

Biomedical semiotics and its limits: opening up paths between the subtle and the evident

Introduction

By radicalizing its basic semiological pre-suppositions based on evidence, modern Western medicine has placed itself in a trap. This process has become stronger as of the 1970s and, in an attempt to consolidate itself in the 1990s, developed the approach of Evidence Based Medicine (EBM). That is, by anchoring itself on the evidence referred to in the medical literature, the practice has deepened the abyss that hard technology (MERHY, 1997) had already set up between doctor and patient.

Ways to get out of this trap must be found, and they must recover the full subjectivity of medical practice and anchor the meaning of evidence in it. Paths are needed that will reveal the subtle and the evident of this practice. The intent of this article is to discuss this trap through an analysis of biomedical semiotics and then call attention to certain aspects of homeopathic semiotics that may broaden the biomedical gaze and indicate its limits. The hope is to present ways to overcome the epistemological obstacle (BACHELARD, 1975), the trap, that biomedicine faces today.

Methodology

Methodologically, this article consists of a theoretical discussion based on the dialectic conception (MERLEAU-PONTY, 1989) that identifies a basic tenet in the construction of knowledge, namely, the clear delimitation of the field of presence of the subject in search of this knowledge, based on the subject's perceptive and phenomenological experience, as it constructs its categories, contradictions and mediations. It is from my experience as a medical doctor in this field of everyday practice, that these questions have arisen, and where a few of the possible answers to these questions have been delineated.

Discussion

The object of the present study is the semiotics often used by physicians, which is based on a set of symptoms that take on a given arrangement that characterizes a specific and a general disease or disorder. This nosology is no longer sufficient to understand a patient's true discomforts in his or her individual universe of subjectivity. One begins from the particular, from symptoms

and signs, and catalogs them according to general nosological criteria. Instead of returning them to the subject in a contextualized and individualized form, medical personnel often return them with conditions that are also general. Prescriptions are thus unrelated to the individual's history, which is always rich in the meanings and signifiers that gave rise to it.

Two problems should be distinguished here. The first is related to the insufficiency of semiological elements to sustain an individualized reading and understanding of the patient's specific demands. The second problem has to do with the impossibility of discerning those demands that are not expressed verbally but are nevertheless present between the lines of the patient's discourse. In other words, these demands are present in the patient's body and in his or her personal history, and are almost always omitted because they are considered irrelevant. They are not considered appropriate as information for the physician.

Is it appropriate to ask the question: is semiotics a science that studies and signals, or isn't it? Taking the definition of a sign as something that announces or makes something else known and whose place it takes, this supposes some cause that interdicts or sets up some obstacle to access to the thing that was signified. For LALANDE (1993), as well as for BARTHES (1990), for whom the function of a sign is to communicate ideas by means of messages, signs have the objective of transmitting information, and are part of the communication process.

BARTHES stresses the importance of the reading of signs: "It seems to me that there are three levels of meaning to be distinguished. [There is] the informational level, or the level of communication. There is also a symbolic level and this is what gives meaning. But is that all? No. I read and I am taken by an evident, erratic and stubborn third meaning. I don't know what it means or, at least, I cannot give it a name. This is the level of significance."

"The symbolic meaning is imposed on my spirit through a double determination: it is intentional and is taken from a type of general common lexicon of symbols. I suggest calling this sign that completes the 'obvious meaning.' Regarding the other meaning, the third, that which 'goes beyond,' which is presented as a supplement that my intellect is unable to absorb suf-

ficiently, and which is at one and the same time stubborn and fleeting, I propose to call 'the obtuse meaning.' (BARTHES, 1990).

It is precisely this 'obtuse meaning' (the word comes from *obtusus*, meaning that which is veiled, that which is not evident, that we perceive that biomedical semiotics is not equipped to understand and that, instead of investing, or "arming" itself to understand what is not evident, it arms itself for quantification and exhaustive labeling of what is evident. It is the search for the subtle that attempts to unveil the obtuse and that calls for questioning.

Until the 1970s, the value of subjectivity at moments of medical decision, when interpreting the data provided by semiological strategies for apprehending our patients' bodies, was always emphasized as one of the basic elements of medical technique and understood as an art in semio-technical books. In the last two decades an attempt can be seen to disqualify and even eliminate any form of apprehension by the doctor that might be considered subjective. The doctor should always move in the direction of proof, in other words, he or she is only able to judge in the light of concrete and labeled evidence, thus producing what is seen as the best decision and that makes use of complementary examinations, "armed semiotics." It can be said that "Complementary examinations have taken on increasing importance, and have threatened to make semiotics a lost art and given medicine the appearance of a concrete art. The more objective these examinations are, the more respected they become." (CAMARGO, 1997).

There was a consistency in books on semiotics of the 1970s between the discourse and what was proposed to be taught, from the need to emphasize rapport as an essential component of the interview, to the need to develop human warmth, flexibility and empathy. Teaching strategies stressed the patient's clinical history as one of the most important semiological instruments available for defining the diagnosis as a process in continuous construction and in the understanding of the interview as one of the most important therapeutic elements available, based on the incredible power of the spoken word. All this was part of the legacy from French clinical practice, broadly discussed by FOUCAULT (1980).

One can find the following types of statements in treatises on semiotics of the 1940s: "The patient's apparent daydreams can be very elucidating. What may often seem to be a side road can turn out to be broad highway. And sometimes the topics the patients avoid

are the most significant" (MACBRYDE, 1975).

We read in another text in semiotics that: "In the physical and functional propedeutics of clinical observation, both student and physician should educate themselves, discipline themselves, to perceive with all their senses, to recognize everything that might be normal and, especially, of course, in the perception of all deviations toward abnormality... The physician's senses should be educated and perfected during the entire propedeutic practice, and all are of the same order of importance: sight, in the method of inspection; hearing, in listening and in percussion; smelling in checking exhalations and especially in the different qualities of breath... Sometimes all the senses, or at least two of them, are used to perceive a given symptom or sign" (RAMOS, 1973).

It is this sensualism that was later to be harshly criticized with phrases such as; "Purely semiological (or better, sensualist) clinical work might be work with a medulla, but not with a brain" (CEDIEL, 1984).

In the early 20th century, medicine in the United States introduced the idea that medicine should be "scientific" (FLEXNER, 1972).

"As a scientific medicine, Medical practice can only be understood as inseparable from scientific investigation... [M]edicine as a science, like physics and chemistry..., which are its underpinnings, [is] consequently understood as the application and production of this science. Thus the clinical method is identified with the method of elaboration proper to those sciences" (SCHRAIBER, 1989).

Increasingly, and literally, therefore, "sensualism" was abandoned, whereas it could have been re-evaluated and enhanced. It has been replaced by a non-reading of the singular, by the generalization whose point of climax is Evidence Based Medicine, EBM. MacBryde's words might be appropriate here.

"One of the reasons why doctors tend to become more like technicians and less like doctors is that being concerned with both the patient and the disease is much harder and takes longer than treating just the disease" (MACBRYDE, 1975).

However, this "armed scientific" semiotics is unable to resolve the questions asked by the eminent 19th century anthropologist Viktor Von Weizsäcker, one of the founders of medical anthropology: "Whenever a doctor is with a patient he must ask these three questions: Why here? organic location; Why now? biographic indication; and What truth of the patient tends to evidence the non-truth of his or her disease process?... existential clarification" (WEISÄCKER, 1956).

Is this not the moment, then, to re-examine the limits of this practice? Is Evidence Based Medicine able to approximate medical work to evidence? One might be able to come close to the evidence with EBM, in the sense of the search for written proof on which to base itself. When biomedical rationality (LUZ, 1993) bases itself on the generality of the health-disease process, it can only focus on evidence that is possible, anatomopathological and ethiopathogenic, therefore only on what is quantifiable, estimable and revealable by the concreteness of machines. In other words, it is based on hard technology.

“There is, let us say, a fascination with technology, an enchantment that the development of these techniques exercises on their producers, their mediators and their consumers. This is why sophisticated techniques are so often used to diagnose illness as that could clinically be diagnosed with semiological resources and with working instruments closer to doctors, who often acritically make use of this type of technology. But eventually the fascination takes over, because the laws of the market are alluring and in today’s consumer society the use of technology tends to irrefutably prove the hypothesis that one wants to prove” (CHACRA, 1995).

By striving to find evidence in clinical practice, medicine proposes to us a basic dogma: never doubt systematic studies until they have been replaced by others. The truth is that such studies provide us with rationality and the strength of generalities expressed in rates, levels, reasons of chance of “randomized” studies.

When criticizing this trend one must nonetheless recognize the advances that this type of medicine, with its biomedical approach, has brought us during the last century. There is no denying the value of the development of infectology, immunology, genetics and oncology. The purpose here is not to reduce this type of approach to knowledge that is maladjusted to everyday practice. The question is to point out its limits and its incapacity to recognize other possibilities of evidence.

What should be done, then, with uncertainties that cannot be quantified? What should be done with content that is immersed in the subjects that come to us and who want to receive more than a prescription, but a way to transform their discomfort?

All these questions are necessary if we want to avoid perpetuating ourselves in the trap where radical armed “rationalism” has placed us. The evidence has to be displaced from the video to the perspectio,

(CHAUI, 1988, 37) which opens the gates to perception, intuition, the subtle, the non-expressed that mobilizes, to accurate observation and to anamnesis that reveals itself.

Indicating directions; the necessary interlocution with other types of knowledge

Once some limits are indicated, the need comes up to review the factors involved in biomedical semiotics and in other medical rationalities that can enhance the semiological perspective and provide ways to overcome the epistemological obstacles described above. They are merely aspects for reflection, but we consider them factors that can be discussed in the search for ways to attenuate the trap that is being created in biomedicine.

The diagnostic process: clinical logic and interpretation of signs: Like other possible approaches, the homeopathic approach has much to add to our understanding of what should be observed for a more accurate diagnosis. Hahnemann called this aspect minute observation:

“In order to perceive with precision what has to be observed in patients, we should direct all our spirit to the material we have at hand. To some degree we have to come out of ourselves and incorporate ourselves into [this material], so to speak, with all our power of concentration, in a way that nothing that is objectively present, that has any relation to the subject and that can be evaluated by the senses, can escape” (HAHNEMANN, 1995).

It is extremely interesting to see that, for Hahnemann, the act of observing is a broad highway with many different lanes. One has to have the precision of a portrait painter and nothing that might individualize the patient can be allowed to escape, and one must observe oneself, one’s interior, which implies a completely subjective act of criticism about the slightest impressions and understanding of internal feelings. He once stated that one should feel in oneself what the other is feeling: “To some degree we go out of ourselves and incorporate these feelings into ourselves.” For him, this capacity of observation was not innate. It had to be the consequence of constant practice in dealing with patients, and should also involve training in other disciplines that would allow such precise observation. He also underscored the importance of the patient’s behavior and general aspect during the appointment, including clinical signs, the physical examination, the great importance of identifying the

biopathographic, that is, the specific conditions referring to the illness.

Hahnemann clearly demarcated that only on the basis of the rare, the particular and the characteristic can one arrive at the individualization of symptoms in a concrete subject. This does not mean converting biomedical rationality into homeopathic rationality, but rather of indicating what has been omitted because it does not make sense or does not have a nosological meaning.

It will therefore be necessary to uncover the patient's history, not only through the word, but through his or her body as well, including physical postures and all other indications that patients give us, so that we can come up with a more effective result of this diagnostic process: "Uncovering the history of the existential plot is the best and most faithful marker of our therapeutic activity" (ROSENBAUM, 1998).

Verbal and non-verbal communication: the interview

Interviews imply an encounter of representations of body and of illness between doctor and patient. There are symbolic messages behind the literal messages expressed by the patient and the doctor must have the internal ability to read them if he or she is to avoid receiving a message without a code. Language that is always meaningful can be "empty" or full of significance. This difference between meaning, associated with concept, and signifier, associated with image, which the subject makes interiorly or, to use SAUSSURE's (1974) term, the auditory image (signifier), is a problem that is not thought of as the ability to understand, in the interview, that this difference exists and that messages can permanently serve as "levers for change." A signifier is also generated when communication actually takes place, always maintaining the "link" that existed between the symbol and the referent, between the affect as a generator of this signifier and the subject in a psychological context, which is also a generator of signifiers (CHIOZZA 1987). With this type of permanent care there is better approximation to almost obtain a message with a code, a transforming and revealing code.

There is also non-verbal communication, which is the process of transmitting information without using words. It includes the way people use their body, such as facial expressions, glances, etc.

Another important element is the paralinguistic aspect, or the "how" of speech. Another important component involves the use of personal and social

space, which has to do with how physically close we come to another person, and how close we let others get to us (COULEHAN & BLOCK, 1989, 56-57). All these non-verbal aspects of the relationship, whenever captured by the consciousness, can generate important transformations in the encounter and the relationship with the other.

Biomedical rationality tries to frame reality as if it were a painting. Medical knowledge based on anatomo-pathology "focuses on" this image as reality. This fixity, no matter how hard it might try to broaden its framework, is insufficient to grasp the whole, or even the parts of the whole, since it is merely an image that excludes the observer who is grasping: "[It is as if,] from this fixity, through analytic broadening, we could finally apprehend the true landscape. Once the immobility of the gaze has been broken, the dizzying movement that includes the one who is looking appears" (PINHEIRO, 1998).

In the interview, what are known as social, or "common sense" representations also appear: "Words are woven from a multitude of ideological threads as serve as the fabric for the social relationships in all domains. The understanding of speech requires, at the same time, the understanding of the social relationships it expresses" (MINAYA, 1995). Patients attribute meaning to the situations they have experienced, and their subsequent behavior is largely determined by this meaning. But it is rarely perceived, and much less unveiled.

The phenomena of transference and countertransference in the relationship between doctor and patient, should also be re-considered, as they are always present in medical work, and go totally unnoticed. Many other paths could also be considered, such as the basic integrity between body and mind, the physical examination, subjectivity and objectivity, the concept of diagnosis and the diagnosis itself, as well as possibilities for treatment and prognoses.

Each of these topics deserves careful attention, but they are indicated here merely to remind the reader that there are a number of paths to be taken.

Why shouldn't we teach our medical students to see the limits, to observe and notice other diagnostic and therapeutic possibilities beyond our strict biomedical perspectives? I am not defending here the training of some special type of doctor able to individually encompass a broad range of diagnostic and therapeutic approaches, but rather the need to train doctors who can reflect on the extent of the semiological, diagnostic and therapeutic instruments they have

learned. They could attempt also to recover what is worth being recovered, historically, in their own rationality, that "clinical gaze" that gives importance to semiological signs, but broadened in the light of the current concepts of sign. Why don't we broaden the concept of sign using a psychoanalytic frame of reference, or with the concept of signified body, introduced by body therapies, or with the concept of sign used by linguistics?

Technology has developed an unquestionable wealth of diagnostic precision of the body and of organic processes. This an undeniable fact, and EBM has provided us with broad possibilities in medical analysis, which, judiciously used, can help provide more effective biomedical treatment. But what should be

done with signs that do not lend themselves to hard technological decoding?

I believe that other semiologies, other medical rationalities, and other therapeutic approaches have much to contribute to medical training personnel. These types of knowledge have aspects that can question biomedical practice and knowledge. Obviously, they should not lose the notion of their own limits. Nor is any intent implied to transform them into alternative obstacles to biomedical rationality, since they themselves contain specific limits. However, they constantly question the limits of our rationality, and can certainly offer perspectives for the training of a new type of doctor, free from dogmatism, whose goal will be the ethics of caring.



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