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Producing bodies, illness and treatment in the clinic: case presentations and medical records

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ABSTRACT

The article analyzes two types of practice involved in medical training — case presentations and the annotation of consultations in medical records — that play a fundamental role in divesting patients of their personal qualities and reconstituting them as an objective body, a set of organs, the site of a lesion and the object of intervention. The ethnographic material presented here is the result of observing case presentations made by students to their tutors in a cardiology outpatient clinic at the University Hospital of UFBA. The article highlights the role of scientific and technological conceptions in this process. It also shows that both the case presentations to tutors (a descriptive and performative type of speech) and the written notes in medical records (a training practice that both shapes speech and reflects it, thereby authorizing the student) are procedures for objectifying the patient that depend on interpretation, although this takes place in surreptitious form.

Key words: Medical training, Biome-dicine, Body, Objectification, Medical practice

> Fabiana, medicine student, a little over twenty, blonde and short, attends to Mrs. Magali, a very fat black woman who appears to be around 60 years old. At the start of the appointment Fabiana speaks in a low and hesitant voice, seeming not to have entered into character and, for this reason, tries to improvise in the role of doctor without showing much confidence in her performance. As the encounter proceeds, however, she becomes more sure of herself. After concluding the first part of the consultation, in which she obtained information concerning her patient (filling in a form with socio-economic data, obtaining the history of her afflictions, listening to the symptoms, jotting down the results of laboratory analyses, and carrying out the clinical exam: measuring arterial pressure and heart

rate), it was then time to present the case to her evaluating tutors, so that they might deliberate on the appropriate treatment and/or suggest further exams.

Due to the temporary absence of the two people responsible for the clinic (a cardiologist and an endocrinologist), she began to discuss the case with Alberto, a resident cardiologist, all the while remaining in the very same office in which she had attended and before the patient whom she had just seen to. The conversation ran smoothly up until the moment when she asked if she should advise Mrs. Magali to take walks. The resident found the answer to this question in an exam that showed the parts of the patient's heart that were congested. He commented – still before the patient – that the case seemed exceptionally serious, noting that the exam showed a homogenous result, which suggested that everything was either congested or uncongested. Since she had had an AMI and is very fat, he went on, the former is the more probable hypothesis and that, for this reason, her state was exceptionally serious (he repeated himself) and she should therefore be barred from any type of physical activity.

Fabiana and Alberto did not seem at all concerned with the fact that they held their conversation in the presence of Mrs. Magali. It was as if that conversation did not concern a person whose life appeared to be at risk. They spoke of information registered on a form, of printed images that represented the material present in the interior of a body whose nature was itself purely material.

The discussion of this case develops in interesting ways, but I will interrupt the narrative at this point. Everything up until now seems to be a perfect fit with the usual critiques of medicine's dehumanization of its patients, of its tendency to reduce them to mere objects, to bodies of a biological nature, destituted of subjectivity and of relationships with the social world. What is medicine in this view? It is the application of knowledge in the search for an objective, neutral and rational answer to a pathology situated in the body.

But what if we were to change the focus somewhat and, instead of trying to say what it is, we were to inquire into the way in which it comes about? In this case, if medicine objectifies patients, the questions we must ask are: how is this process carried out? How does it succeed in emptying a person of her human qualities, and transforming her into a material entity with a pathology? Which interpretative procedures are advanced in order to produce an objective version of the ailment – an ailment which, for the person suffering from it, is a lived condition and not a simple biological fact?

Following this path in our discussions of medicine and its forms of objectification implies precisely in not considering objects and objectivities as givens, but in treating them as

a practical outcome, as a means for determining and framing that has the characteristic of covering up alternative framings and perceptions, and of eclipsing the very process of interpretation involved in the constitution of objective reality.

This article will focus on the ways in which these objectification practices are learned. Even if we argue that our culture is pervaded by a biological conception of the body as something that lives among a number of other things of a material nature, and that disease possesses a real, carnal substrate, when we consider the experience of our own body we do not understand it to be an entity that is separated into physical and psychic components. Instead, we understand it as an ambiguous mode of being, a union of these two dimensions that contains a sedimented history of habits and abilities acquired through a specific trajectory. It does not, therefore, correspond to a mere aggregate of physiological processes, but rather to a way of being in the world (Csordas 1993; Casey 1998)

For someone to enter into a universe such as that of biomedicine, which conceives of the body in a manner so different from the way it exists in our own experiences and history, it is thus proposed that it is necessary that the person undo and reconstitute – if only momentarily – her previous sense of reality. This requires an effort towards learning not only the contents of a specific discipline, but also attitudes that take shape during coexistence with trained professionals who offer a series of lessons on how to extract the general configuration that constitutes a person as a medical case (Good 1993). In this process, some abilities are refined, others developed, resulting in a type of knowledge that becomes a dimension of their identities.

More specifically, I intend to detail and explore this issue through a study of two types of practice that are a fundamental part of medical training, and which are deeply implicated in the process of reconstituting the person as an objective body, as a set of organs, a bearer of a lesion and the object of medical intervention: case presentations and the recording of the consultation in medical files. The descriptions that will be presented here are the result of ethnographic observations carried out at the Hospital of the Federal University of Bahia (UFBa Hospital), an institution that not only provides assistance, but is also a place of learning. I will thus begin with a brief description of the ward and of its functioning.

A brief outline of the cardiology unit

On the afternoons of every Monday and Wednesday, I crossed the huge entrance door to the UFBa Hospital and walked past an ample hall until I reached a wide and dark corridor, with heavy wooden benches on one side, jammed with people. On the left, in a hot, dark and cramped room, I would meet with medicine students, residents and doctors who worked at the hospital. I was in the cardiology ward, an outpatient unit whose functioning I followed for two years – recording appointments and interviews, holding conversations in the waiting

room, and observing what went on in the tutorials. The roughly 1000 men and women who were being treated, most of whom were undereducated, over fifty years of age and working class, suffered from cardiac ischemia, dyslipidemia, and many of them also had diabetes.

In the hospital, the area reserved for the ward (lent out by the physiotherapy department) was precariously divided into three rooms in which six “offices” operated, one being separated from the other by cloth screens. There was also the small room I referred to above, which functioned as both a place for organizing work and an area for tutorials. This is where students, residents and tutors would talk amongst themselves, while the patients waited in the “offices” to hear the deliberations on their case.

During the course of one afternoon, an average of twenty people were attended by six interns, all students in their third or fourth year who were fulfilling their annual extracurricular residency requirements. There were twelve in all, and they divided their time between two days of appointments. Two tutors, or preceptors, supervised the students, and two cardiology residents would help them. The interns had to attend to the patients, fill in the forms with the latter’s data, present the case to the preceptors, register the appointment in a file, fill out prescriptions, carry out certain tasks linked to work organization and also attend the weekly cardiology teaching sessions.

During my research, I spent most of my time with the students who had recently joined the ward. When they arrived, they behaved fumblingly. They were unfamiliar with the jargon of cardiology and easily discomposed when the preceptor would ask them questions such as: “what is the functional class of angina?”. In time, they began to familiarise themselves with the terminology, and some of them became quite fluent in the medical vocabulary of their specialty. However, it was not only cardiology and its jargon that the students were learning. They were also learning how to deal with a patient, to present a case, to fill in prescriptions, files and reports, as well as how to relate to doctors and colleagues.

In spite of their hesitant demeanour when in the presence of the preceptors, some students already knew how to play the part of the “doctor”. This was particularly true when they dealt with their patients, and many seemed to have a sort of internal switch with which they turned on or off the “doctor” function. At one moment they would behave like students, worried about their classes, exams and recreation and then, in the blink of an eye, they would transmute into doctors, speak in voices of authority and carry themselves with certainty, only to then shift back to the personae of timid students before the tutors who were evaluating them.

Generally, they attended to patients in the following manner: the student arrived around 13:00 and found a list of patients, their medical files and forms stacked in the order in which they arrived. Each student would then seek out one of the available “offices”. There would be some dispute over the best ones, since the cloth-screened units were not exactly

equivalent in terms of privacy, lighting and quiet. A pre-work scurry for the available chairs and tables was also a common fixture. After the battle for space and furniture was over, the students would ponder their patient's file and begin the appointment, or, rather, the first stage of the appointment in which they would gather the data that they would later present to the preceptors. Once this was done, patients remained in the waiting room while the intern left to argue his case. After the discussion, he would return and bring with him a prescription and a form soliciting exams.

The to-and-fro of appointments could last for over an hour, which some of the staff of the clinic found excessive, discreetly expressing their criticism at the administration. Students were thus asked to shorten the length of the appointments. They, in turn, criticized those colleagues who took longer in their consultations. Furthermore, preceptors discouraged long conversations during case discussions, insisting that expositions limit themselves only to what was relevant to the issue at hand.

The time spent by preceptors, residents and interns in the ward was not, however, wholly dedicated to consultations and the discussion of cases. Between one case and the other, or when no preceptor was around, conversations often drifted in other directions. These were occasions for more informal chats, even if these too often swung towards their chosen profession. Students would speak of their specialty and the type of practice that they hoped to have in the future. The way that these topics were brought up confirm what Goulart (1998) has shown: that, despite changes in the job market, what medicine students want from their career is to have their own practice with a large clientele.

But these conversations did not only concern professional matters. One's own personal affairs (or that of others), exceptional cases and entertaining anecdotes were also among the themes that enlivened work intervals. Humour always found a place in the confines of that small room, and this contributed towards a more congenial atmosphere in a place in which young people had to deal with difficult situations and patients faced heavy dramas.

The outpatient clinic was the place for a peculiar encounter: young people who listened to the suffering of others rubbed shoulders with doctors in different moments of their career and their lives and with varying degrees of experience. This is an important factor in the training of students, and not only in the more obvious sense that students are there to obtain knowledge from those who have it. The coexistence of a plurality of voices speaking about the profession and their jobs, and also about hospital negotiations concerning the use of space and equipment, allowed students to profile the life and career of a doctor. It therefore becomes progressively more evident to them that being a doctor implies more than the simple application of scientific knowledge in the intervention of a pathological process or a lesion. This occurs in spite of the explicit value given to the technical expertise acquired during the

clinical phase of their studies (Menezes 2001; Ronzani e Ribeiro 2003). This accrued knowledge has not gone unnoticed in social scientific reflections on medicine. Let us briefly offer a synthetic and far from exhaustive review of some of these ideas.

Some notes on the social science literature on medicine

In the contemporary world, technology and science pervade our lives, being embodied in our daily existence. Medicine is one of the spheres of social life in which technological and scientific conquests make themselves present and in which they reveal themselves to be spectacular: they enable safer and more precise surgical interventions, the understanding of our genetic makeup, the production of more potent drugs, the visualization of the body's interior, the discovery of pathologies that have not yet appeared as symptoms, and so on. Science and technology point us towards infinite possibilities for correcting nature, and allow us to envisage a future without disease, suffering and – who knows – ageing and death. At the same time, we hear of dissonant voices that suggest that medicine is undergoing a crisis. What does this crisis have to do with medicine's more salient, successful aspects?

In order to understand this question, we must first reflect on the relationship between science, technology and medicine. Although certain naïve views welcome the advances made, and, consequently, the increasingly more effective interventions on the diseases that afflict us, the anthropology or sociology of health demands a more critical perspective. It is generally argued that the presumed success of medicine goes hand in hand with its tendency towards controlling and normalizing existence. It is believed that this occurs at the expense of the human dimensions of illness, treatment and cure, since medicine is characterised by a biologically and individually determined view of the body, disease and cure (Martins 2003; Caprara and Lins e Silva 1999; Koifman 2001; Acioli 2004; Scherer et al. 2005; Martins 2004).

The model of medical understanding relies on the objective apprehension of a natural event, and it purports to be based on solid certainties that stem from the supposed stability of things and bodies. According to Good (1993), for medicine to fulfil its promises of a continuous progression, it is required to remain committed to rationality, neutrality and scientific objectivity. Yet the fact is that these ideals are never fully realized in the clinic (nor are they realized in science, but that is not our present theme).

The ideal of medicine as science and of the body as thing of a material nature raises many questions, and distinct approaches have sought to account for the relationships between the biomedical model and the clinic. Some authors have focused on the type of knowledge acquired by doctors and on their reasoning during their activities. This is the case of Camargo's (2005) work on the ways in which medical knowledge is acquired and renewed. He shows that the knowledge applied in the clinic involves the incorporation of diverse

information, some of which is implicit and contradictory, and which furthermore contradicts practical activity. This fact points towards a fundamental distinction between the knowledge that works in clinical medicine, which is supposedly based on scientific medicine, and the image that we have of science as a methodical, rational and coherent activity.

Koifman (2001) also focuses on the question of knowledge in his analysis of changes to the curriculum of the Fluminense Federal University in 1992 – changes that were guided by a more humane view of practical medicine. Like Camargo, she points out the existence of fragmentary and contradictory views within medicine, and of the impossibility of conceiving of its knowledge base and practice as anything approaching the universality of a scientific concept. A recognition of the inevitable interweaving of medical knowledge with its practical contexts, however, does not prevent the author from affirming that medicine is pervaded by a biological determinism that is rooted in specialization, and increasingly centred on the use of technology. This latter fact ensures that the effective integration of subjective and social dimensions with the practice of medicine remains difficult. We can here ask a further question: since the biomedical standard of science that pervades the ideal model of medicine does not materialize, how does it manifest itself in clinical activities? What are the consequences of the adoption of this standard for the encounter between a doctor and his patient?

Studies clearly inspired by Foucaldian analyses consider that this materialist and mechanical understanding of the body, which is an essential component in the way that medicine is configured, results in biological reductionism and in the destitution of the patient from his rights over his body, his right to "live, grow ill and die in a manner that suits him" (Martins 2004: 22). Medicine is here characterized as being a sphere of activity that is in tune with the more general process of normalizing life and existence in our society. In line with the critiques of the submission of the individual to diffuse mechanisms of power and domination, we have here an attempt to make evident the moral facet and political dimensions of medicine that are otherwise covered up by its pretence scientificity and the universality of its knowledge, and which lead it to adopt a totalitarian position by mixing up the quantifiable aspects of reality with reality itself.

Other studies do not emphasise so much the moral or political aspects of medical science, but seek instead to elucidate the dynamic connections between medicine and other spheres of social life by focusing on the relationships between medicine and the market. It is argued, for example, that interests of capital inflate the production and use of technology, transforming doctors and patients into raw materials of production – a situation that seriously atrophies the care-taking dimension of medicine (Merhy 2000). One of the problems behind these types of affirmations is that they state their claims in such a generic and apparently evident manner that they lose sight of the fact that capital only makes itself present in clinics

through a series of mediations. And if capital does indeed transform everyone into mere components of its machinery, it is necessary to make evident the ways in which this is carried over in practice. A more fine-grained approach to actions and experiences therefore remains lacking in these studies.

Without neglecting the importance of science and technology in medicine (nor its relationship with other social domains, such as the market or politics), some authors nonetheless argue that the clinic is not merely a place where knowledge and expertise are applied. Schreiber (1997) draws attention to how practice is anchored in specific, pragmatic contexts that condition the ways in which a professional develops his activities. Medicine's two facets – on the one hand art; on the other, science – is also taken up as a theme, as are the many contrasts that animate a doctor's day-to-day affairs: duties/difficulties, expertise/ethics, physical aspects/communicational aspects. The tension that exists between these poles makes the practice of medicine particularly difficult. According to the author, the fact that in our culture we are inclined to seek the certainties and guarantees offered by technology and science, or, more precisely, by their projected images, does not preclude the existence of subjectivity and judgement. In moments of uncertainty, then, doctors should guide themselves above all by ethics.

By following a trail of research that leads to the discovery of elements that are apparently alien to science, but nonetheless evident in medicine, we reach the matter of emotions. Affect, which we tend to think of as something that disturbs the neutrality required of any scientific practice, nonetheless makes itself evident to those who seek it out in speech and actions. But things are not quite so simple. The curriculum is silent on how to deal with death and the suffering that ensues and, consequently, it ends up veering the student towards denial, in which he attempts to dissociate himself from his emotions (Quintana et al. 2002; Menezes 2001; Souza 2004; Hoffmann 1993). One of the ways of concealing the uneasiness that death brings is to treat it as a statistical probability or as a simple natural event. For Bonnet (2004), "feelings", in a broad sense (and not only the pain caused by a patient's death), are present in the clinic, and they constitute, along with the knowledge that had (for a time) been the privileged dimension of medical discourse, one of the structuring axes of tension within the biomedical field.

The attempt to stress these under-explored aspects of medicine – its artistic dimension (Schreiber 1997), emotions (Bonet 2004), culture (Souza 2001; Gilbert et al. 2006), and difficult ethical decisions (Menezes 2001) – has invigorated a social science perspective on it. I believe that this move is not only the result of analytical or conceptual changes, but also the outcome of a methodological shift towards ethnography. Studies carried out in hospitals, ICU's, wards and medical clinics, specify and add another tone and colour to the themes traditionally addressed in studies of the medical profession. It is certainly easier to embellish

the generic model of medicine as an activity that objectifies the patient, that reduces its professionals and clients to instruments, when we focus on the concrete situations in which doctors act and in which they deal with real people. This does not mean that there is no objectification, but rather that in practice it will always combine or be in conflict with the various other aspects that we have drawn attention to, and which are always involved in its exercise.

There is, however, something that I believe still begs for closer attention. This something is, precisely, the most obvious and unanimous aspect of medical practice: its processes of objectification. When the complexity and multiplicity of doctors' knowledge, contexts and ways of acting are made visible, there is a tendency to emphasise the significance of that which contradicts or embellishes objectivity, while the latter is treated as a given. It is perhaps time for a return to our old theme – so often the object of our critiques – so as to observe it with the same attention that we dedicate to the humane, social and existential meanings of medicine. A brief overview of case presentations and of the registration of the consultation in a case file – which, as Good (1993) argues, are essential components in medical training – will allow us to account for the field of interpretative practices involved in the objectification of the patient[1].

The discussion of cases

A student enters the world of medicine through the biomedical sciences: physiology, anatomy, biochemistry, etc. It is from here that he is inducted to the realm of de-personalized bodies; initially, in his studies of anatomy, he does not even come across conserved corpses in their integrity, but is rather faced with anatomical parts (Quintana et al. 2002). A student's initial steps are thus guided by sciences that apprehend the body as a mechanical and passive object (Goulart 1998). Furthermore, the (manifest or implicit) embodied epistemology of the curricula of most medical schools conceives of science as set of established facts, or at least of facts that that can be resolved. It views the world as an agglomerate of atomized units, without considering the provisional and contingent nature of all knowledge (Atkinson 1984; Corrêa 1995). It is only after a student's initial contact with dead and fragmented bodies that he is authorized to deal with living patients in hospitals or ambulatory care units (Goulart 1998).

A student's clinical training is marked by the experience of direct contact with the patient and his disease, which he had hitherto only encountered on a theoretical level. He is

[1] In his study of these practices, Good was primarily concerned with students' perspective on them. I will focus not so much on specific actors, but rather frame my discussion from the vantage point of the observation of the interactions and conversations that characterise presentations and the case file.

now face-to-face with concrete cases to which he must respond. The underlying idea behind this type of learning process is that it will enable the student to consolidate what he has learned in theoretical classes, to acquire practical skills, and to formulate the correct course of action to take before a disease and a patient (Sinclair 1997; Hobbs 2002; Geller et al. 1990).

In the outpatient unit in question, interns did not discuss cases in front of their patients (the case that I presented at the start of this article being an exception). Generally, they go in to the room where the preceptors are waiting for them, their papers in hand: hospital files, the ambulatory clinic forms, and the exam results brought in by the patient. In their conversation, students should display the new, distinct abilities that are expected of them. They should show that they have learned to exam their patients by touch, to listen and write in the formal language of the medical files, and also to speak with the patient, the preceptors and the other residents. It is the preceptor's task to advise on how to recognize certain symptoms and signs, how to analyse cases and exams, what standard of normality is expected and required, and what procedures should be used to treat a disease. Furthermore, they can suggest how to consider (or disconsider) the patient, and some of them come to be seen by students as paradigms of what a doctor should be and examples of how they should behave in their profession. In this configuration, residents occupy an intermediary position: they help out in the discussion of cases and they are free to go and watch catheterizations, but they are not fully authorized by the preceptors to take decisions.

According to Sinclair (1997), what is crucial for students at this moment is not so much their relationship with the patients, but with their tutors, since it is they who will evaluate them – and this evaluation is important for their career. The students' performance in the unit itself was certainly taken into account, but it was not graded; they did not need formal approval at the end of the internship in order to proceed with their studies. However, there were certain mechanisms that clearly showed that their performance was being evaluated. One of the ways in which a student's efforts were rewarded was by being offered a scholarship to remain linked to the unit, either working in research or as a monitor for the next class. Students would also often require letters of recommendation so that they could obtain internships in other research or teaching institutions. Only those students who believed that they had a chance would ask the preceptors for these letters, and those who had shown commitment (punctuality and assiduity, a careful regard for routines and organized procedures, interest in learning) would receive a flattering presentation and an indication to occupy the position that they sought elsewhere. Conversely, in one instance a student whose work conduct was deemed negligent, was removed from the unit altogether.

Even if other factors were taken into account in the evaluation of students, it was the way that cases were presented that was decisive. All of their qualities should have converged

into that one moment: seriousness, the ability to talk with the patient, to conduct a physical exam, to be familiar with the relevant jargon and the theme at hand.

Most case presentations began with information concerning the sex and age of the patient; a name could also be presented, but in many instances the patient remained anonymous. This was proceeded by the description of the disease and its history, which could take the following form: patient with a history of AMI (acute myocardial infarction); three years ago had an angioplasty intervention, with or without a stent (tube used to keep the artery open), or a complete or incomplete myocardial revascularization (a complete revascularization means that all obstructed arteries were unobstructed; incomplete means that some obstruction remains), hypertension for five years and diabetes mellitus type 2 for three years. Doctors some times found this information insufficient, and they may then have asked the student to describe the state of the coronary arteries, which chambers had suffered damages, etc.

The patient's history, as told by the student, is that of a process of disease, temporally and spatially located in tissue lesions and in dysfunctions of physiological processes. In the narrative of the case presentation, the patient who suffers from the affliction is presented as the *locus* in which the disease takes place. It may be said that, through a metonymic process, person and disease stand in for each other (Gilbert et al 2006). The student should be fluent in the narrative genre of case presentations, which implies the construction of a report through which the "person is framed as a patient and as a medical problem" (Good 1993: 79).

During the presentation, it is not only the disease and its time frame that matters, since the ability to properly report on the symptoms is equally important. The student should be able to express the patient's complaints, how he has been feeling, if he is in pain, if he lacks for breath, is tired and dizzy. If there are symptoms, these must be understood as either following from or being independent of the cardiac problems, and it is also necessary to try and establish what they may indicate. At issue here is not the use of symptoms as a guide towards a possible diagnosis, since patients already arrive in the unit as sufferers of cardiac ischemia and dyslipedemia. What is intended is the construction of the frame of his current condition through the interpretation of his symptoms and, above all, of the exams that will show if the patient's complaints possess a "real substrate".

Of all complaints, chest pains warrant the most attention. What the patient is feeling must be thoroughly investigated during the consultations, so that the student will obtain sufficient data to characterize the pain as either angina (following from ischemia) or as pain of another nature situated in the chest. At this moment of the discussion of a case, the preceptors tend to raise a series of questions for the students so that they may specify what the patient feels, in order to conclude whether the pain follows a pattern typical of angina and, if so, if it is stable or unstable, and of functional class 1, 2 or 3. If his answers provide little or

insufficient information, the embarrassed student is then told by the doctor to return to the office and "question the patient further". The need for a more detailed and clear description of pain is justified by the preceptor: since suffering is subjective, pain requires a meticulous investigation that will allow it to be stripped of its personal elements, so that only the information necessary for adequately understanding the symptoms remains. This procedure is one of the mechanisms used for determining the objective data of what otherwise appears most subjective: the patient's suffering.

Yet pain is not the only criteria for diagnosis or treatment. The patient's narrative is seen to be a type of veil through which the disease can be glimpsed, but it is not an objective testimony of his condition, and it therefore only serves as clues which must be confirmed through more solid evidence: exams, particularly those that use image technology, that enable the visualization of the arteries, the muscles of the heart, of the obstructed and unobstructed areas, etc., are a crucial means towards apprehending the reality of the condition. Images and the results that are obtained from them may be open to interpretation, but they are nonetheless dealt with as non-mediated, direct representations of the interior of the body (Monteiro 2004; Joyce 2005). The privilege that is accorded to these types of exams is evident at various moments, such as, for example, at the onset of case presentations, when doctors demand from students information concerning the obstruction of arteries and the state of the heart chambers (where there are lesions and where there are none). It is equally important in determining the way that the case is to be conducted – such as in the snippet at the start of this article.

Nevertheless, sometimes there are important divergences between what the patient narrates to the student and what the images attest. Attempts at accounting for these problematic discrepancies often lead to the admission that interpretative processes are at play in the evaluation of exams. In these cases, the belief in the image as a faithful representation of the interior of the body is suspended. This does not thereby imply radical doubt, however, nor does it lead to a relativization of the model of body and disease upon which western medicine is based. All that is allowed is that not all exams share the same degree of objectivity and that, therefore, the prudent doctor should base his decision on a set of exams, the analysis of which will result in a more secure decision.

Let us turn to an example. Dr. Alberto was discussing a case with Michele, an intern, who began by saying: "Rosa, a 36-year old patient, had an AMI two years ago". The patient had stable concentration levels of HDL, LDL, etc. A catheterization had only revealed an obstruction of 50% (lesions are only considered to be serious when the obstruction is over 75%) in an important artery, and nothing more. In spite of having an insignificant lesion, Michele argued that she complained of chest pains when under emotional stress; these pains, however, did not follow from physical effort. In his reply, the doctor first lectured on the causes of heart attacks when lesions are at 50%: the problem lies not in the degree to which

the artery is obstructed, but in the quality of the platelet, which releases a type of thrombus that clogs the artery. He then argued that, in the case at hand, the problem might not be in the artery or platelet, but rather in the results of the cardiac MRI, which depends on the interpretation of whomever watches the film. It is possible, he went on, that a professional claim that the artery is 50% obstructed, but this claim is somewhat "subjective", since another doctor watching the same film can conclude that the obstruction is at 75% or greater. The MRI depends on a degree of subjectivity and it cannot, therefore, accurately express reality. In his opinion, the objectivity of the matter should be established by further exams that will allow them to reach a degree of certainty concerning the patient's complaint. The latter will be real if its is backed by an actual lesion that is detectable through the use of these various instruments.

This example leads us to consider objectivity as something towards which facts converge when sufficient elements are brought together and when the possible discrepancies between them are eliminated or levelled. The "objective reality" of the disease is thus the result of an interpretative procedure, but, when the process is concluded, it emerges as something that was there at the onset, only waiting to be discovered.

But let us return to the case presentation. After the intern deals with the symptoms, it is time for the clinical exam. The student always provides information concerning the pulse rate and arterial pressure, and although these exams involve listening and touching, these are only mentioned if something positive is observed – that is, something that indicates a problem, such as edemas, crepitation of the lungs, etc. A report that is too detailed is frowned upon, and those who are fond of details are told to stick only to what is important. The student's clarity concerning what is relevant demonstrates to the preceptors his grasp of the narrative style of case presentation, as well as the degree to which he has matured. We should also keep in mind that even in those ambulatory units where appointments are long (and, indeed, often because of this) time is a critical factor. The need for concise presentations is thus linked not only to knowledge of the rules for good presentations, but it is also justified by the time constraint of appointments.

What is said also needs to adhere to a certain logic. If the student reports a finding, he must be clear on what these findings imply for the case at hand. If he does not do so immediately, the preceptor may ask questions that he must try to respond and justify. The questions asked by the doctor are typical of the questions asked by a tutor: he knows the answer, and he wants to test the student, to know if he is able to discern what is correct in that situation. When he asks "what is the functional class of angina?", he expects that the student not only responds with a number, but that he also elaborate on why it fits into that category. A logical argument is thus necessary. The totality of the narrative should be a concise and

coherent report. For this, it is essential that the student synthesise the long replies that he obtained from his patient, selecting only that which he judges to be relevant.

After the clinical exam, the next step in constructing the case is the exposition of the results of other, mostly laboratorial, exams. The levels of glycemia, of LDL and HDL cholesterol, of potassium, of hepatic enzymes, and whatever else is known are presented. The student may follow two strategies: he may only state what he believes to be altered, or he can report on all the results. The preceptors appear to have more difficulty in apprehending the meaning of this data simply by what they hear, and they therefore tend to lean into the student and glance at the file so as to read what it says.

It is certainly difficult to be attentive to information and to formulate a synthesis of the patient through nothing but a roll of acronyms and quantities. It is precisely that which is pure quantification – the ideal of good science – that fails to attract the spontaneous attention of the preceptor. On the contrary, he knows that he runs the risk of digressing, and therefore makes a deliberate effort at concentrating on this information. This effort is not evident at other moments, such as when he listens to a report of the symptoms. It is possible that what carries with it a human significance and brings us closer to the experience of another also evoke a more immediate type of understanding, which remains present in the clinic and is distinct from the understanding that takes place when we apprehend reality through formulas or quantities. This occurs in spite of medicine's positive assessment of what can be validated through instruments that measure physiological processes, lesions, and so on.

As the discussion continues, the time comes for the student to mention the drugs that were prescribed for the patient. This once again impinges on the problem of the distinction between what is objective and what is subjective. The question here emerges in the following terms: a clear distinction must be made between what is prescribed and what is used. This makes it possible to recognize the actual effects of the drugs on the patient. For example, in one case presentation, the following dialogue between a student and a preceptor occurred:

> Preceptor: Is she taking one or two per day?
>
> Intern: Two, every twelve hours. I saw it on the prescription.
>
> Preceptor: The prescription is one thing, what she is actually taking is another. Ask her if she is really taking them, because her pressure is high, but I think it would be complicated to prescribe another drug.

Information on what medication is being taken is crucial in deciding the path along which the treatment must proceed, whether prescriptions should be altered or maintained. Pharmaceuticals are the main therapeutic strategy followed by doctors, and most patients take reasonably high quantities of drugs, and so it is to be expected that not all of them adhere to

the prescribed quantities. When something in the treatment is not working, it becomes necessary to know if this is due to a shortcoming or insufficiency in the prescribed medication (objective aspect) or to the inadequate use of a drug (subjective aspect).

Once the patient's data has been presented – that is, once he has been defined as a medical problem that requires a solution – it is time to determine what can be done in order to minimise his symptoms (if he has any), and to obtain or maintain the desired profile. The latter includes regulating blood pressure, glycemia, adequate levels of triglycerides, HDL, LDL, as well as maintaining other indexes at recommended levels. The aim is to "optimize" the patient, to conform him to established patterns of normality. When a suitable profile has been established as an aim, the types and quantities of adequate drugs for achieving the aim are sought. Various factors are explicitly taken into account when a preceptor recommends the prescription of medication: the costs that these have for a National Health System patient is important, for example, but what matters most of all is the role of a drug in increasing longevity, and not only in alleviating symptoms.

Deliberations on suitable medication are a privileged moment for a preceptor to play the tutor role: "what would you recommend for this patient?". In cases that are apparently more simple, students take a stab at a reply, suggesting, for example, that anti-hypertension medication be increased. In more complex situations, however, they tend to keep silent, stare at the floor and wait for a reply. Contrary to what Good (1993) showed in his study – that students often felt that there was a degree of arbitrariness in the medication chosen – in the case discussions that I witnessed none of the students questioned the doctors decision. It may be true that the student's opinion could be due to his assessment that it was not worth expressing doubt in the preceptor's, or the resident's, decision. Nonetheless, all that I can assert is that there was no open conflict concerning the preceptor's decision.

Doctor's clear preference for the prescription of medication over and above other possible strategies (such as dieting and exercising) is due, it is claimed, to the greater reliability and efficacy of drugs. It did not seem to reasonable to them to expect that patients would adhere to a lifestyle filled with prohibitions and proscriptions, nor to wait the necessary time for a change of habits to produce effects. There is here an opposition between the objective, unrelenting and immediate effect of the drug and the uncertainty of depending on the somewhat "subjective" nature of the patient's willingness to change his ways.

Even if the prescription of medication is the more common outcome of case presentations, at times the solicitation of exams that are not a regular part of the ambulatory unit's routine is also considered. In these cases, the preceptor explains to the student why the exam is being solicited, and how the relevant reports and forms are to be filled out, particularly for expensive and complex exams.

The preceptor might, for example, tell the intern: “the ergometric test is good for patients that you already know to have cardiac problems. You just keep increasing the resistance, and if he passes the third level, the prognosis is good. If he stays at the third level, he has less than 1% chance of having problems the coming year. The ergometric test does not offer a diagnosis. I already know that she has a 75% lesion in the proximal DA. What I now want to know is how she will behave, if she has evolved with the pain. When you write the solicitation, you need to put down ‘cardiac patient, test to evaluate clinical condition’”.

This example shows not only the didactic style of a case presentation, where the preceptor not only deliberates on what to solicit, but also justifies his conduct to the student, but it also reveals how the uncertainties concerning the patient’s future are dealt with. The exam results indicate the patient’s chances of survival for a quantifiable period of time; expectations concerning his future are converted into a calculus, and it is therefore framed in the objective form of numbers.

Besides calculations, a further way of dealing with uncertainty is recourse to the Guidelines or Consensus, which carry a series of standard responses to cases that can be found in the clinic (Berg et al. 2000). One of the doctors always brought his copy of the Cardiology Consensus with him, which he would read in-between appointments. Sometimes he would question other doctors: “On what type of angina patient should you not use nitrate?”; “My patients? None. I tend to use nitrate...”; “But the Guideline says that you should start with beta, then a calcium channel blocker and, as a last resort, nitrate. Almost nobody does that”. Even if it is recognized that there is some distance between what is crystallized as consensus and what is normally done in practice, the doctor will still refer to the former when making certain decisions, as a way of legitimating them and making them seem non-arbitrary, or based on mere personal fancy.

Case presentations conclude with the student writing up the prescription and the exam solicitations or procedures. This is what he will normally take back with him to the appointment after his talk with the preceptor. He will also return armed with a specific rhetoric (not always appropriate or efficient) to explain to the patient why medication was modified or why a specific exam or procedure is being solicited.

The case discussion is over; the patient has been configured as a medical problem and a solution has been envisioned (Good 1993). In the presentation, the student has (or should have) excluded all themes that are not directly relevant to the treatment. Students therefore need to eliminate what is superfluous, learn what is relevant and present it in a persuasive manner (Cox 2001; Geller et al. 1990; Haber and Lingard 2001; Lingard et al. 2003). A narrative and argumentative style in which the history of the patient is made into a case is thus one of the dominant motifs in the discourse of health professionals, and it is linked to the production and assurance of scientific objectivity (Haber and Lingard 2001; Lingard et al

2003). We have seen how this is carried through certain interpretative resources: the removal of subjectivity from symptoms, the search for evidence in exams, and the specification of drug use, among other procedures.

Yet the conversation about patients in case presentations is not only descriptive; it is also constitutive, insofar as it expresses the person as a patient. It is furthermore persuasive, for it seeks to convince an audience of preceptors that the student possesses the abilities that are expected of him. Speech is also guided by writing, by what has been registered in a file, and for this reason it is neither redundant nor repetitive, but rather seeks to be precise, scientific and unambiguous. Let us now turn to the files.

Case Files

A doctor's training involves not only learning to how to hold consultations, to present cases, and to prescribe medication, but also to write up case files. A student's work at the unit, in fact, often commences with these files. Before he even talks to the patient, he studies his medical history. Kept in light brown folders, these contain not only exam results, but also information concerning consultations in other wards or units, internments, and so on. At the end of the appointment, the student will add another sheet of paper to the file. These sheets are standardized, and their content should ideally also be standardized, recording, in general terms, the following: the diagnosis expressed by an acronym (e.g. CAD, coronary artery disease), if the patient has had a heart attack (AMI in the file), how long ago, the results of the catheterization with information concerning the date in which the procedure occurred and other relevant data, such as which arteries are obstructed and to what degree they are obstructed. This description also depends on knowledge of certain recurrent acronyms (such as RCA and CX, which are coronary arteries).

Next, the file records the diseases that are associated with the cardiac problem: AHS (arterial hypertension), DM II (diabetes *mellitus* type two), dyslipidemia, renal failure and so forth. Immediately beside the information concerning the disease should be its time frame. This time frame, expressed as months or years, does not concern how long the patient has been suffering from the disease, but rather the time that has elapsed since its diagnosis. After the record of diseases and their history (which is not a history of events, but one of chronological units expressed as months or years), comes the symptoms of which the patient complains. If the patient has not mentioned any, some of them should be entered even if absent, by writing, for example: 'patient denies feeling pain, no edema', etc. Or, if the patient does complain, the file will record: 'patient complains of pain or fatigue', or something along these lines. This recourse to indirect discourse is an artifice used by students and doctors to avoid commitment to the patient. He cannot say that the patient feels pain, or that he suffers from flatulence, but instead that the patient denies, claims or reports something. Next come

the results of the clinical exams; blood pressure and heart rate are always recorded, but other information is only entered if something positive is observed, which is the same protocol followed during case presentations. The results of further exams are also entered, as is the new prescription.

The case file is supposed to remain faithful to what the patient says, but it is not a transcription of the consultation; it is, instead, a re-organization and an edited version of talks with the patient (Berg 1996; Cox 2001; Good 1993). On the other hand, not everything that is recorded comes up in the appointment. Notes concerning the diagnosis and the state of the arteries are frequently copied from previous consultations, since data on catheterization need not, and cannot, be updated in every trip to the doctor. There is, however, a close similarity between case presentations and the files.

The order of what is said to the preceptor more or less follows what is written. In fact, students hold on to the files during case presentations, since these contain the data that is necessary for the discussion (even if these remain insufficient). Preceptors, for their part, repeatedly listen to the students while they read the file, or, not uncommonly, even read the file without paying any attention to what the student has to say about the case, preferring to focus on the sheet of paper and not on their interlocutor.

What follows is a common example of what one finds in these instances: Danilo, an intern, begins to talk about a case; Dr. Marcelo, the preceptor, looks aloof (this was previously justified: he had just come from a night shift and was exhausted). Danilo sees that he is distracted and stares intently at him, as if begging for his attention. When the student stops speaking, Dr. Marcelo takes the paper from his hands and, then, begins to focus on the case; he reflects on it while his eyes remain fixed upon the paper, as if it were easier to think while looking at it, since all of the information is bundled and concise, and one can shift between data, establishing one's own order rather than observing a given sequence. The way that he glances up and down the paper that he took from the student's hand further suggests that the preceptors do this in order to obtain a global image of the case – one that can only emerge from the different items that make up the file. As in case presentations, objectivity is the result of a synthesis that must be constructed out of a series of factors and the ways in which these converge. Here, too, the patient is forged through an interpretative process that gives rise to a general configuration, even if it ends up seeming as if the latter had always been there.

The perfect, well-written file is ordered, objective, unambiguous and contains all of the necessary information. These requirements emerge in the peculiar literary style of the file. In contrast to other genres, for example, the file despises variations, creativity, lexical prolificacy, and rhetorical elements; what is valued is a colourless writing, with no metaphor or imagination, bureaucratic and firm, containing nothing that might be contested or that

gives it a personal touch (Hobbs 2002). The words chosen must be a part of the received jargon and, if possible, acronyms should be used to spare the time of whosoever is writing.

The student only knows what the patient says (in files, of course, the patient never speaks, says or feels, he only "claims"), and he must therefore look for the appropriate medical expression to describe what was said. One day in the ambulatory unit, during the temporary absence of the preceptors, a group of students were set on helping a colleague find the correct term to describe a patient who complained of recurrent farting. A consensus was finally reached, and it was decided that flatulence was the appropriate term. The importance that the students accorded to finding the precise word suggests the role that the learning of the correct terminology plays in their attempts at displaying a professional image, one that is sanctioned by the world of the clinic, since the ears of doctors are tuned into the frequency of a shared vocabulary (Lingard et al 2003). The choice of words and the plain and unambiguous style of the medical file are also related to the latter's functional dimension: it is a document meant to be read quickly and it should tell a story in linear fashion, without the characteristic embellishment of quotidian language. It reveals an unchanging past and a geography of the patient's body with its lesions situated in the interior space of matter.

Since the file is the legal and formal document of an institution, it also confers authority upon the student (Good 1993). Allow me a brief digression. I was unaware of how important it was for a student to feel as if he had authority, until the day that I saw one jump for joy when, for the first time, she placed her seal on a form soliciting a blood exam, which she proudly showed to everyone. To return to the file, a further important aspect of it is that it is produced for doctors: for other doctors who will not only make decisions based on what it contains, but will also evaluate the student who wrote it up. Even if, as I have already mentioned, the method of evaluation was less formal than in curricular internships, I witnessed many instances in which the preceptors asked a student to redo the file. One doctor in particular, who was always adamant about the importance of this practice, often said: "all of you will have to leave this place knowing how to write up a good file".

This insistence was not only the whim of a particular doctor, for it is necessary to note that even though the aim of the file is to provide memory and a framework for the patient's condition, it is often poorly organized, its information being dispersed, lacking and incomplete. This is not only the result of unintentional omissions, for there is something else that the file lacks: complementary information about the patient – information that can be decisive to his treatment. The clearest and most common example of this concerns the use of medication: whether the patient really takes them, if he lies, and why he does not follow prescriptions. None of this information is available in files. Although it is relevant to the discussion of cases, it is not registered, since only that which was decided for the patient makes it into the written document.

Neither is there a record of uncertainties. The whole process of the appointment and the discussion of a case is presented as fixed and determined: what is the problem and what procedures have been adopted. The type of reasoning that led to certain decisions is silenced, allowing only for that which was decided. In subsequent consultations, this may result in attempts at recovering the process through which past decisions were taken – an aim which may not always be achievable. It is possible, for example, that the information contained in a file does not make it clear what, exactly, made someone decide to submit a patient to surgery. The absence of the decision-making processes might indicate that these are superfluous, since it is believed that doctors posses a shared stock of knowledge, which would make the description of why a decision was taken unnecessary. Writing down what was decided should suffice, for it is believed that practices are unequivocal – which, in fact, they are not.

Files are repositories of facts that serve different purposes, and they can be more or less adequate or complete. The ideal model, however, is free of error and ambiguity, being organized in a way that allows for the immediate recognition of all that is relevant. It should enable the case to be reconstructed in a clear and objective manner, because it supposedly contains an accurate representation of facts and events. This view of the file suggests a conception of practical medicine that is transparent, unified and rational (Berg 1996). It reveals, yet again, the objectification of the patient, his description as a set of ailments, organs, symptoms and pathological processes. An abstract patient that, although reduced to materiality, seems to lack substance.

The way in which consensus, calculi, exams, medications, and even reports of symptoms appear in both case presentations and in medical files is often linked to claims of objectivity and a corresponding resistance to what are considered to be subjective matters. It is these aspects that I have sought to highlight in order to show how the idea that body and disease are material realities is constructed in practice. My argument is not meant to claim, however, that medicine is reduced to this, nor that it is successful in separating the objective from the subjective. What makes the actualization of this split difficult is evident in the practice of medicine, particularly when we consider certain problematic patients (and there is more than one way to be problematic). In these cases, there is no way of avoiding parallel narratives, of seeking motives or specific situations that can render the enigma (in the form of a patient) intelligible (Souza 2004). The literature on the theme is filled with examples of the impossibility of realizing the goal of complete objectification, neutrality and rationality.

Returning to the narrative and conclusion

In order to conclude the article, I will return to the case that I interrupted at the beginning:

As Fabiana and Alberto continued to disagree in front of their patient, Dr. Tiago, one of the preceptors, entered the room to discuss the case. He immediately recognized the patient, and called her by her name: "Magali, you're thinner, looking very good. Stopped eating *mocotó* and *feijoada*[2], have you...".

He re-did the clinical examination, all the while addressing Fabiana, and also having fun with the patient: "Maggie... this one used to eat some mean *acarajé*! She would eat them more than she would sell them[3]!". Magali laughed. Dr. Thiago listened to the patient's heart rate, and then taught Fabiana how to organize what she heard: what needed to be observed first, what came later and how to check if the stethoscope was working. Since the exam also served for teaching purposes, it went on for much longer than usual. But this does not mean that the doctor treated the patient as a mere body, as a model for the teaching of a medical procedure. He told Fabiana: "Magali is so used to these types of situations that she doesn't mind being examined by students, isn't that so Maggie?". The words were not so much an attempt to describe the circumstances in which they found themselves, and more of a plea for patience from the one who lent out her body and her time to the teaching of medicine. Magali remained silent and resigned to her situation. Fabiana, for her part, paid no attention to the exchanges between Dr. Tiago and Magali; she was too busy trying to master the stethoscope, and had no time to learn how to grab a patient's attention at a moment in which that patient is being treated as an object.

After the physical exam, the resident went to Dr. Thiago to clear his doubts concerning the obstruction of Magali's arteries. His reply was: she has nothing, she's fine. The resident explained his logic: since the exam showed up homogenous, he thought that it could mean a complete obstruction and that, therefore, her state could be exceptionally serious. Dr. Thiago interrupted the resident before he finished saying the word "serious", referring instead to "her problem", without qualifying or naming it. Suddenly, Alberto became aware of the patient. He turned to quickly glance at her and took note of her existence, realizing that she was not only an exam result that he needed to interpret, but also a person who sat beside him. He then repeated his query, phrasing it in the terms of Dr. Thiago. But his glance at the patient had only been a momentary lapse, and

[2] Translator's note: *mocotó* and *feijoada* are particularly rich and fatty Brazilian stews. Their main ingredients are the hooves of cows and bulls (*mocotó*) and black beans and a variety of cuts of pork (*feijoada*).

[3] Translator's note: *acarajé* is a Brazilian dish consisting of a dough whose main ingredient is cowpea. The dough is then fried in palm oil and garnished with shrimps and spices. It is a common dish in the Brazilian northeastern state of Bahia, where it is often sold on the streets by women.

> he soon returned to what interested him: to show that his reasoning concerning the exam was correct. Dr. Thiago insisted that he knew the case and that he doubted that she actually had had a heart attack. He kept Magali on the prescribed medication, comforted her, said that she was fine and that she needed to take daily walks, and then said goodbye.

In light of what has been discussed above, the way that this event develops can lead us to a range of conclusions. We can reaffirm some of what is by now obvious, such as medicine's tendency towards becoming increasingly technical and scientific, and how, in practice, this process results in a commitment to objectivity and neutrality. In general terms, for those who practice clinical medicine, science is basically an endeavour that involves the use of reasoning in order to establish a diagnosis and to find the appropriate drug to be prescribed in each case – or, to be more exact, the appropriate drug for a set of images and laboratory exams, such as catheterizations, scintilographies and so on. This conclusion suggests that doctors avoid risk, and situate themselves in a domain of certainty that is guaranteed by exams which, it is believed, are objective evidence and accurate descriptions of the internal structures of the body (Schreiber 1997).

Drugs, the main treatment strategy, are a part of the wide range of resources made available by science and technology, and their efficacy has been established through experiments carried out on thousands of people. Since this is the predominant conception, the student is more concerned with learning how to wield the stethoscope than in being attentive to the patient in order to bring her back into the scene, as someone less impersonal and passive. This objectification of the body appears to be more crystallized in the resident, who only for a short amount of time becomes aware that he is before a person. The preceptor, however, who has been in the profession for some time, possesses virtues and abilities that are important to his practice, but which are ignored by his tutees, at least for the time being.

How, then, are students introduced to this world, and how do they learn to inhabit this atmosphere? There are a series of factors that swerve them in that direction. Belief in science, in technology, and in the world as an aggregate of natural, objective facts – all of which are a sign of our times – guide the student in what he will find in medicine. The learning process furthermore privileges a view of the body and disease as being essentially biological and material realities. This path ultimately takes him to hospitals and ambulatory units, where he simultaneously acts as "doctor" and student.

His education then takes a new turn, since, confronted with real patients, he must learn how to manage in practice his idea of objectivity, body and disease, and to show his instructors that he can understand the instruments that are available for conducting an appointment and for settling a case. Even though he is not fully responsible for the patient, the

student needs to be competent enough to report in medical terms, and to edit, in an appropriate manner, the data that he collects, arguing his case in presentations and registering it in a file.

Students elaborate the patient's profile in terms that are adequate to scientific conceptions: a purely biological body, a part of which is lesioned. The lesion is only concrete and real when evidenced by exams that allow one to know what is going on inside the body. With this knowledge it is possible to envisage an intervention which is itself of a material nature. Although medicine is not limited to this, as we have seen in the review of the literature and in the way that Dr. Tiago dealt with his patient, medical training, in its more explicit aspects, is primarily oriented towards impersonal interactions with a patient who is, through a specific process, destituted of his personal qualities.

The fact remains that this objectivity is itself a construction that depends on interpretative processes. This, however, remains covered up (at least in non-problematic cases), and matters proceed as if exams – particularly the more high-tech ones – or other objectifying practices were a straightforward description of the material reality of disease. The medical student who takes his first steps in clinical practice tatters between this view and one that admits that the interpreter elaborates somewhat on what he sees (Joyce 2005; Monteiro 2004). However, even in these cases, they seek to constrain the perspectives on disease, so as to assure that what is perceived is the object itself.

Attempts to eradicate all ambiguity, contingency or human significance so as to recognize and deal with the disease, is a part of medicine that is in tune with a more general move towards a rationality based on calculations in our own culture (Gadamer 1996). The danger in this bureaucratic trend is that those abilities that are not reduced to instrumental rationality, or which do not lend themselves to an absolute explanation, but instead require other forms of understanding (such as intuition) cease to be encouraged and become atrophied by an excessive trust in the calculability of everything.

The exercise of medicine requires an understanding that goes beyond calculations, but the latter is becoming ever more present in clinical medicine. There is nonetheless room for a practice that may be conceived of as being of a strictly pragmatic nature, geared towards the physical dimensions of disease, but which also embodies other forms of understanding – an understanding that recuperates something of the existential dimensions of the patient (even though he proceeds to be objectified), and thereby refuses anonymity by prizing humour, a consideration of lived dramas and the search for complicity.

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