The sickness or the sick person?

When I think about this question—sickness or sick person?—one phrase immediately springs to mind from a book by Professor Protásio da Luz, do Instituto do Coração, em São Paulo (Incor, SP), in which he says "The doctor may be seen as the faithful companion of the unfortunate, always willing to help the patient, or as a professional, who, though competent, is restricted to scientific truth, heedless of the human feelings and emotions involved in the case".

We have seen a surge in publications over the past few decades on the doctor-patient relationship. Some have called the more traditional model of this relationship "doctor-centered" or "disease-centered", typified by a relation that tends to be more authoritarian, in which the patient and his or her needs play a passive role and the doctor comes to be seen as the sole possessor of expertise and knowledge. This type of approach is based on the biomedical model of disease, whereby medical care is defined as the treatment of physical signs and symptoms in quantifiable terms, and, according to which a cure is defined by objective indicators. The advantage of this model is its scientific character; it is based on objective medical data. One important disadvantage is that it neglects other contexts in which the patient's signs and symptoms occur, which include the functional, social and emotional aspects of health.

As a result, we have more recently seen the emergence of what has been called the biopsychosocial (or holistic) approach to medicine, which includes the social and psychological dimensions of physical symptoms. This model allows doctors to broach psychosocial issues during consultations, and, more importantly, to discuss the impressions of the patient with regard to his or her own physical and functional state and quality of life. From this point of view, the doctor should encourage the patient to discuss his or her experience as a "sick person" in such a way that the consultation take into account both the patient's and the doctor's agendas. This means that the "doctor tries to get inside the world of the patient in such a way as to be able to see the disease through the eyes of the patient" (McWhinney; 1985). This "patient-centered" approach is based on a more equitable relationship between doctor and patient, giving equal weight to the values, thoughts and feelings of both.

Another way of addressing the same question of the doctor-patient relationship has been called the "two faces of medicine", which includes, on one hand, the professionals whose aim is to cure the disease and, on the other, those whose aim is to care for the patient. The former involves instrumental attitudes directed towards tasks to be carried out by a qualified doctor, while the latter involves the more caring aspects of the medical relationship. Although there is a consensus regarding the importance of both faces of the doctor-patient relationship, day-to-day reality suggests that, in most cases, they act against one another. In an interesting study conducted in Europe by Grol *et al*., 1990, it was shown that most of the doctors interviewed accorded privileged status to the technical side of the relationship, which led to a tendency to increased prescription of medication to alleviate symptoms, shorter consults and inadequate recording of case histories.

Leaving aside more academic positions on the doctor-patient relationship, I would like to go back to Professor Protásio da Luz (Incor, SP) who, even though he is an academic in the most positive sense of the term, wrote a book entitled: "Science alone cannot produce a cure". In the very first chapter, entitled "What do we in fact treat: diseases or people?" we can get a sense of the extent of his concerns with regard to the so-called medical act. In his view, the doctor-patient relationship depends on many variables, two of which are fundamental: trust and understanding. He thus claims that clinical physicians need to like people, because that is the only way we are going to be able to understand what the other person wants to tell us and enables us to establish and trusting and frank relationship. Another aspect of fundamental importance concerns the fact that the search for a more humane form of medicine by no means dispenses with excellence in terms of medical knowledge. Confusing scientific data and personal beliefs is a common error among so-called practical doctors and those who have no formal scientific training. In fact, although personal experience counts for a great deal, we cannot make do without up-to-date knowledge viewed critically in the specific context of the patient. Professor Protásio da Luz believes that experience is acquired by doing something repeatedly, while excellence reflects the capacity to do something better, to master the situation. Furthermore, he remarks "differently from a mathematical problem, a medical problem is like a gift received; it is always conditioned by being wrapped in a hu-

man personality. We must carefully break through this wrapping in order to find out what is inside".

Recent advances in science and its application to the field of health have allowed human beings, in some situations, to live longer and better lives. At the same time, technological control of life (cloning, artificial prolongation of life, organ transplants, in vitro fertilization and so forth) have spurred vigorous debate regarding the ethical questions involved, with the result that there can be no doubt that these have come to pervade doctor-patient relations in a way that beyond the extent to which this relationship always should be ethical. Although there is no immediate parallel, this issue reminds me of a book I read thirty years ago—a book called Medical Nemesis by Ivan Illich, which begins with the following words: "The medical industry is a threat to health" and goes on to claim that "The greatest threat to health is modern medicine". Illich—who died in 2002—argues that health is the capacity to deal with the human realities of death, suffering and disease. Technological advances may blunt the inevitability of these facts, but modern medicine has gone much further, launching an unprecedented full-frontal onslaught against death, suffering and disease. In so doing, it has turned people into consumers of medical services or the objects of medical experiments, destroying their capacity for health.

Illich identified three levels of pathology brought on by modern medicine:

- Clinical iatrogenesis – which includes all the injuries and/or diseases caused by medical error or by the use of ineffective, toxic or unsafe treatments;
- Social iatrogenesis – which results in the medicalization of life, usually through the intermediary of the pharmaceutical industry's interest in profit;
- Cultural iatrogenesis, which is the worst of all, because it has destroyed the traditional ways of dealing with death, pain and disease.

His book provoked and still provokes much heated debate among those who have had the opportunity to read it and among those who were able to attend one of the conferences that this Edinburgh professor held around the world. In Illich's view, we have reduced the experience of "being alive" to an abstraction called "a life" which may lead the individual to plunge into a stifling void. Nowadays, the quest for health is practically diametrically opposed to the quest for the healthy "as a social liturgy in service of an idol that annihilates the subject". In other words, the more "health" there is on offer, the more problems, needs and diseases people have. Furthermore, the more the supply of clinical paraphernalia generates the political engagement of the population, the more intensely the lack of health is felt, to the point where there is a transition from a "physical to a fiscal body" (Sajay Samuel, Universidade de Bucknell).

Professor Charles Rosemberg of the University of Harvard thinks in broadly the same way when he speaks of the "tyranny of diagnosis" in medical practice. In his view, the notions of sickness and disease, apart from being culturally diverse, stand in need of redefinition, since, in most cases, they are supposed to be already understood and thus become invisible. I would thus like to suggest that people read article written by Professor Naomar de Almeida Filho, entitled "Towards a general theory of health: preliminary epistemological and anthropological notes" published in Cadernos de Saúde Pública in 2001.

However, to return to Professor Rosemberg, the need to name diseases is socially useful in the administrative world of medicine and has served almost exclusively to determine or control the duration of hospitalization or the cost of consult with a specialist. At this point, we can broaden our discussion of humanization of the doctor-patient relation to cover that of health care in general, which, as Professor William Saad Hossne has frequently observed, means more than having a clean, well-ventilated hospital, uniformed staff, no beds or stretchers lining the corridors, voluntary workers, more ambulances, or TV sets in the examination rooms, the latter being something that I particularly deplore. All of these provide more comfort for the sick, but do not automatically humanize care.

The humanization of medical care should be related to the effort made to treat people in a way that respects their intrinsic needs, taking account of their freedom of choice in defending their own interests, their need to be valued as human beings, to belong to a social group and to feel accepted, to be listened to and understood, to name just a few of the pillars on which human dignity is founded.

Finally, I would like to turn for a while to the question of the meaning of "ethics as virtue" within the medical profession. Aristotle's definition of virtue is, in my view, the best suited to the medical profession, in so far as it allies moral excellence with excellent work. In public, doctors profess two things: that they are competent and that they always have the patient's well-being in mind. Implicit in this is the assumption that the doctor-patient relation should lead to a cure, where possible, should always involve "care", should relieve suffering and foster health, which is what Pellegrino (Professor of Medicine at Georgetown University) has called "a

medical ethics based on virtue". In his view, a good doctor is one who displays the characteristics that are indispensable for attaining these medical objectives. More specifically, Pellegrino proposes six basic principles for his ethics of virtue:

- Loyalty – the basis of trust;
- Benevolence – as in the Hippocratic Oath – always set your sights on the patient's well-being, and, as a consequence, do no harm;
- Intellectual honesty – remember that medicine is an instrument that can be used as easily for good as for evil, depending on the way its knowledge and praxis are used;
- Courage – as a doctor is exposed to the dangers of contagion, physical injuries and, in cases of emergencies, may have to work under adverse political circumstances. He or she is also prone to human error and, not infrequently, has to challenge the power of the economic elite in the name of the well-being of the patient;
- Compassion – mainly in more difficult and complicated medical situations as a way of ensuring that his or her medical judgment is morally defensible and in keeping with the physical conditions of the patient;
- Truthfulness – since the patient should have the necessary knowledge to make appropriate choices in his or her life.

If doctors and others who dedicate their lives to human health were to follow these six articles of an unwritten "code" of medical ethics based on virtue, I am sure that we would no longer need to ask ourselves whether we are treating the sickness or the sick person.

It is, therefore, immensely satisfied, as we embark on the 2009 academic year of this institution's Post-Graduate Program, to be able to trust that the research that is underway and yet to be undertaken will always take people's well-being as its guiding thread. This, without doubt, duly reflects the personality of IMIP's founder, Professor Fernando Figueira, who always taught that high-quality medicine can only be achieved when technical and scientific knowledge are allied with respect for and dedication to patients.

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