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Medical power and the crisis in bonds of trust within contemporary medicine

El poder médico y la crisis de los vínculos de confianza en la medicina contemporánea

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ABSTRACT Based on the Brazilian context, this paper addresses medical power in terms of the current conflicts in the intersubjective relationships that doctors establish in their work, conflicts considered here as a product of a crisis of trust connected to recent historical transformations in the medical practice. Reading these conflicts as questions of an ethical and moral order, we use Hanna Arendt's theoretical formulations to further analyze this crisis of trust. In this way, utilizing the concepts of "crisis," "tradition," "power," "authority," and "natality," we search for new meanings regarding these conflicts, enabling new paths and solutions that avoid nostalgia for the past.

KEY WORDS Power, Professional; Humanization of Assistance; Ethics, Medical; Humanities.

RESUMEN Basados en el contexto brasileño, en este artículo abordamos el poder médico en términos de los actuales conflictos en las relaciones intersubjetivas que el médico establece en su trabajo, conflictos considerados aquí como producto de una crisis de confianza vinculada a los recientes cambios históricos de la práctica médica. Al interpretar esos conflictos como cuestiones de orden ético y moral, recurrimos a las formulaciones teóricas de Hannah Arendt para analizar con mayor profundidad dicha crisis de confianza. De este modo, a partir de los conceptos arendtianos de "crisis", "tradición", "poder", "autoridad" y "natalidad", realizamos una lectura con nuevos significados de estos conflictos, que posibiliten futuros caminos y nuevas soluciones que eviten una nostalgia del pasado.

PALABRAS CLAVES Poder Profesional; Humanización de la Atención; Ética Médica; Humanidades.

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INTRODUCTION

In this work we will address the changes in the doctor-patient relationship in contemporary medical practice. Through the contrast between the medicine established by "tradition," a concept that we have borrowed from Arendt,[1] and the current technological medicine,[2] we will analyze here the way in which the transformations in work relationships and the introduction of new technologies affect a central element of the clinical encounter. It involves a bond of trust between the physician and the patient that was built throughout the development of liberal medicine from the 19th century until the middle of the 20th century. This bond undergoes extreme tension in contemporary times, due to disruptions in the interaction that such relationships are experiencing.

The present work is part of a research study entitled "*Collective Health and Philosophy: Hannah Arendt's contributions to the humanization debate*,"[a] which studies the Brazilian bibliographic productions on the theme of humanization/dehumanization in healthcare. These productions highlight the progressive incidence of abusive treatment, verbal aggression, negligence in medical attention, or obstacles in the access and use of services, which are considered to be acts of violence towards the users of those services.

Although, on the one hand, much has been discussed with regard to the working conditions of the professionals and the difficulties of the Brazilian healthcare system to provide a more efficient model of attention, and, on the other hand, with respect to the extremely technical basis of the professional training and practice, an aspect that, in our view, should be at the center of the debate is the issue of the transformation of medical power into institutional violence.

We understand that such transformation requires deeper critical reflection and, for that reason, we draw upon the thought of Hannah Arendt, whose differentiation among the concepts of power, authority and violence has emerged as a fundamental source for this analysis.

The choice of Arendt's thought is reinforced by our thesis: we acknowledge this crisis in the bonds of trust as a product of different disruptions in the interaction between doctors and other actors involved in medical practice. Such crisis would be related to ethical and moral conflicts in medical practice, leading to the loss of the legitimate authority of these professionals in interventions upon the body and person of the patient. Due to this fact, we look to Arendt, as a leading thinker of those contemporary issues related to political action involving authority and morality, for theoretical formulations to support the development of this thesis.

DOCTORS AND POWER

We find in medical sociology and the sociology of the professions the macrosocial foundation for the contemporary phenomenon of the crisis in the bonds of trust. Sociology is a privileged field of study for reflecting on agency and structure: the relationship between human action and the structural determination of social relationships through the so-called "relationships of power." According to Turner,[3] when sociology deals with the medical field, it is interested in the relationship between knowledge and power in the distribution of health and disease within the social body. It would be a sociology that is concerned about the role of medical discourses in the substantiation of medical power, which, in turn, outlines the possibilities of understanding the relationship between health and disease as well as its distribution.

Turner argues that to address the medical power, it was of vital importance to classify the vague notion of disease into three different categories: *disease, illness* and *sickness*. Generally speaking, we can say that the term *disease* refers to the anatomopathological character of the disorders, as

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described by Foucault[4]; the second category makes reference to the subjective experience of becoming ill, and the latter category (*sickness*) denotes the sense of disease related to macrosocial and cultural forces, in terms of the determination of the roles of diseases and diseased individuals in society. Thus, this approach shows diseases beyond their biological character, by placing them within the social construct of modern societies.

Furthermore, Turner mentions that another point that should be taken into account is the division of labor in the area of healthcare, since the doctors are responsible for the treatment of medical conditions (*disease*), psychotherapists deal with psychological disorders (*illness*), and social scientists seek to understand the process of the socially constructed disease (*sickness*). The author states that the status of scientificity of the knowledge of those professions is hierarchical, given the fact that medical intervention is socially deemed accurate, precise and scientific while the interpretation of the social scientist is often considered to be an opinion.

However, if Turner identified the different powers related to the exercise of authority in professional intervention in terms of the diversification of the knowledge involved in the definitions of health-disease, other knowledge modalities may be added, which also compete for the status of scientificity in subordinate hierarchies. As a product of the experiences with disease, we have the knowledge of the patients themselves (who are the ones that directly deal with the treatments for the care of such diseases) or popular knowledge, and the practical knowledge of the doctors.[2]

This latter knowledge derives from their healthcare practices and was fundamental in the construction of modern medicine due to the different status it held in the practice of the liberal doctor as opposed to its almost complete lack of significance in current technological medicine. Thus, the practical knowledge of the medical professionals was relevant in the construction of the medical tradition in terms of the clinical encounter and the creation of bonds of trust.

This differentiated hierarchy as regards the scientific status of that knowledge leads to an understanding of disease as a natural and neutral entity over which doctors will act based on scientifically grounded techniques. Therefore, these would be technical interventions of a neutral character upon a dysfunction that has a natural source. The power of the doctor, the neutrality of this power in the face of social and political interests and its naturalization as action are based on this view, which has been widely criticized by the sociology of healthcare and medicine.

The contribution of the French philosopher Michel Foucault is essential to the deconstruction of disease as a natural entity, as well as for the formulation of knowledge as a mechanism of control. The author's concern for analyzing the relationship existing between certain medical discourses and the exercise of power is particularly relevant to our study. These discourses evolve in relation to the growth of State surveillance through the exercise of discipline over the bodies and the control of populations. In this sense, Foucault observes the same behavior in the clinic, the psychiatric asylum and the prison, through a panoptic model of surveillance.[5] In his analysis of the alliances among discourse, practices, professional groups and the State, Foucault argues that knowledge-power was organized around the control of the body of individuals within those institutions, and around the body of populations, through the birth of social medicine.[6]

The Foucauldian epistemology posits that human beings can only know (or see) what their language permits, and, therefore, the scientific discourse is understood as a narrative that is determined by linguistic conventions: the different societies in the history of mankind have their own conventions, and therefore, different realities. In the case of disease, it can no longer be understood as a natural event outside the language that describes it but as a product of the medical discourse that reflects the dominant mode of thinking of society.[4],[7] Therefore, for the author, what we understand as disease is

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an effect of power-knowledge relationships. According to Foucault[4],[5] – and also to the American sociologist Elliot Freidson[8] – the expansion of medical scientific knowledge gave doctors enormous prestige and influence towards the end of the 19th century, because an entire institutional field – which also formed the modern State – created the conditions for this, enabling medical doctors to define normality or deviance.

When delving deeper into matters of medicine in the 20th century, Freidson[8] showed that the constitution of an autonomous medical profession that monopolizes knowledge, practices, institutions and its social evaluation included a series of processes. First, the medical school of the universities of the Middle Ages prepared the context for the criteria that identified the specific group of medical workers. Later on, as a result of the importance that the university program of medical studies had for the elite of the time, graduated medical doctors quickly obtained the support of the State to become arbitrators of their own work.

This led to the control in the formation of future medical doctors by their colleagues, as well as to the limitation and even the prohibition of other activities that dealt with the same object of study. Later, the State would grant doctors the right to limit, supervise, and manage the exercise of all those activities or occupations that could enter into competition with medicine. This is the definition of professional autonomy: the right to diagnose and prescribe for a patient in accordance with the standards of medical knowledge as well as the right to be evaluated by professional peers. From this perspective, medical power is understood as the capacity of the corporation to control the formation of new doctors, as well as a self-regulated professional autonomy.[8]

In his compilation of interviews and dialogues entitled *An Invitation to Reflexive Sociology*,[9] Pierre Bourdieu defines *field* as a network or configuration of objective relations between positions. These positions may be identified materially or in terms of the relations that they establish among themselves.[10] Thus thought, the fields are relational, dynamic and subject to contingency and permanent change, so they should be thought of in a relational or dialectical way.[11] The field dynamics does not occur randomly, but follows a logic of its own that shall determine its specific way of functioning.[9] Therefore, the act of thinking in the medical field means thinking in a space that is made up of a number of institutions that deal with, through laws and rules, the matters of health within a society, that is, the healthcare policies and those who formulate them, the different professionals that take part in the network of services, the training of those professionals, and the users of those healthcare services.[10]

Bourdieu also developed the concept of *habitus*: "...a structured body, a socialized body, a body that has incorporated the immanent structures of a world or of a particular sector of that world."[12] Thus, the study of the medical power according to Bourdieu will be possible through the analysis of the institutions that are constituted as a network within the medical field and of the relationships of those institutions with the formation of the professional *habitus*.

Moreover, sociologist Paul Starr[13] believes that the medical power is based on the technical-scientific authority of the profession, through the scientific legitimation of their knowledge and the dependence of society upon such knowledge. Thus, medical power would originate if the organized professional groups could generate new forms of dependence on their knowledge and competence. What confers a distinctive character to those relationships between consumers and the profession is the fact that the professional groups, through the most varied mechanisms, manage to impose their interpretations of the world as truths, becoming social and subjective references that help understand the world and our reality. Starr[13] names this specific kind of authority as "cultural authority," in which although physicians are looked to and consulted by the public, they do not have the power to impose a specific treatment if the patient refuses to follow it.

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What is implied by this impossibility of doctors to impose something on their patients? From our perspective, and according to Freidson's study,[8] medicine is primarily a consulting profession and as such, the patients consult the physicians spontaneously and they do so because they are acculturated in that same social order, sharing that medicalization of the determinants of disease. This process occurs as a result of the education of the populations[8] and – rather than from technical-scientific efficacy or "technical success" in Ayres' words[14] – from gaining trust during the clinical encounter[15].

The material and symbolic process for the construction of a "tradition" of the medical profession is based on both the technical success and the development of bonds of trust, albeit with certain asymmetry of authority in the subjects involved. This is an ideology in which the professionals and society are acculturated. A wide set of values and virtues correspond to that "tradition," as will be later discussed. A part of this ideology still persists today, especially with respect to cultural authority, including a number of values and virtues that were present at the time of its construction and that currently contrast with the deep material, institutional and technical changes in the conformation of the profession.

Indeed, from the accounts of doctors from São Paulo that were interviewed as witnesses of the historical changes in the Brazilian medical profession,[2] we learned that as a result of the development of an increasingly technological medicine, the bonds of trust in physicians started to be breached, giving rise today to significant crises in the clinical encounter with regard to intersubjective relationships and radical tensions, so that physicians might exercise their power.

Thus, we associate "tradition" with the liberal modality of the medical practice and profession.[2],[15] Medical professionals position themselves in the working world as the holders of the means of production of their work and as regulators of their client flow. This position, which emerged in Brazil during the first three decades of the 20th century, refers to an autonomy that has a commercial nature, due to the great freedom in the exercise of its practice as the social production of a service as well as the freedom in the way remuneration was fixed, in addition to the autonomy concerning technology and the organization and control of their service [2].

Donnangelo[16] defines such a condition as "typical autonomy," in contrast with the readaptations that resulted from the doctors' insertion in their professional market during the 1970s and 1980s. By the middle of the 20th century, as a result of the incorporation of the new technologies, either in the form of novel treatments or as diagnostic resources, the liberal medical work, which, additionally, was a "solitary practice"[2],[8] based on a single producer, almost disappeared. The doctor then created and incorporated the culture of working alone and invoking, above all, his authority through the clinical decisions he made.

The impossibility of the individual producer to afford the costs arising from the acquisition and maintenance of the means of production of his service gradually led this medical category towards salaried positions, both in the public and the private sectors, with the emergence of the large healthcare companies.

Some authors consider that this new medical position is part of a much larger process of deprofessionalization[17] or of proletarization[18],[19] of doctors, an aspect that will not be addressed in this work. What we would like to highlight here is the impact and the significance of this new position for the relational bonds between doctors and patients, which result in doctors losing control over public access, thus becoming for the population mere intermediaries in the access to health: patients seeks a doctor only if he can be contacted through their health plan or is part of the staff of a specific hospital. Doctors will have contact with patients only if they are "listed in the provider directory" of the patients' health plan.[2] To this "anonymity" that evidences a depersonalization in the doctor-patient relationship,

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we can add the demands of public or private business productivity, and the progressive valorization of a practice focused on the use of additional studies or therapeutical technologies. All this gives rise to the perception, both in doctors and patients, that the sphere of interrelationship is not at all well. In addition, we should also mention the growth of information technology and its incorporation into the medical practice, which also contribute to an erosion of the interpersonal bonds on which trust rests.

The accounts of two interviewed doctors from the mentioned study by Shraiber[2] serve to illustrate these matters:

> *There was a time when the patients chose a doctor for the trust they had in him and it would be very odd for them to end this professional relationship with their doctor due to a lack of trust, to consult another doctor and then come back to be operated on with the doctor they had first chosen. The system of trust appears to have weakened a little* [...] *For example, when I can't see a patient for an unexpected reason, the patient consults another doctor who is available to see him. So, instead of consulting Dr. X, he goes to Dr. Y, and period. Nothing changes. It's just going to the doctor and that's it. One or the other is the same thing...*[2 p. 123-124]

> *Nowadays, the access to information has changed a lot. The patient comes to see you with the information...with a folder under his arm and discusses with you as an equal!* [...] *What place should I take as a doctor in these cases? Because I will use some values for the decision that are very different from those of the son of a patient suffering from cancer. For him what is inside his folder will always be wonderful!*[2 p.200-201]

TECHNOLOGY, VALUES AND RUPTURES IN THE INTERACTION

Medical practice is the exercise of a specific intervention technique, a treatment that aims to cure or control diseases. Although much has been said about the ethical nature of this technique – commonly understood as a consequence of the implementation of such intervention on the patients – what we affirm here is that ethics is consubstantial with technology, since those two dimensions are completely intertwined in medical practice, being so closely intertwined that the technique itself may be considered to be "morality-dependent,"[2],[15] a value-laden action that, by means of modalities of interaction, allows for the implementation of the most objective use of scientific knowledge and technological resources. In this sense, we state that ethics is not restricted to the personal disposition of the medical professional, as an individual and independent realization of the technical action. The absence of that ethical exercise compromises the foundation of the scientific action.[2] After all, medical practice is the intervention of man upon himself, mediated by technology and science. If that practice is substantiated only through technical aspects, the relationship would transmute into the intervention of man upon an object. Therefore, it is not only about adding ethical elements to the technical act, as if it were an adverbial complement. We often observe incentives to encourage, for example, a conversation with a patient, as a solution to the criticism that results from the ridiculously short time of the medical consultation, which in turn, evidences the lack of interest in the patients. Thus, if this is proposed as something external to competence and the use of scientific resources, which does not interact with the actual technological moment of the intervention, it may appear that this conversation has been established by faking an interest in the patient or as a "useless" conversation, in contrast with a conversation that produces the necessary knowledge for the intervention.[2]

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The goal of these considerations is to draw attention to a different view of medical practice in terms of the way the professionals conduct that practice. For them, their intervention focuses on the technical dimension whereas the social and ethical matters are disturbing and disrupt the freedom of technology.[2] From this perspective, when an ethical need in the relationships between the doctor and the patient is acknowledged, as for example, in situations that conflict with technical freedom, the solution lies in adopting a nicer and friendlier behavior towards the patient. However, that component does not interact with technology.

In healthcare production, there is currently a shift of the practice towards the scientific-technological pole, with an apparent elimination of previously adopted ethical values. This is indeed a great change in the way doctors interact with patients or with other professionals, whether doctors or not. Since the 1990s, with the development of the model of technological medicine,[2 p.67] the modalities of interaction have changed and, as a result, professional challenges have become more complex. These challenges are always present in the form of moral conflicts, conflicts of duty, since the scientist adopts a stance of generality when confronted with a particular case in his medical practice. We can even affirm that, as a result of the development of the scientific-technological pole, both the range of actions and of conflicts have greatly expanded. These are the various situations that today require attention and care in health services, serving as a model of reference for the much debated humanistic crisis.[20],[21]

According to Arendt,[1] the crisis is experienced as a rupture with "tradition" when, in the face of a conflict, the past no longer provides criteria to validate and authorize responses; that is, when we cannot use the same references that have shaped the world up to now. Thus, doctors cannot resort to the ways used by the medicine of the past to solve the conflicts. Hence, the crisis is not characterized as degeneration but as a rupture with the norms that distinguish, for example, truth from falsehood,[22] therefore causing the loss of previously legitimate models of reference on which trust was built in solving the conflicts in relational bonds.

By this we mean that tradition is historically embedded in the constitution of modern medicine, since it is a practice that is grounded in modern science and, as a part of its scientific justification, it has established bonds of trust between doctors and patients. Therefore, it acts as liberal medicine, whose way of conducting practice is more artisanal than technological. We refer here to the classical figure of the doctor in his consultation room as the small-scale producer of services, who has fewer technological resources than those currently available but who already conducts his intervention within the framework of modern bioscience.

The radical change is evidenced in the bonds of trust based on the intersubjective relationships built by liberal medicine, which could be relied on to solve dilemmatic situations. The absence of such bonds is the result of ruptures in the interaction, due to the material and symbolic change technological medicine provoked in the position of doctors, other healthcare professionals and patients with respect to the relationships established: the place they occupy and the significance that they have in the relationships of care are now different from traditional ones.

Freidson[8] characterizes medical practice as the difficult exercise of complex judgement and risky decision making, difficulties that impassion those choosing the profession, as is shown in the statements of medical students participating in various studies,[23] and whose intersection does not depend only on scientific competence, as hasty common sense would have us believe. The author shows that this complexity, as a professional challenge, lies in the fact that in modern medicine, clinical judgement had to respond to the pragmatism of the intervention that always needed to find solutions, even in those cases in which science had no answer - thus the identification of medicine as an artisanal practice during modernity. However, that lack of scientific response was based on the idea that science did not yet have an answer,

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this formulation derived from the great value ascribed to scientific knowledge and technological resources that had become "an asset in itself" during modernity.

Pragmatism demanded from doctors a double technical action: on the one hand, to use technical knowledge when pertinent, and on the other hand, to use a practical knowledge of the profession, that is, the rich experience acquired by each of them individually and by doctors as a whole in similar cases, without scientific grounding for the action. It was for this reason that during modernity medicine positions itself as the science and art of healing.

Furthermore, as stated by Schraiber,[2] when science is used as the application of universal knowledge to specific cases, especially because medical practice is conducted in the form of individual consultations (which coincides with the liberal practice in the private consulting room), the complexity of clinical judgement increases. This is in addition to the need of doctors to decide how to adapt the use of the universal knowledge to the contingencies of a particular case, that is, the extent and appropriateness of this use, given the specific peculiarities of the case in question.

We highlight here not only the reflexive character that was demanded of medical judgement but also the fact that for this same reason the doctor was who symbolized medicine, in evident contrast with current references.

CONTEMPORARY REFERENCES

If not the doctor, what is the reference of medicine? We may answer: technology; medical teams or the great institutions such as hospitals, which are the home to technology; or health insurance and social security organizations, which give access to technology. Technologies are today the references of medicine and symbolize it. Therefore, they generate professional behaviors that emphasize these references by stressing the loss of the old references.

Such configuration gives rise to a change in the intersubjective realm by which the means become ends in themselves, altering the meaning of the relationship among individuals: doctors no longer interact with patients, but the technical resources are now at the service of such interaction. The doctor is now a "means" for the interaction between patients and medical technology. Likewise, the patients have become means for the doctors in their interaction with knowledge – science and its discoveries – and also means for doctors' interaction with the corporate mechanisms that are inherent to the exercise of their profession.

When doctors and patients are instrumentalized to become a means for a specific end, it is worth remembering that the hegemony of the systematic utilitarianism of modernity, imposing its logic of means and ends on all the categories of life, brings with it important consequences. Among them, the impossibility of "understanding the difference between utility and full meaning, which we express linguistically by making a distinction between "in order to" and "for the sake of."[24 p.191] Thus, everything is placed in the chain of means and ends, and, as a consequence everything becomes a means to a specific end and will only be the reason for something, or "for the sake of" something. This option allows utility (what something is for and what purpose it serves) to suppress the meaning (what it is), the consequence of which is explained by Arendt "'In order to' has become 'for the sake of'; in other words, utility established as meaning generates meaninglessness."[24 p.192]

With this we do not intend to advocate for the abolition of technological resources in health, as if our goal were the restitution of traditional medicine. In this sense, we agree with Ayres[25] in the conceptualization of care as the assistential act that expands and flexibilizes the normativity of the application of the technosciences; a normativity that arises from the constitution of the body as an abstract and generic entity in the sciences, in its technological products and in procedure protocols. Expansion and flexibilization here not only mean the treatment of the body and diseases

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in their morphofunctional singularities, but also the establishment of a shared therapeutical project with the patient. Thus, if both the technical and practical success[14] could establish a dialogue through the permeability existing between the technical and non-technical aspects, the relationship between the doctor and the patient would cease to be just an encounter of the doctor with science mediated by a body and would become a shared journey across an intersubjective dialogue, whose destination is the result of this negotiation among the subjects and their intended and possible life projects.[14]

Some Brazilian doctors, who were interviewed at the end of the 1990s[2] and in the early years of the following decade,[21] expressed their great uneasiness regarding the new contexts within their professional practice. They stated, with a certain degree of indignation, how they had become anonymous for the patients, but without acknowledging that they had behaved in the same way with their patients.

Another aspect that describes these transformations in medical practice can be seen in the way additional studies to be included in the medical history are used; they are simply called diagnostic tests, and thus the notion that they complement the clinical judgement disappears.[21]

CONTEMPORARY CHALLENGES

What to do in clinical situations in which the most common tests do no not provide a definite diagnosis? Give more credit to clinical judgement, by relying on the reflection and experience acquired, maintaining technology as a complement, or trust more in the aid of technology? Continue doing research and try to learn more, or accept the possibility of proposing a treatment that needs to be reviewed? Accept the fact that research has its disadvantages as regards costs, which can turn clients away, or keep cutting-edge technology as the criterion to adopt, thus elitizing the public?

These matters were mentioned by many of the doctors interviewed. They are situations of conflict that mark for contemporary medicine what the path to take in terms of clinical judgement, the solution of which could be finding the best possible resolution for the case in its context, meaning that in the choice between two equally accepted values (clinical judgement and the objectivity of the tests), the best path could be chosen every time. The best way is not always technology or the practical experience of the profession, but each option is, in turn, a responsible and cautious choice in relation to a specific and concrete situation. Responsibility and caution characterize moral deliberation and the ethical practice in technoscientific intervention. However, it is already known that the general trend is to increase the number of tests, as this is part of the technological frame of reference, thus creating a vicious circle in which the excesses give rise to more excesses and the limits of technology are the hardest to see.

With regard to the matter of increasing the number of the so-called complementary tests, Hannah Arendt helps us analyze the changes in the production process in modernity. The author believes that one of the signs of the industrial revolution is the transformation of all human production into consumer goods:

> The endless cycles of production can only be assured when the products cease to be items of use to gradually become consumer goods, or, in other words, the rate of use is so tremendously accelerated that the objective difference between use and consumption, between the relative durability of use objects and the swift coming and going of consumer goods, eventually dwindles to insignificace.[24 p.137]

The increase in the use of complementary tests shows how these tests have become consumable goods, even to the extent of being one of the economic reasons for the existence of medical companies and of the medical-industrial complex. Nowadays, the relationship between the patient and healthcare is built

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upon the consumption of diagnostic tests and the possibility of accessing the technological equipment available in hospitals. In such a relationship, doctors are mere intermediaries. This is also due to the transformation in the significance and the exercise of responsible medical practice. The reference models for the latter have also changed, as will be discussed later; however we will now analyze another qualifier/attribute of medical practice: the fact that it is a complex act that also implies making decisions, which are always risky.

Clinical decisions imply risks based on uncertainties, because they are concerned with probabilistic knowledge related to vital events, and, therefore with fluctuations with respect to the expected result. However, in addition to these uncertainties, there are others that have to do with the social strata themselves and subjective aspects that are coterminous with the natural characteristics of these events, which complicate our topic of discussion even further. Although it may seem that the clinical decision is related to the diseases, in fact, the intervention is conducted on the diseased: the development of the concrete therapeutic decision depends on the patient's biopsychosocial factors. It is worth noting Freidson's[8] interesting reflection on the topic with regard to the following contrasting argument: medical practice is permeated by uncertainty; however, what prevails in the social imaginary is the reference to a safe intervention, because it is scientifically substantiated. The construction of scientific knowledge is based on the establishment of universal concepts regarding the function of the body, the mind and disease. The place of medical decisions lies in the space between the universal character of science and the uniqueness of the case that is being considered. The direct application of the universal concepts of science through its technological and pharmaceutical devices is one of the main changes in medicine, from liberal to technological, and may be understood as one of the reasons for the perception, among physicians and patients, that they are becoming mere intermediaries for these relationships.

For professionals there was also, in their occupational imaginary, a construction regarding safety, though different from the previous one, which moves in this same direction. Analyzing this movement is key to our understanding of how the bonds of trust in the physician-patient relationship were built during liberal medicine and why, due to the change occurring during technological medicine, those bonds were breached and this tradition in the relationships was lost.

In liberal medicine this construction is based on the fact that physicians believe in their own judgment, that is, they believed themselves totally able to properly articulate the scientific aspect with their practical experience, and the iconic figure of the doctor became reinforced as a reference of a sound and safe intervention. Therefore, they were always professionally available to accompany their patients during the interventions, closely following every case they had, and if the decided therapy needed to be modified, they admitted the possibility and the need for such a revision.

Trust in the liberal practice was constructed on the basis of such moral behavior in the profession. Trust was based on the disposition to think, judge and accompany the case. These aspects have currently been transformed, whether for resorting almost automatically to technology, as a sort of fixed and *a priori* judgment, or for the great change in contemporary corporate medicine regarding the possibilities of case follow-up and interpersonal relationships, given the fact that in corporate medicine physicians lose control of the clients and of the equipment with which they work. According to Arendt,[24] Galileo's discovery that the Earth revolves around the sun and not the other way round, elevated man-made instruments to a position in which the traditional understanding of truth was transformed, establishing a generalized distrust of the human senses in relation to the search of truth. In modernity, the distrust of medical judgment seems to grow in proportion to the development of the instruments that aid in professional judgment,

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whereas in contemporary times they tend to substitute such judgment.

Thus, the scientific and technological development on the one hand expanded the possibilities of medical intervention, generating greater convenience for physicians in their performance, and, on the other hand, caused the annoyance of reducing doctors to mere intermediaries in the access to the new technologies. In this way the figure of the doctor is questioned as a role model for good practice, with this crisis casting doubt over the professional's authority and giving rise to the defensive attitudes that are frequently seen today and which are also exercised *a priori*. In a search to impose their authority, which they believe is more legitimate as a result of a greater development in the scientific foundations of their practice, doctors seek to impose their perspective rather than to establish a dialogue with their patients, ensuring such imposition through the control that they effectively assert over the access to the different diagnostic and therapeutic technologies and to the healthcare system itself. These attitudes reinforce the loss of the doctor-patient interaction and become apparent in the relationships in which authority is substituted for violence, leading the social movements to fight for a new (another) humanization of medicine. Thus, as a result of this loss of legitimacy to use the position of power that they had formerly enjoyed, the physicians turn this relationship into an exercise of command and control over the patient, a situation in which, according to Arendt[26], there is no power, only violence.

As Gomes[21] points out when discussing the alienation of doctors with respect to the social nature of their work and technical practice, it is observed that there is a certain degree of discontent and surprise within the profession that everything doctors do will not be perceived as being human-oriented, when they in fact believe that their practice is highly "humanized."

In this sense, we should consider, and we prefer to believe, that physicians also want to overcome this crisis of trust. However, it is necessary to bear in mind that the models of reference of the past cannot be valid any longer, and therefore it is not about reconquering lost territory but about achieving new conquests for which it will be necessary to have an open attitude, as historical subjects, with respect to other new professional experiences. However, this is by no means an easy position, as can be seen from Marilena Chauí's reflections[27] on appealing to ideology in situations of crisis: individuals have great difficulty in perceiving themselves as historical subjects, precisely because this perception raises awareness with respect to the new positions in society. Chauí mentions this aspect when she analyzes how, specifically for scientific production and its representatives, at the edges of an ideology of harmony and the permanence of social positions, the term "crisis" is transformed into the notion of "misadjustment," encompassing as a solution, within the framework of that same ideology, a return to the position of alleged "adjustment" that had been previously constructed (before the misadjustment/crisis).

The temptation to reconquer is strong, but as Arendt[1] argues, it is necessary to be born again in the historical-social sense; a rebirth as subjects, renewing tradition. In this sense, and just to promote new reflections, we propose two dimensions in which we can seek this new rebirth as subjects, or a new "natality," according to Arendtian references. The first dimension opts for a "society of rights," in the way we would like to construct it, and in which new relationships and a new kind of authority could be established. The second dimension, which interacts with the previous one, is based on the historical fact that the liberal doctor was built as subject and authority through his practice in the consultation room, which we recognize as a "solitary" practice and as a situation by which the physician also identified his professional autonomy. Thus, the changes in the working relationships described in this article, in addition to the diversity of professionals that are currently part of the healthcare field, require reflections that could renew (and not recover) the doctors' positions in the working

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world. In this way, sharing judgments and decisions with other subjects-patients or members of the work team, and restoring the sense of responsibility in professional performance may be a good new beginning.

ENDNOTES

a. This research project was approved by the Research Ethics Committee (code No. 728479), through the *Certificado de Apresentação para Apreciação Ética* (CAAE) [Certificate of Presentation for Ethical Consideration] No. 33405514.0.0000.0065.

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