibility for the development of more efficient therapeutic actions which promote autonomy and restrict medicalization as much as possible.

To finish, it is worthy to highlight that the construction of a less medicalized clinic practice tradition in health centers and PSF is an urgent need, not only to the professional graduation, but also to a permanent education. The relative youth of SUS and PSF as well as the difficulty to interact with the medical graduation explain, up to a certain extent, the backwardness of this construction. And, in case it remains, it may affect the potentiality of the PSF and the investments in health centers. In fact,

it means the danger of acceleration in social medicalization, in case the PSF develops without enabling innovation regarding the clinic it offers to its users.

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<sup>1</sup> The term “clinic-epidemiologic”, usually similar to “biomedical” is used here only to highlight that it is about an integrated group that involves the subjects and statements both from epidemiology and auxiliary subjects and clinic and auxiliary subjects as proposed by Camargo Jr (1992a, b, 1993) as a clinic-epidemiologic paradigm to guide biomedicine. In this way, we avoid explicitly, the tendency to disconnect clinic (medicine) from epidemiology (collective health).

<sup>2</sup> To a critic and epistemological view of this ideas, see: Tesser & Luz, 2002.

<sup>3</sup> It can be said that every tool hard enough carries, within its structure and conformation and in its working, values and purposes that are projected for its usage. It is impossible to tight a screw with a bolt spanner. However, it doesn't mean one cannot distort a tool or use it with adaptations, certain difficulties and limitations to distinctive purposes from those carried within it. This is exactly what is proposed as follows.

<sup>4</sup> The importance of a longitudinal follow up is yet undervalued to a permanent education and medicine teaching in what its potentiality to increase the clinic quality is concerned. Such possibility, almost obstructed by the hospital environment, by biomedicine specialization and its centrality in diseases-entities has a vital importance for the construction of an innovative tradition that compensates the inadequacy, danger and iatrogenies of medical practice in health centers (as well as its perception) and, particularly, to social medicalization.

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