The Words of Clinical Medicine

Caring for our patients, interpreting their signs and symptoms, and choosing and prescribing a therapy are tasks performed on a “natural” platform of concepts and presuppositions that we take for granted. We believe that the words and language that define the problems we face, the metaphors of the disease, the risk and prognosis, and the recommendations we give are scientific tools “inherent” to our profession that are not subject to criticism or considerations beyond adjusting to evidences or guidelines.

Language exploration may seem a very complex task, more suitable for philosophers, linguists, psychologists or experts in communication sciences. Nothing more true. We also see it as natural that psychotherapists—who heal with words—be aware of the need for a deeper study on language and a supervised training of their dialogs. But I am afraid we physicians will not be able to overlook this issue.

WHAT IS THE ACTUAL MEDICAL SCENARIO AND THE ROLE OF PATIENTS’ AND PHYSICIANS’ WORDS?

Most of our work consists of listening, examining, talking, and prescribing. At first, we must pick up the patient’s narrative in order to interpret his/her condition. Prescribing a diagnostic method or a therapy—a decision the patient may see as almost automatic—is grounded on “evidence-based medicine” and is the condensed expression of what we consider our professional contribution. It requires the study and experience we have built throughout our medical education, as well as reading, congresses and seminars; that is what we have been trained for. Endless renewed debates about who may receive statins (and in what doses) or aspirin, or about the ideal blood pressure level.

In contrast, how much time have we dedicated to analyze patients’ narrations, go into their world of beliefs and presuppositions, reflect upon the “discourse” we will use to try and “find meaning” in their reason for consultation, think about the scenario that will be posed in their lives after diagnosis or therapeutic advice, and about how we can help them?

Medical practice finds us as passive users of one of the most powerful tools: the language. As other “therapeutic agents”, it has its indications and contraindications, its great success and its significant adverse effects.

For years, patients often remember some inspired phrase we have said and has reinforced their wellness or some therapeutic behavior. Why words have that unexpected impact on some patientes—or vanish before entering the office in the case of other patients—remains a mystery.

It is not unreasonable that a medical magazine director put forward research on some linguistic aspects of the medical practice. I will try it from a clinician’s point of view, convinced that it may help improve our daily practice and enrich us in the human dimension of our profession.

Since I am not an expert on this subject, I will resort to the authority of the reading, and I will dare to give some opinions only about the medical act.

Scientific medicine and its language

In the second half of the XVIII century and the beginning of the XIX century, there was a revolution in the medical thought: the emergence of scientific medicine, which brought about a new language. In “The Birth of the Clinic”, Foucault has documented (1) this phenomenon in French, and something similar has been done at least in English. (2) A revolutionary change of the medical thought takes place in that period: The individual in question was not as much a sick person but a pathologic fact that is perpetually reproducible and must be found in every patient who suffers in the same way. The paradigm is the discovery of diseases as subject of the medical study, which grounds in physiology and pathology, on the concept of “body as machine”. Some decades later, this scientific view will be consolidated in a broader concept through physiopathology. The claim that “there are no diseases but sick people” is defeated. Today, it is considered an adequate reference to the need for recognizing the characteristics of each patient. At those times, it was an argument against the “nosology” theory. The typical findings in tuberculosis, atherosclerosis, and inflammation appear; descriptions become thorough and detailed; and physicians begin a process of “splitting hairs” towards the mechanisms of the disease, which continues even today.

Gap between physicians and patients: Rituals and language

Historians explain that, at the beginning of the XVIII century, the knowledge gap between a professional and a layperson was not very significant, and any avid reader of popular medical works (true best sellers at that time) was able to master the concepts and useful therapies of that period in history. This becomes unthinkable at the beginning of the XIX century, and is symbolized by the wearing of the white coat (of course, lab researchers wore white coats to avoid stains in their clothes, but its spreading among physicians represented the debut of science in the doctor’s office), and by the use of the stethoscope, some decades later. Both signs are indicators of the abyss of knowledge that separates medical science from general knowl-
edge and, of course, they are indicators of the pretended authority that such knowledge can come with. Medical language acquires the “naturalness” and “neutrality” of scientific language, with a huge advance on nosology, the successful presumption of giving names to those problems that induce suffering to create understandable and treatable diseases, a sort of biblical Adan giving names to the animals living in his world. During the past decades, we have learnt that segmenting the reality of human suffering in nosologies is neither neutral nor natural. As we will insist later on, no aspect of language use is neutral or natural either.

DOMESTICATION OF FATE

Another revolutionary aspect, with explosive influence on therapeutic thinking and prognostic disgression, has been the introduction of statistics. In a thorough literary page on the subject, Ian Hacking (3) tells us about the explosive rage of measuring and estimating everything—which burst at the beginning of the XIX century—and, the introduction of statistical thinking into medicine, with its derivations. (4)

The epidemiological thinking, initially used to recognize factors related to “epidemics”, spread at those times into the estimation of the intervention impact such as Jenner smallpox vaccine, and after many intelectual and experimental wanderings about its actual use as basic tool for “risk” estimation and assessment of therapies. It also underlies to a concept of society as a body that can be influenced by measures that modify its behavior in terms of morbility and mortality, and consequently, to preventive medicine and its scientific and ideological presumptions. Population-based medicine, as opposed to patient-based medicine (sufferer) is full of probabilities, percentages, and risks.

THE PROBLEMS WE SEE AS DISEASES

The epistemological discussion about what a disease is, what is normal, and health, is one of the most complex and debatable issues among philosophers on medicine. It intertwines with the socio-cultural values and our concept of suffering and death in such a way that its approach is very complex. By way of example, suffice it to mention two polar approaches to death: “a normal, comprehensive, and inevitable stage of life”, as opposed to “a failure of medicine”. The abundance of English terms for “disease” adds to the complexity of the subject: “disease” (defined entity – organic affection), “illness” (condition), and “sickness” (more unspecific discomfort, more related to the social role it modifies). These terms make these debates more difficult to translate into Spanish.

An easy aspect to undertake is the analysis of the evolution in nosology for the past decades, related to a medicine inserted in the market economy, hegemonized by the research of the pharmaceutical industry, and with very active pharmacological interventions in areas of everyday living.

Discomforts in life and medicalization

The strategy of the so-called biomedical model—which we profess and practice—consists in listening to the patient’s narration to detect specific symptoms that help us diagnose the disease that causes them. In this model, narrative analysis is highly focused on nosology. Reasonably, most consultations due to body and mental discomfort and related to our complex emotional and social life do not lead us to any biomedical diagnosis. These undiagnosed pains, which may be incapacitating in certain cases, are out of the model.

Nowadays, scientific medicine has also invaded some of these grounds. For the better or for the worse, over the past decades an effort has been made to medicalize all aspects of life. Seen as a conspiracy by Ivan Illich, (5) or as a tragedy with actors but no guilty persons by others, (6) we are the protagonists of this unique phenomenon in human history, in which our lives could be guided, planned, improved, and perhaps perpetuated by the medical science and its scientific knowledge.

Discomforts in life and new diseases

Together with the advances in the development of the pharmaceutical industry, discomforts in life or natural circumstances have “ontologized” as diseases. One of the most debated examples has been the characterization of menopause as a disease due to hormonal deprivation, and of course curable with estrogen therapy. Every situation that can be modified with a drug has followed the intention of being ontologized (become an entity). Thus, children’s attention deficit at school is a syndrome that must be treated with psychiatric drugs, freeing their parents and teachers from further considerations. This hypothesis might be applicable in extreme cases, but in practice, it includes almost half the students in many series.

Nosology is not innocent; it induces significant changes in our way of thinking about our fellow people and, of course, in the limits of the medical practice. Thus, to qualify someone as very shy is an empathic view, but to consider him or her as a “social anxiety disorder” individual is to talk about a pathology that may require a drug to cure it. Sexual dysfunction, by definition, is based on a pretended knowledge of “normal sexuality” as scientific data, which is something undoubtedly pretentious.

Ontologization of constant variables

For the evaluation of risk factors, we have also had constant modifications in the defining criteria. The reading of the HPS (Heart Protection Study), in which statins lowered the risk whatever the initial cholesterol level was, lead to consider that “we are all hypercholesterolemics” (7). The same could be said
about hypertension, and maybe about other conditions. Over the past years we have learnt that our civilization is based on new biological parameters, away from our cousins, the superior primates, and even from our paleolithic brothers. This is the result of huge modifications in diets, reduction of bodily work, and urban life, in a completely different life context. In this regard, blood pressure and cholesterol levels have turned into elements subject to medical manipulation in the prevention strategies for all the population. Their application or intensity depend on individual risk models. This model of thought is complex and not very compatible with the hypertension definitions of the consensus, and far less with the prehypertension definitions.

What we have learnt about blood glucose is similar. Many authors have discussed the proposal of changing blood glucose level from 140 mg/dl to 126 mg/dl to define diabetes. Kaplan (8) has reported that this change multiplied three times (from 9 millions to 33 millions) the number of people requiring diabetes therapy in the United States. Have we found out that individuals with 135 are diabetics, or that 135 is a level that is worth changing, and therefore we define it as pathology? It may be necessary to reconsider this issue from a different perspective, given the little or no benefit shown in controlled trials when trying to place blood glucose at very low levels. (9) In popular beliefs, diabetes is very different from the risk increase implied by 135 of blood glucose. This is not a diabetologic approach but one more element to assess the individual cardiovascular risk and minor measures.

Anecdote 1
A 75-year old female patient with no typical risk factors and living a healthy life is tested and detected a blood glucose of 132. She is referred to the diabetologist, who performs a new test and confirms a similar value. Trying to show himself friendly, the doctor tells her:

“I have two news for you, a bad one and a good one. The bad news is that you have diabetes, and the good one is that I am going to be your doctor. He prescribes her medication, diet, and a device for frequent blood glucose monitoring at home.

The patient pricked herself for three days; then she stopped that and came for consultation raising the following issue:

“Doctor, you know... I have had some problems this year. I gained seventeen pounds (8 kilos), and gave up swimming. Before taking all that medication, I would try losing some weight and doing exercise. The patient reverted the news and turned them into two equally good ones: the first news was that the diabetologist was not her doctor any more, and the second and best news was that she did not have “dia-

Scientific medicine knows everything and, above all, can give opinions
If medicine knows everything about the science of life, then it can determine how long to sleep, what to eat, how much to exercise, how often to have sex according to age and how long a sexual intercourse should last, how often to empty one’s bladder and to have a bowel movement, how many times a day to smile. Of course, also what chemical mediator explains every discomfort in life. Newspapers are full of daily news with this approach, and many times they are embedded in our discourse.

To observe that people who smile and have a good time are healthier, is not the same as to prescribe smiles. Also, if the habit of having a nap is associated to less cardiovascular diseases, it does not mean that those who do not have this habit but adopt it unnaturally will improve their prognosis. The same can be said about exercising and about most of what is said about diet. Considering that a person who exercises 45 minutes three times a week since the age of 40 adds one year of life at the age of 70, we can make the following estimation: the person will spend 3,510 hours running, an equivalent to 146 days. It is evident that if our new Forrest Gump (10) enjoys running, he will have made a great investment, but if he does not like it and prefers writing or reading, he will have lost a precious time pursuing the unattainable. It is not so easy to set what is good or bad for one’s health.

Medicalization and direct-to-consumer medical advertising
On many of these aspects, medicine works as a back-drop for businesses –at times almost awkward. (11) These days, two yoghurts are being advertised on TV. One dedicated to daily “alleviating”, and the other to avoiding the terrible gas and bloating that apparently affect all young and pretty women; a true biblical curse, even worse than “give birth with pain”, which is a more sporadic suffering. Both are the result of the sin of eating what is forbidden. One of these ads is even rounded off with a sentence of apparent scientific support: “The Argentine Society of XX recommends to take care of your digestive health everyday.” This phrase, unobjectionable in itself for its vacuity, could also be valid for urinary, cardiovascular, dental, capillary, or axillary health. In this context, it suggests that the scientific entity wants Argentine women to have at least a daily catharsis ensured by this healthy yoghurt. The medical discourse presumption that we live for our health on a daily basis does not fit real—and probably iatrogenic—life.
THE PHYSICIAN-PATIENT CONTACT - WORDS AND NARRATIVE

Over the past years, a tendency that demands the need for teaching narrative competences at schools of medicine has emerged. (12, 13) One of the goals is to recover the patient’s narration and his/her life (“patient’s narrative”) in the medical practice, partly as opposed to the “biomedical model” and the dynamic pair “classificatory passion-drug”. Nowadays, medical issues are dealt with in narrative magazines, and they intend “...to insert culture within the narrative model of the physician-patient interaction, and to defend the argument that culture –the circumstance in which physicians and patients are historically placed– influences significantly in what is said and listened to”. (14)

This training implies an opening-up: expand our patients’ discourse analysis and the way of listening to them, and to produce our own discourse, which is also crucial.

A first easy-to-apply dimension is the modification of the medical record and its presentation during rounds. For instance, teachers from relevant schools of medicine have suggested the recovery of some basic strategies to avoid the “reification” of the hospitalized patient: there is an infarction on bed four. In this regard, they suggest including a brief narration of the patient’s life in the written medical record: what he/she studied, what his/her job is, and information about his/her family and current abilities. (15)

A frequent issue as practical exercise: non-compliance with treatment

One of the commonest situations at the doctor’s office and in the series of medical cases is the interruption or modification of the recommended strategy on the part of the patient. For years, this failure to follow treatment has been called “non-compliance” in Anglo-Saxon literature.

Industrial revolution and market economy have moved most of the population to the cities. This has moved people away from the traditional medicine of those we now call folk healers, changing their view on health problems and generating, for the first time, the possibility that the medical institution cares for the whole of the population, and not just for the minorities that had access to health care. The knowledge gap in patients and their distance from the institution have consolidated a model of “paternalistic” medicine and of the figure of family doctor, at least for some society sectors. This is obviously a general view and does not intend to hide that, in our country, there is still significant population segments that lack medical care and access to technology. But this is not the topic under discussion here.

The term “non-compliance” refers to that model. When the paternalistic model of the professional who gives orders that a patient has to obey was questioned, the term “non-compliance” was replaced by “adherence” to a plan.

Over the last decade the model of “concordance” has been suggested, in which physicians and patients have an equality relationship for decisions, and agree on trying one therapy. (16) The thousands of works that are published every year confirm that non-compliance with treatment is still very irregular. Even though it can be approached from an epidemiological perspective, the issue is present in the consultation practice of any physician. As a result of this, we can and should explore our individual training. One of the highest qualifications experience at the office provides the ability to prescribe treatment that will be accomplished in the long run, with all the craft this achievement implies.

The rhetoric view

The non-compliance problem has been discussed from different perspectives, and an “original” possibility is to analyze the rhetoric in the physician-patient contact.

This is how Wikipedia defines “rhetoric”: it is a discipline, used in different fields of knowledge, that studies and systematizes procedures and techniques of language use to add a persuasive or esthetic purpose to language, in addition to its communicative purpose.

We are referring to the art of persuasion, so relevant to the topic we are discussing here. Judy Segal dedicates a recent book to a thorough analysis of the rhetoric in medicine. (17) She explores in depth the relationship between medicine and its historic and cultural circumstance from the definition of what is normal and pathologic, its values and metaphors, (18) the analysis of historical examples such as headaches and hypochondria, rhetoric of life and death, and the evolution of narratives of diseases, even in their new blog versions.

One of the chapters focuses on medication compliance. We know this issue is influenced by socio-economic variables (years at school, the economic possibility of buying medication, ease of access to consultation) that are obstacles to be actively fought against. In this analysis, I am most interested in highlighting that even with none of these barriers, many patients take their medications irregularly, or change them, or many colleagues play among themselves rotating the therapies, etc. From a somehow paternalistic model (phone patients to remind them to take their medications and control their weight), the DIAL study (19) has shown that this strategy increases “adherence” and decreases hospitalizations.

Training in persuasive behavior techniques

Another form has been through behavioral approaches, with the use of rhetoric techniques. When analyzing a discourse of the physician-patient contact, we can recognize arguments related to the ethos (to
the being and the attitudes of the discourse sender), to the pathos (the affection that is to be aroused in the receiver: calm, anger, fear), and to the logos (referring to the discourse topic and message).

From a cognitive approach, it can be considered as “theory of persuasion”, in which a source, a message and a receptor can be recognized. This way, we can predetermine discourses, interview stages, etc. This is widely applied to selling strategies, and, in our field, it is based on the intention of the medical authority to influence on the patient and achieve concrete goals. In this regard, valuable contributions can be mentioned: how to break bad news, (20) how to structuralize consultation, “etiquette-based” medicine (21) (to introduce oneself to the hospitalized patient, for instance, providing the physician’s name, greeting the patient, showing interest in what he/she does, etc.). These contributions can surely help improve our practice and be the basis on which to deal with an issue generally ignored by medical training.

However, these are instrumental approaches that may avoid the need to create a different communicative dimension with patients and their families in order to place these natural and inevitable measures into a better context.

**What do we listen to when a patient talks to us?**

We have already commented that for the scientific medicine, the hospitalized patient due to infarction becomes another manifestation of a continuum of Q-wave or non-Q wave myocardial necrosis, which is absolutely true and operative, but has limited possibilities for us to help. Another author expresses it this way: with the consolidation of scientific medicine and the loss of patient’s narrative, “doctors begin to sound like doctors, and patients’ voices disappear”. (2)

From this perspective, it is possible to understand non-compliance with treatment as an expression of the silenced voice of patients, who are saying they do not trust or do not want to take the medication. As a result, they decide to stop it, with the excuse of apparent oversights, intolerance problems, economic problems, and many others.

**Anecdote 2**

- Joaquín, what calls my attention is how your cholesterol level is higher in this test. Are you taking your medication?
- Yes, doctor.
- But didn’t you stop it, at least for a few days?
- Well, I had run out of medicine a week before, but I thought it could not influence... Then I bought it and went on taking it...

Reading: the patient decided to stop taking the drug a few days before being tested, in the hope that his cholesterol level would not increase anymore, and so he could stop taking the drug. His physician would probably have been against this strategy.

**Dimensions of the physician-patient dialog. Paternalism versus concordance**

To think in terms of concordance, that is, to have an in-depth discussion of the reason and rationality of medication in a language and a context understandable and capable of being incorporated to the patient’s conceptual system, undoubtedly enriches the dialog and should improve the outcomes. The patient will take a decision—harder and more relevant than the one taken by the physician—regarding what to do with the recommendations, but it will not be about “disobeying orders”. (22) However, we must not forget that physicians’ and patients’ dimensions of disease are different: we, physicians, think of diseases in their literal meaning; patients think diseases are discomfort, suffering or threat. For us, medications are highly positive elements, true “remedies” for patients (and often for us when we ourselves are patients), they are considered stigmatic elements of disability, necessity for help, weakness, dependence, disabling condition; and, of course, they may be harmful to them.

**Anecdote 3**

José has had an infarction.

- Will I have to take all these medications all my lifetime?
- Do they make you feel upset?
- No, doctor, but at my age... See how many I take...

(A complaint resumed here about the stigma of seeing oneself—and especially being seen by others—as a medication-dependent individual; the tremendous failure of life that has lead needing all these at the age of 50; a shame that cannot be hidden.)

Answer (one of the thousands of discourses available):

- I understand. When you and I were children, we would have some relative who took lots of pills; either the relative was very sick or he/she was weak and hypochondriac. One way to estimate how severe health problems were was to tell the number of drugs the person was taking. But that was also a time at which only a few drugs were useful. In fact, if you did not take most of what we prescribe you, you would feel exactly the same way. These medications prevent further artery blockage and avoid new attacks. You do not depend on these medications; you can stop taking them when you want to, but you will simply be deprived from the benefits medicine can offer you today. Also, researchers say that these four drugs should be taken by all people aged 55 or older to prolong their life expectancy by 10 years on average.

How much time do we dedicate to preparing these discourses, adapted to the patient’s look and mood—and, of course, to evaluating if they have been useful? Who listens to us or corrects us? Who do we discuss it with?
THE PROPOSAL OF A NEW RHETORIC

In her book, Segal suggests a distinction between the persuasion theory, which we have mentioned above as instrumental or technical, and the rhetoric theory, which goes deep into the aspects of physician-patient communication from a different perspective. The true rhetoric communication –she says– only occurs when patient’s and doctor’s minds agree and speak the same language.

She starts from a verification: for the paternalistic model to work, it is detrimental that weakening of the physician’s ethos has occurred, that is, the physician’s authority recognition and wish for help. There is no doubt that the image of the doctor who knows everything, who is over-arching and warm, whose authority is unquestionnable, is quite different from the image of the doctor we meet in the actual consultation in most of healthcare contexts. A second reading –not dissociated from what was said above– is the weakening of the identification between patient and doctor. Pretending that these difficulties be overcome by giving the patient more responsibility from a horizontal rhetoric (physicians and doctors are equal), as opposed to a vertical rhetoric (the doctor knows and the patient ignores) has not been successful either, and it could worsen the medication problem.

Equality must be absolutely respected concerning the right to express oneself and the final decision making, but it is difficult to accept that what has been said is of similar value, given the knowledge gap on the topic. I may give my opinion to the mechanic, but his opinion will highly likely suit better to the problem. The rhetoric of the physician-patient equality belongs to the consumer’s rhetoric and his/her rights, which is probably inappropriate in terms of health and disease.

What do patients really know about their conditions?
The physician is an expert on conditions, but the chronic patient is an expert on his suffering; nosology versus experience in it. During the contact with the doctor, this expert knowledge must be negotiated virtuously. In fact, much of the medical task with patients who have had infarction and suffer from multi-form pains, or patients with symptomatic extra-systoles, is not to relieve symptoms but to alleviate the fear that they could be symptoms of a threatening disease.

CONCLUSIONS

We are as unable to definitively reach the reason and the agreement among spirits as to give up doing it. To see the human being from the outside is the criticism and the health of spirit. But the aim should not be to suggest that all is absurd, as Voltaire did. It is much more a question of implying, as Kafka does, that human life is always under threat, and of using humour to prepare the ground for those rare and precious moments at which human beings come to recognise, to find, one another.

MAURICE MERLEAU-PONTY (23)

I have tried to review the topic of words and medical language from just a few of their possible dimensions, inviting to reflect upon their lack of innocence, and the therapeutic potential a correct interpretation of the patient’s narrative and some rhetoric aspects may provide to us. We may talk about malpractice of the medical words, the metaphors on health and diseases, our discourses to patients in intensive care units, and innumerable topics of theoretical and practical interest.

Considering these problems is not enough to solve them. Addressing them implies a training discipline, revising our practice, generating dialog settings on narrative, groups for debating and exercising in depth our “rhetoric” the way this issue deserves. Not only do physicians listen to patients in a certain way, but also educate them to tell us what we are interested in listening from them. It is obvious that the patient does not tell the same to the homeopathist, who is interested in knowing about the patient’s feet perspiration or persecution dreams, than to the cardiologist or the clinician. Chronic patients speak for the doctor, who is trained in warning signs, but at the risk of hiding new symptoms that could be relevant. We physicians tend to listen only to what the patient “is” as a pathology.

Perhaps there is not a course on medical communication and language, but there are partial teachers who can help us improve our development. This task must be carried out in groups. We can work in the production of discourses on different topics, consolidating our present thought: we should then have a discussed rhetoric on diuretics, diet, or exercising. But this is not at all enough.

Jude Segal suggests the need to learn more about rhetoric terms, but basically to achieve the identifi-
cation with the patient and his/her condition. Whatever the technique to be applied, it will fail if there is no empathy. Empathy is not practised by decision. It arises naturally when we are capable of generating the appropriate communicative environment in which our own conflicts and sufferings, and our own wisdom for life will also be engaged.

The ethos –our persuasive ability as physicians– depends on our training but also on the ethos of the medical profession as a whole, so defined with illusions of eternal health and so scorned in practice with unfair compensation and mistreatment, as well as overwhelmed by corruption and idleness. Physicians must be reliable experts in order to ensure real communication development, reinforced by arguments and adequate rhetoric situations during the conversation (place, times, atmosphere). Claiming for credibility –first step towards the physician-patient relationship– is also questioned in a complex model: the doctor is seen as part of a professional corporation, and also as an agent of prepaid health insurances and public health schemes; in short, a professional with certain power.

**FINAL WORDS**

In the patient’s narrative, there will always be aspects of his/her emotional situation, and just by asking about the issue we will give the patient the possibility and the relevant value of what is really going on in his/her life. In this sense, we usually try to influence on patients by giving recommendations or opening the doors to psychotherapy. Unfortunately, this is not safe either. Recently, the novelist and journalist Eduardo Blaustein, has humorously expressed:

> The other big problem is that of patients who have had infarction and do not go through life full of optimism, jumping for joy, and throwing petals in the air. If, to extremely simplify, the doctor tells them “Watch out, sad people, you are condemned to infarction”, that will also be an impertinent remark.

Clearly, we are dealing with a complex dimension of medicine. To hide it has its cost in reducing the dimension of our practice to a poor evidence-based technical task, and in little help. Opening this dimension for discussion involves great reflection and engagement, but it will undoubtedly enrich us.

Carlos D. Tajer

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10. *Forrest Gump* is a film, released in 1994 and directed by Robert Zemeckis, in which Tom Hanks plays the role of an individual with poor intelligence but strong passions. At a point in his life, he suffers a loss and decides to start running. He runs for years, for no apparent reason.
13. Tajer C. *Quote from CONAREC*