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Medical responsibility and implications for clinical practice

Gardênia Holanda Marques ¹, Karla Patrícia Holanda Martins ²

Abstract

This article aims to provide contingency and epistemological elements to locate and discuss, within the history of medicine, the question of responsibility in clinical medicine. Grounded in authors such as Foucault, Canguilhem, Scliar and Engelhardt, Jr., the issue of medical liability and its ethics is examined in the context of the requirements of scientific discourse, and especially in the context of current clinical practice. The findings of the literature review point to the clinical importance of listening in medical practice as a major benchmark for considerations of medical liability and the care dimension from a perspective that is not restricted to diagnostic practice. As it distances itself from the clinical medicine is in danger of losing what is essential in its work with each individual clinical practice for each case.

Keywords: Medical clinic. Codes of medical ethics. Responsibility.

Resumo

Responsabilidade médica e suas implicações na prática clínica

O presente artigo objetiva fornecer elementos epistemológicos e contingenciais para situar e discutir, no âmbito da história da medicina, a questão da responsabilidade na clínica médica. Baseando-se em autores como Foucault, Canguilhem, Scliar e Engelhardt Jr., a questão da responsabilidade médica e sua ética são examinadas no contexto das exigências do discurso científico e, sobretudo, a partir do contexto das práticas clínicas atuais. Os achados da revisão bibliográfica apontam para a importância da escuta clínica nas práticas médicas como balizador importante para pensar a responsabilidade médica e a dimensão do cuidado em uma perspectiva que não se restrinja à prática diagnóstica. Afastando-se de seu lugar clínico, a medicina corre o risco de perder o essencial de seu trabalho com cada indivíduo, a clínica de cada caso.

Palavras-chave: Clínica médica. Códigos de ética médica. Responsabilidade.

Resumen

Responsabilidad médica y sus implicaciones en la práctica clínica

El presente artículo tiene como objetivo proporcionar elementos epistemológicos y contingentes para situar y discutir, en el ámbito de la historia de la medicina, la cuestión de la responsabilidad en la clínica médica. Basándose en autores como Foucault, Canguilhem, Scliar y Engelhardt Jr., se analizan la cuestión de la responsabilidad médica y su ética en el contexto de las exigencias del discurso científico y, sobretudo, a partir del contexto de las prácticas clínicas actuales. Los hallazgos de la revisión bibliográfica apuntan a la importancia de la escucha clínica en las prácticas médicas como un importante punto de referencia para pensar la responsabilidad médica y la dimensión del cuidado en una perspectiva que no se restrinja a la práctica diagnóstica. Alejándose de su lugar clínico, la medicina corre el riesgo de perder lo esencial de su trabajo con cada individuo, la clínica de cada caso.

Palabras-clave: Clínica médica. Códigos de ética médica. Responsabilidad.

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Declararam não haver conflito de interesse.

This article reflects the contingent and epistemological processes of medical responsibility under the view of Moacyr Scliar, Georges Canguilhem, Michel Foucault and H. Tristram Engelhardt Jr. Based on the reading of some of their works, we may point the problem presented in medical clinic when its fundament is forgotten: the listening.

By following the steps of Scliar ¹, when presenting the stories of medical practices and the concept of health in parallel, it is noticed that the medical discourse has established, along the centuries, ways of life in society. Simultaneously, this discourse is permeated by various social, political and cultural changes. Its directives are oriented by codes, which have been discussed since ancient Greece up to the present and impute responsibility to medical practice.

Since the beginning of times, humanity has tried to understand the threat that afflicts men: illness and its correlative suffering. According to Scliar ¹, different forms of cultural organization have answered the enigma of illness and death. From conceptions magical-religious, in which the illness has been associated to sin, to understandings in the scientific field, each culture answered, within its own time, with its own logic to this state. Depending on the causality at risk, the responsibility for the care of the ill was attributed to a specific social actor.

In ancient Greece, Hippocrates who was considered the father of medicine and whose writings translate a rational vision of medicine, declared the natural casualty for the illnesses and postulated the existence of four body fluids that if in disharmony gave origin to sickness. Hippocrates based himself on the empirical observation and preceded other doctors who advanced in the study of pathology. The introduction of the anatomy with Leonardo da Vinci in the XVI century allowed the conduction of studies about the circulation and the localization of organs in the body. Among these, the first description of the circulatory system is included, published by William Harvey, to whom the current scholars attribute the knowledge obtained by the Arab doctors who remained in the Iberian Peninsula for almost eight hundred years. In the following century, René Descartes, when introducing mind body dualism, opens way to the understanding of the dead body, or that of which is unprovided of soul ¹.

For so, the comprehension of the illness presents a correlative clinical change: the body observed could be manipulated and its manifestations were liable to verification. The displacement of the spirit from the body was thought, under this perspective,

as an epistemological advance in the practice and medical science.

At the end of the nineteenth century, with the pasteurian revolution and the use of new technological instruments, the illness starts being treated and prevented in the light of the discovery of etiologic factors. Within the same period, epidemiological studies have flourished which boosted the control of the social body. And it is from this moment on that state policies of intervention on health and sickness were defined.

The State's entry in the care of health stimulated international debate over the process of health-sickness. By so, the World Health Organization was created in 1948 (WHO), whose intention is to establish a notion of health that contemplates all the nations. In its constitution, the WHO defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* ², still indicating the rights and obligations of the State to the population's health.

After such directive, in parallel to the appearance of lines of thoughts on human rights, there were other accomplishments connected to policies for health, such as the Alma Ata International Conference (Kazakhstan) on primary assistance in 1978, which discussed how the social inequalities among various countries reflected on the health of the population ³. As for Brazil, such advances consisted in the introduction of the notion of health in the Federal Constitution, as well as the rights and obligations of the State in the actions of promoting and preventing and with the creation of the Sistema Único de Saúde (Unified Health System) in 1988, forty years after the WHO letter.

It is redundant but necessary to affirm that the unfolding of theoretical and practical questions in the field of health have intrinsic relation with the advance of medical science. By following the previous history, it may be pointed out that the passage of the study on health, life or cure for the study of illnesses has caused an epistemological and clinical displacement of medicine. According to Madel Luz ⁴, it is presumed the existence of a historical passage, which will establish a new rationale in anatomy, leading to the advent of modern medicine. This new medical rationale is understood as an improvement of techniques, which help enable to diagnose and treat illnesses with a higher chance of success and identification of the injured organ.

The technological advances have propitiated to medicine with various forms of treatment; nev-

ertheless, to this scientific support, the medical responsibility nowadays is much greater. Canguilhem⁵ claimed not to have knowledge in the history of medicine in the medical graduation, with subjects that are practice oriented, that excel for their technique and objectivity, leaving behind in a way the human perspective of the profession; in other words, its humanistic vocation. To rescue the history of medicine allows the doctor to contextualize and defend medicine as practical and clinical when placing it in an ethical and epistemological field. It is pertinent to say that to define the place where medicine and clinic meet will relocate from the very structure of medical practice, because it will allow for a dialogue about the principles and directives that the clinical practice assumes in the relationship between patient and doctor.

Such perspective, Engelhardt considers that *the doctors should reconstruct a moral vision based on having the place of clinical experience as a starting point and they should not uncritically accept the bioethical tendencies of each period*⁶. In short, the distancing of medical practice from its clinical perspective may be associated to atomist naturalism and its paradigms in anatomical biology. In contemporaneity, this distancing may be related for instance, to new Technologies. The technique and its mechanical apparatus separate the medical practice of listening from what is only expressed in the patient's voice. It has been lost along the way, the practice of care associated to the patient's psychic suffering.

The figure of a doctor has always enjoyed of great prestige in society, perhaps due to the real or fictional knowledge attributed to him. It fits him to instruct and treat illnesses, to promote health and life. It is also given to him the ethical and moral responsibility over a great deal of the well-being of society. As a consequence of this role, it may not be ignored that, when circumscribing what health is, medicine favors normalizing behaviors.

From what has been gathered, it may be asked: what is understood by responsibility in medicine? Let us place then, this discussion, in the history of medical clinic and its repercussions in the field of health, as well as in the construction of codes of medical ethics, having as an articulator the question of responsibility.

History of medical clinic

Monte⁷ brings significant discussions around the theme of ethics in medicine and reaffirms the

importance of knowing the ethical dimension in the professional actions to deal with the practices and medical procedures. Nonetheless, to place and evaluate the questions that refer to the ethical theme, it is necessary to place medicine in a historical field in reference to its corresponding clinical contexts.

To discuss the changes that medical clinic has undergone along the centuries, Foucault⁸ approaches the rupture between classificatory medicine of the species and modern medicine, from the perspective of a clinical view on death and life. It is from this rupture that the illness starts being defined in a certain locale within the body, and this way, it is organized and the clinic of the illness begins. This happens at the same time that medicine slowly drifts apart from the ill and narrows on the illness. By so, a change in the very question directed to the patient occurs going from "what's the matter with you?" to "where does it hurt?" Therefore, by attaching itself to a scientific statute, medicine associates itself to empiricism, to truth and objectivity, being then characterized as a scientific model of treating diseases.

Such shift in questioning is due to the visibility that the body earns in the collective imaginary, which utterly interferes in the medical diagnosis. Such behavior is immersed in power for it holds knowledge capable of distinguishing an illness from another and to decide which treatment to follow based in a mathematized biological science. If the demand for safety has always met the imaginary of one who comes to see a doctor, with the advent of scientific medicine, it has become even more plausible to look for answers and cure in a practice that has begun being attributed to the "truth".

When it comes to the destination of diagnostic practice, there is a glimpse of a descriptive order of phenomena that substitute the clinic of the private. Current psychiatry is an example that by starting from manuals it concerns in presenting a universal language that facilitates doctors' communication and minimizes the effects of an attention focused on the structure of the symptoms and on the implication of the subject in his symptom.

For Foucault, the question of the medical diagnosis as a result of visibility is made from what is noticeable to the clinical gaze⁸. According to the author, *the clinic appears – in terms of the doctor's experience – as a new outline of the perceptible and statable: a new distribution of the discrete elements of corporal space (...), a reorganization of the elements that make up the pathological phenomenon (...), a definition of the linear series of morbid events (...), articulation of the illness upon the organism*⁹.

He considers that the birth of clinic happened at the end of the eighteenth century, when its rationality appears under the control of his experience and structure⁸. The medical clinic has also linked itself to a function of listening and it has made use of this to, along with the perception of symptoms, to prescribe a treatment in spite of the technological apparatus that it has nowadays.

The clinic is to medicine, the medical act of examining, prescribing and treating illness, or yet, it is the act of placing oneself in a position of discovery. Therefore, the understanding is in accordance with Canguilhem¹⁰, when establishing that the medical clinic has an intrinsic relation with the therapeutic, in a way in which it attempts to restore an ideal of health as being normal. The question seen forward to this is how and by whom these ideals of health and well-being will be established, considering, in this way, the subjectivity in the definition of health and illness.

In the seventeenth century, illness was characterized by a historical experience which gathered everything that could be seen. The ill was useful because he provided the necessary information so that the doctor could visualize the illness. At this moment, the medical diagnosis depended on the patient's report, from the observation of his surroundings and vital signs and the way that these patients experienced their illness. Only with the anatomo-clinical method developed by Bichat in the nineteenth century, the sovereign look was strongly constituted.

From the moment which medicine creates instruments to treat illnesses, there is also a political change. With a place conferred to the sick body, institutional spaces are created for cure, demanding that the State establish necessary intervention for the re-establishment of health. At the same time which medicine undergoes change, society also transforms itself in consequence of the Industrial Revolution. It is known that in this period, the productive forces demanded better working conditions, which occur in paradox to the expansion and development of technologies. With the demand of productive labor force, the workers get ill and become the patients. However, the increasing demands of the industry indicate that they cannot get ill, so as not to diminish the productive force. This way, to minimize the effects of massive transfer of the population from the countryside to the cities, the poor housing conditions, the very insalubrity of the urban area, as well as the decay in feeding habits, it has become necessary to invest in

the production of health and the treatment of the ill workers.

The clinic in the eighteenth century appears to medicine, as it is signaled by Foucault, articulated upon the hospital field, as it used of the clinical experience to the organization and dissemination of a knowledge of the body and the illness. The medical clinic arises, in this period, as a production of knowledge connected to experience, which uses of this experience not to produce new knowledge, but to determine a truth already established. There is a rediscovery of the clinic; the knowledge is built with history. The teaching of medicine is now organized in a systematic body revisited by cases already constituted. So, the clinic presents itself not as an instrument to discover the truth still unknown, but as a determined way to arrange facts already acquired and to present them so *that it* – the clinic – *unveils itself systematically*¹¹.

The hospitals, from the eighteenth century on, have begun to play a significant role in the production of knowledge on the illnesses and the body. If the hospital institutions used to be exclusively destined to the reclusion of incurable cases and to charity, as of this period, they have become a medical space destined to the cure and treatment of illnesses, by the use of medication. In addition to that, the hospitals have become instruments to the organization of medical knowledge, by the establishment of norms and rules to be followed to reach the objective, which is to reestablish the patient's health. With the power of life in its hands, medicine grows considerably. And that does not occur without consequences.

With the outset of the nineteenth century, the medical clinic uses the hospital not only to apply what has been passed on to the future professionals, but also to teach. It is by examining patients that production truly settles, not only for the experienced ones but also for the learners. In this phase of medicine there is a creation of an institutionalized and scientific structure. This is the view which will determine the new paths of medicine.

Standardization of medical practise

The work of Foucault allows to outline some implications on the responsibility of medicine since its constitution as clinical, because the changes caused in the medical eye have produced health norms and interventions which aroused the creation of conducts to guide the work. There was a

period which the practice of medicine was linked to religious concept, when illness was considered a consequence of sin. While medicine was connected to the supersensible sphere, religious values predominated over moral values, which in this context also meant medical values¹²; in other words, religion gave support to medical practice. Even at that time, it was imperative to create codes which regulated the social relations, as it was in the antiquity (fifteenth century B.C.) the Code of Hammurabi, the most significant instrument of regulation of conduct at that time.

The code mentioned refers to the laws and norms of civil life and the administrative practices. It contains a chapter which refers to the professional practices, assessing fees and penalties. Whenever medical errors occurred, they used of the *lex talionis* (eye for an eye, tit for tat) for the punishments, being taken, in this way, as a criterion of reciprocity. At that time, there was already a need to regulate the professions, which were intimately connected to life and society, medicine being among them.

Hippocrates was responsible not only for the change in the conception of illness from the mystical religious field to the area of influence of nature in the cause of illness, but also for the first references to codes of ethics for the medical conduct. The Hippocratic practice was based in the observation and occurrence of the processes of health-illness. With this epistemological change, the advances we see today in medicine were made possible. Hippocratic medicine has not only aggregated theoretical knowledge to the techniques being used, but it has also established the principles of conduct of the doctor which set rules to regulate his interventions, *principles which have been extended up to the present days and from which the medical ethics bases itself: 'primum non nocere' and 'bonum facere'*¹³.

Such principles do not signify maleficence nor beneficence, respectively, and always aim not to hurt the patient but to do him good. Up to now, the Hippocratic pledge which is used at the end of a medicine school course, with some modifications, and its principles continue to govern the ethical formation of new doctors. In the following centuries, the increase in knowledge and of technology used by medicine has induced the increase in tensions and conflicts in the health area, making it necessary to institute some way to diminish them.

With the increasing tension around the hospital environment, Thomas Percival, in the beginning of the nineteenth century, elaborated the first code of ethics in medicine. The intention of this code was

to overcome professional conflicts, to moralize the doctor's profession and character, pointing behaviors to be followed¹⁴. However, since this period, in parallel to the scientific advance which demanded more and more effort from doctors, the tensions in the practice of medicine would increase more and more as well.

In the face of scientific and social demands, the international committees have elaborated some documents which served as a basis to create the professional codes, such as the *Declaration of Geneva*, the *Nuremberg Code* and the *Declaration of Helsinki*, written in the middle of the twentieth century, being the last two documents directed to a regulation of the professional practice to what clinical research is concerned.

The malaise in the relationship among human beings looks intrinsic to civilization, and three other threats exist which disquiet humanity: the forces of nature, to which we human beings cannot dominate; the relationship with others; and *the human body, condemned to decay and dissolution, which cannot even dispense the suffering and the anxiety as warning signs*¹⁵. The third threat may perhaps be the most visible narcissistic wound to the field of health, because it refers to the object of medicine. To handle such malaise, man uses of all possible tools, for instance, medication to ease the pain, improvement of technological innovations as ways to keep the body alive and healthy. These attempts exclude, supposedly, or at least in determined time, what all of us are destined to: death.

The codes always explicitly bring that the medical conduct focuses on the health of men and that its knowledge must be used in benefit of the patient. Therefore, it becomes clear that the ideal state of a sick patient is to become a healthy patient. Canguilhem points to the existence of innumerable discussions over the nature of the harm, but nobody reasons over the ideal of the well. This matter opens discussions to reverberate in medical clinic, when, before the patient, the doctor must offer him a well. But what is well? Who can say what is best for the patient?¹⁶

Canguilhem, in his thesis¹⁰, approaches the question of normal and of pathological in medicine from a philosophical, historical and medical perspective. The discussions deal with the issue of what is normal. The author supports a normativity of life, which differs from biological normativity, but he mentions that both are related with the way in which each organism articulates itself in his symptom. The norm, for the doctor, is connected to his

knowledge of physiology, due to the statistics, which form a pattern to distinguish the normal from the pathological. The normativity of life to which he refers to addresses the conditions which the person/organism creates to deal with his illness and with his life. This means that this normativity implies subjectivity and it allows affirming that it is not absurd to consider the pathological state as normal, *since it is not the absence of normality which constitutes the abnormal. There is absolutely no life without norms of life, and the morbid state is always a certain way of living*¹⁷.

We may cite, for example, the case of a patient who is tetraplegic due to an accident. During its admission, he assures to everyone that he is well and that he does not need special care. Nevertheless, the team from the section where he is, does not believe that, since, a number of time, it is driven by an ideal of health which the body must follow the biological standard of the healthy body, meaning, a perfect physical state. Due to a belief in an ideal of standardized health, the team is convinced that the patient needs psychological and social support to overcome the new phase of his life.

Even if the patient reaffirms that he is well and reassuring that he will be able to adapt to the new routine when facing the new norms of life, it is difficult for the team to believe in the affirmation of such state of well-being. The normativity of life is: construction of norms, of mechanisms and of senses to keep oneself alive. Apart from what is understood to be normal in the sciences so called objective, what must also be taken into consideration is the way which each person is able to create possibilities to deal with the disease. It may also be added that, according to Canguilhem¹⁰, the state in which we are after the illness is never the same as the previous state. To understand that is the *sine qua non* to create new norms of life which will adapt itself and to enable better conditions to the current state and permit that something previous may have other meaning.

Clavreul¹⁸ warns that, even though medicine is connected to ideology predominant at the time, the medical ethics problems should not be restricted to scientific ideology, which excels for its objectivity and rapid results. On the other hand, Lacan¹⁹ points out that from these same social and ideological demands that the problems of medicine will come into existence. Both affirmations permit an understanding that the distanced thought of the practice, in other words, the practice which does not justify the procedures based on the beliefs taken *a priori*

as truth, is a fundamental attitude to free the praxis of dogmatism inherent to the very construction of knowledge.

From what has been put, it may be thought that medical responsibility is not connected only to an ideal of well, but also to a relation with what is subjective, to the extent that the concepts of normal and abnormal, well or unwell, are connected to something which is of therapeutic order, to something which is constructed in the relationship with the living creature. The responsibility of medicine, in some moments of its history, is translated into an elimination of illnesses and a search to preserve health. According with the construction of the clinic, we can understand that there is a chance in medical clinic from a look on the illness to a way of intervention focusing on the preservation of health. This way, the medical interests correspond to a normative ideal of health imposed by its socio-historical and economical conjuncture.

Medical responsibility

The patients look for a doctor believing that he has the answer to all of their malaises. They base themselves in a significant master of health and judge that the doctors are their keepers, and then they believe that doctors may provide and offer the statute of health that they long for. As a result, they accept the interventions that they believe to be necessary for their demands to be met. We know, with Clavreul²⁰, that the discourse of illness is the discourse of the doctor. It fits him to possess the knowledge on the patient's illness; and so, only he could indicate the treatment.

In spite of the construction of such knowledge and place of speaking, techno-scientific advances make the doctor lose power and answer to an institution that we denominate medicine more and more, to which, in its turn, constitutes itself of extreme specialization and composes itself from the group of biological sciences. As it is noticed, when using the benefits that the sciences have to offer, the doctor distances himself from the interpretation of the ill person on his own illness. The patient's voice goes, little by little, giving way to exams, x-rays and tomography exams, in benefit of a supposed efficiency offered by the scientific progress.

The ill person is only asked what is of interest to a diagnostic. The meaning he gives to the illness is set aside. From this, there is a result that both doctor and patient answer to, not for themselves, but,

by the medical institution and the illness, respectively. On the one hand, the ill person speaks on behalf of his illness, his discourse is directed to predetermined questions and of interest of diagnosis. On the other hand, the doctor answers not for his place of clinic, of listening, but for an institution which directs its own diagnosis. Such situation reaches a paroxysm when the illness reported by the ill is not diagnosed because the exams which should indicate its existence do not prove so.

Donnangelo and Pereira²¹ alert to a care which must be taken which is not to mistake medical science for medical act. The science reduces itself to a set of principles biophysical-chemical and technological apparatus that help in the construction of the theory and intervention methods. The act implies in a relation which involves at least two agents: the doctor and his object of intervention, who, in this case, is the patient or part of his body. It is under this relation that something is established and that provides a construction of a therapeutic bond which, in some instances, becomes more important than the prescription of the treatment. As the doctor assumes a marginalized position in front of his act when responding to an institution, he momentarily distances himself from the therapeutic that enabled his practice. This comes as a consequence of the scientific spirit from the end of the nineteenth century, which excelled for the task of answering to human pathology for a scientific-biologic perspective. It may be indicated here that the ethical problem of medical responsibility when acting most of the times in conformity with a scientific ritual, not considering the connection established with the clinic and the patient, bringing about consequences to the treatment.

Now, which doctor has never noticed that the links of trust established with his patient help obtain better results in the prescribed treatment? Or even, that on occasions, it is not even necessary to prescribe medication, since, with some few words, that migraine or stomach ache are resolved? Or, even if, by prescribing the same treatment for two patients with a common diagnostic, the improvement is only seen in one and not the other? These factors, which are directly related to subjectivity in the relationship between professional and patient, indicate the importance of a construction of a therapeutic link.

If, in one hand, the codes of ethics lead to a medical conduct for a search of the full biopsychosocial well-being, on the other hand, what medical practice visualizes in its doings is the impossibility or the inaccessibility of a state of cure as total absence

of signs of malaise, because there is something which will always reoccur. According to the current medical code of ethics, the medical responsibility is related to public health, the sanitary education and the production of legislation referent to health. And it is the doctor's responsibility use the best of medical resources for the patient's benefit. But what benefit is this? Is there a limit to the doctor's answer?

To reach the state of health according to the renowned WHO is impossible, in a way that there is not how to define what such full well-being is, because "to be well" is of a subjective field, and health is a value which is not accurate. Besides, the full well-being would involve a state outside temporality, since this continuous could only exist in an immutable field, beyond or previous to any kind of relationship, including that established by a simple going of time. Even by using all the technological apparatus at hand, the doctor knows that something remains out of therapeutic resource used by him. Perhaps it is due to such inapprehensible something by medicine which may consider the entrance of other practices and knowledge of health in the hospital as an institution, which is the case of psychology and psychoanalysis, combined with the intention to try to widen the range of knowings in health so as to answer the imponderable.

The practice also teaches, and it may be confirmed by doctors, that in some cases, when the patient approaches the doctor, he does not simply wants the cure. The patient tests the doctor's knowledge, demanding that the professional takes him out of that ill state, which implies that he may desire to remain under such condition¹⁹. As an example, we may think of the case of a patient admitted to a hospital and whose exams prove his physical improvement, but every morning, during visiting hours, presents a complaint which ranges from strong headaches to fake nausea. With that, he can remain in the hospital for another day.

Such example helps understand that the responsibility over health is not only of medicine, but also, and mainly, of the patient, once he may not desire to do away with the symptom and look for a doctor so as not to be cured, but to certify of his illness. In fact, such situation is not uncommon, since the doctor has the power to define the existence or not of such pathologic state and, therefore, certify the existence of the illness which may not only keep the patience in the hospital, but dismiss him from work for a definite or indefinite amount of time or even entitle him some kind of financial compensa-

tion, for instance, in situations which subscribe the power of the professional.

This exemplifies the demand, which is the dimension to which the function of the doctor is for. The demand is an appeal to the realization of satisfaction. It is characterized as a request to restore to a previous state to which the person supposed to exist. The demand is represented by what is said, it is what comes in the form of request; in other words, there is a need of someone else's intervention to intervene and that he play a role of intermediary of his satisfaction within the demand. Quinet²² states that it is not the answer to a demand that brings forth the dimension of desire. It is right in the absence of an answer that we find permission to go meet the desire.

Medicine is sustained by ideas of health that are produced from the socio-cultural context. These ideals work as somethings which are necessary to reach; so, it is attributed to medicine the responsibility to offer such destiny to those who address it. When placing itself in a situation of knowing it all and being able of all, the dimension of desire is ignored, since it does not correspond to its object of interventions. However, the way it responds to the demand may change all the direction of the clinic. It is in the clinical act – when, as it is questioned, prescribed and diagnosed, the medicine takes into consideration the existence of each single case – which it will answer from a proper place, having in mind its responsibility.

Pierre Benoît²³ considered that, so as to have modifications in the attitude of a doctor, in other words, a change in the position as a therapist, it would be necessary to rescue the history of the patient and of his circle, which would be done from words, which are not accessible to science, characterized as objective. The French doctor warns that, after obtaining recognition from the doctor as something essential, this principle will produce meaningful consequences not only for the professional but also for the patient.

In the article “The place of psychoanalysis in medicine”, Lacan signals: *as much as the register of the medical relation with health modifies itself, to which this kind of generalized power which is the power of science, gives to everyone the possibility to ask the doctor the benefit ticket, with a precise and immediate objective, it is seen drawn the originality of a dimension which I denominate demand and it is in the register of the mode of answer to the demand of the ill which is the chance to survive of the medical position*¹⁹.

It cannot be forgotten that the desire is the factor responsible for someone to become a doctor. Benoît²³ reminds that the therapeutics is something impossible to teach, to transmit, because it depends of the relationship established with each patient and with his own experiences of getting sick and cure, and this is not found in scientific theories which aim objectivity. According to the author, what is really relevant is *the desire of the doctor of becoming a doctor and caring for people, and such wish supports his technical knowledge*²⁴.

It may be possible to think that the desire to care, to assist the ill, to hold the knowledge, present not only in doctors, but in so many other professions in the health field, is connected to a dimension that is so little discussed in the scientific and personal fields, without which we would not be able to exist: the dimension of love. This dimension allows us to go from a mere physical body to a language body and a desired body. Care comes with the voice, the touch, the look is consequence of a loving discourse, which, possibly, sets the desire and the responsibility at similar levels, because it tries to answer, from an apparently complete and insatiable place, with the intention of offering to someone else something that would leave him at complete satisfaction.

When Scliar²⁵, approaches the history of medicine, he presents a literary form to passion as the act of caring and treating. The author presents medicine as an art of love that, even though it has been undergoing change through the centuries, it still brings in its essence the fight for life. He assesses another look which is not mentioned by Foucault. Whilst Scliar assesses the unvoiced gaze, of the clinic which is made in each case, with each report, with each word said or not, of a language on the body and not of the body, Foucault deals with the look over the body which the medical clinic goes on modifying starting with the techno-scientific advances and the epistemological changes in the doctrines that form the theoretical frame of medicine.

Who knows it may have been through this loving way that the doctor accepted the scientific and social demands, in an attempt at answering to the patients in a way with could be possible to present a scientific proof that would probably have faster and more efficient results. It is on behalf of his desire to medicate and of his Hippocratic oath that he always seeks to bring benefits and not harm the patient.

What we consider, therefore, as responsibility to medicine is the support of his own action, in other words, his act. The act promotes change in position, or from a pathologic state to a healthy state or the

permanence in the first state. No matter what is produced, the medical responsibility is related to what can be done in each case. And, when it comes to the question of being healthy or not, that depends on how each one articulates his desire and establishes himself within the social bond.

Final considerations

From the readings undertaken in this article, the propositions of Scliar ¹ and Canguilhem ⁵ stand out as to the importance to rescue, in the history of medicine, the clinical principles that were basis to the beginning of medical practice. Engelhardt ²⁶ emphasized the perspective of the human condition as basic issue to limit the action of medicine. The common discussion developed by the authors leads to medical responsibility, to which assuming a position that goes through the fields of ethics and alterity, taking into consideration the limits of his practice. The bodily finitude of men indicate the impossibility of do it all and know it all, thus imposing boundaries.

This article explicits that the responsibility of medicine, more precisely of the doctor, is connected not only to a moral question defined by conduct codes, but also to a support of a cause which puts at

stake the clinic activity of listening to the suffering of the patient. Since the time prior to the Christian period, it was attributed to medicine the function of good, in other words, its practice has always been based on the principle of beneficence, that is still present in the doctor's oath. However, what we also observe is that there must be care to know how far it is possible to go and how to answer to the demands which are presented.

We cannot forget to consider that the field of health jeopardizes two orders of responsibility, to know: the responsibility of the doctor, in a way he responds to the act and the responsibility of the ill in whether or not to uphold his illness. *Therefore, we should not think that, in our medicalized society, the person is passively dragged into a condition of mere scientific object* ²⁷.

If medicine moves away from its clinical place, it then gives in to the scientific demands and loses its moral and ethical value. It marginalizes itself in what it has of essential: its work with each individual, the clinic of each case. It is fact that the scientific advances have provided undeniable contributions to the treatment of patients. Nevertheless, it is prudent that the clinic listening not be forgotten, with the risk that medicine lose the fundamental of his specificity.

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