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Ethnography in the consulting room.

General practitioners' attitudes towards Italian and Immigrant patients in Perugia (Umbria)

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The following paper is based on the data that emerged during my first six months of fieldwork within general practitioners' consulting rooms [(1)]. The enquiry, which is still in progress, is set in the Umbrian region, more precisely in District n. 2 of the Local Health Unit of Perugia. The object of my research is to study the patient/physician relationship by observing medical examinations in act, with particular focus on the physicians' point of view, emotions and experiences in the daily proceedings of their professional practice. I have chosen general practitioners because the lower technical-sectorial competencies their role requests mean that they have more opportunities to relate to patients in a more constant and profound way than specialists (working in hospital or on their own). The importance of this choice becomes clear, however, if one considers that, also for the complex implications it involves (compulsory professional secrecy, privacy, physician's duty to respect the deontological code, and so on), medical examination as it happens is currently not being studied as it should. As well as participant observation of medical examinations (and of the relational, linguistic and proxemical aspects of doctor-patient relationship), further investigative elements are the analysis of the implicit messages conveyed by the organisation of waiting and consulting rooms, and several in-depth interviews carried out with some general practitioners.

1.

A few years ago Edward Shorter, a well-known medical historian, wrote *Bedside manners: The troubled history of doctors and patients* (Shorter, E. 1986 [1985]). With this title he defined very well the complexity of a still open question which only recently has been object of medical-scientific reconsideration, although for centuries it has been a field of reflection, research and analysis of various epistemological sources [(2)]. Psychoneuroimmunological research, in fact (Bottaccioli F. 1995), strengthened once and for all, even inside the scientific community, hypothesis and theories spread in anthropology since the beginning of the century, when in 1926 Marcel Mauss, for instance, wrote his *Effet physique chez l'individu de l'idée de mort suggerée par la collectivité*. The intersection in the human being between the biological and social dimension was thus starting to receive the first decisive impulses toward a progressive expansion to spheres and spaces confined before in the "natural" field. This was the beginning of the definitive corrosion of a false boundary, that is to became aware of the reciprocal influence of two aspects which, as it is clear now, acquire an operative value as analytical-interpretative categories precisely when the risks of dogmatic separation and objectivation is rejected.

Therefore, it is possible today to establish a dialogue between anthropological and biomedical research by looking at the close link between the central nervous and immunity systems: the arena is the specific incidence exerted by the psycho-emotional mood on the immunity defence mechanisms and on the whole physical functioning (Seppilli, T. 1996). Freud, *mutatis mutandi*, had already considered the same idea, in 1890, when he affirmed that the relationship between the patient and the curer, as well as the way in which it is handled, has an evident therapeutic efficacy within the health/sickness dynamics.

> «Probably, the effect of any remedy that the doctor prescribes, of any action he undertakes, is composed of two parts. One of these, sometimes major sometimes minor, but never completely negligible, is due to the psychic behaviour of the patient. The trustful expectations with which he affronts the direct influence of the doctor's action, depends on the intensity of his will to heal, and from his faith in his having taken the opportune steps. Then from his esteem of medical art in general, moreover from the power he attributes to the person of his doctor and even from the purely humane liking that the doctor arouses in him. There are doctors who possess a particular capability to earn patients' trust; the patient then feels relieved just seeing the doctor come into the room. […] Throughout history, and in ancient times in fuller manner than today, doctors practised psychic treatment. If, for psychic treatment, we understand the will to create in the patient psychic states and conditions in order to help the healing, then this kind of medical treatment is historically the most ancient one» (Freud S. 1967 [1890]: 100-101) [(3)].

2.

The patient-physician encounter is, as we know, the place in which cultural logic and discursive rhetoric about body, "health" and "sickness" intertwine, clash and transform each other in a negotiation process that medical anthropology contributed to revealing, although it still looks as nebulous and rich in contradictions as ever. It is widely acknowledged, however, that the increasing dissatisfaction with the kind of patient-physician relationship legitimated by the biomedical approach (felt as "cold" and depersonalising, especially by patients) is one of the disruptive elements in biomedicine's profound present crisis which, it seems, can only be solved by once again questioning some of its axioms (4).

In Saussure's words we could define the patient-physician encounter as the moment of "*parole*"; that is, one of the moments in which the biomedical code of "*langue*" expresses itself through its speakers, who at the same time contribute to continuously modifying its structure. It is precisely these "human" features that such a kind of relationship introduces, and it means an incessant production of new meanings and new sense assignments, often clashing with each other. This explains why the patient-physician relationship is one of the privileged sites in which the biomedical paradigm (as well as the ideology of neutrality it bears and through which it legitimates itself) seems not completely succeed in dissimulating the relativity and arbitrariness of its epistemological assumptions. This reveals biomedical system to be the result of specific historical-cultural determinants, as much as other medical systems (5). With the same interpretive key we can read some of the dynamics within patient-physician relationships, such as the way those dynamics are implicitly handed down to medical students, as containment devices for the risks of "breaking up" that these encounters constantly engender, particularly when the social actors do not share the same cultural patterns, as in the case of foreign patients. In other words, these devices seem to bring such centrifugal forces back to the biomedical paradigm, thus making it more refined, and "open", though still (even more) hegemonic (6).

A considerable amount of research carried out in this field – including the anthropological – has focused on the patient; many other researchers have shown how medical behavioural training must be measured in order to improve relationships with patients, considering the hermeneutic process and the communicative flow between both subjects as essentially one-way. In a certain sense, this seems to paradoxically consolidate and maintain a prejudice: the idea that physicians are bearers of psychological and "cul-

ture-free" neutrality, learnt through the long and hard initiatory path towards the "Truth" that biomedical apprenticeship assures to its "followers". As Canadian anthropologist Brenda Beagan states: «increasingly medical schools offer courses in cross-cultural medicine and instruction about how patients from divergent social backgrounds may differ in their approaches to health and illness. Though a promising start, such approaches retain the belief that differences reside in the Other, in the patient, leaving the supposedly-neutral norms embodied by physicians unexamined and unrelativized». (Beagan, B. L. 2000: 1263)

I think, then, that we have to focus our gaze on the figure of the physician, and try to grasp on a more profound level the way in which he incorporates the biomedical paradigm as a specific "cultural system", and also reveals – acquiring them "personally" – its limits and contradictions. Such an interpretation would be useful to show us that there are complex and structural mechanisms at the basis of physicians' difficulties in relating to patients. There is, for instance, the way in which a biomedical paradigm tries to work out those centrifugal forces I previously mentioned, taking possession of further instances of "opening", without seriously discussing some of its basic assumptions, thus arousing conflicts that produce, like a vicious circle, new breaches and new "crises". As an example of this, every physician holds in himself, like oxymora, both medical "souls": the objectifying, reductionistic one and the empathic, "humanising" one. Therefore, the reductionistic core of some scientific approaches transmits values leading to the concreteness and materialistic objectivity of physical phenomena, to the measurability and reification of what concerns the human organism, and then to the detachment required for its correct management and manipulation (one example is the practice of anatomical dissection, for instance) [7]. Then, there are tendentiously excluded, or unfavourably featured, inclinations to emotional involvement, counter-transfer, and excessive "humanisation" of the relationship with patients (regarded as more suitable to the nurse's role, for instance). In another way, values such as altruism, devotion and in general a humanitarian essence of the medical profession are interiorised as well, both through a real training process and through a more widespread myth of the physician as "saver" of human lives. Both these medical patterns therefore co-exist, clashing with each other, in those who decide to become doctors through what we must actually consider a true initiatory path. We ought to remember how much medical schools drive medical students to embody – teaching them a highly skilled, technique and a somewhat ritual language [8], and also a wide range of other "dispositions" [9] – systems of values, representations and attitudes

which mould their profession, their world and their *Weltanschaung* [10]. Being collectively socialised, then, such rules, conceptions and values, which often contradict one other, constitute the cultural heritage with which doctors approach professional practice. The idea that it is possible to dissipate them with just a mere invitation of comprehension and "cultural sensibility" is to some extent unthinkable, naïve or "inauthentic" at least [11].

3.

As early mentioned, the current research, the results of which constitute the present paper, set out to investigate, through an ethnographical survey of the patient-physician encounter inside consulting rooms, what it means "to be a doctor". That is to say, I wanted to find out how the role is constructed and how it appears "in action", also through the narration of the physician's personal experiences and emotional moods, in the way he perceived them. The fundamental presupposition from which I started, in fact, was the idea that before their training doctors represent "human beings" embedded in specific social networks. They are therefore the bearers of cultural patterns and "common sense" values, which are more widely shared than the ones they acquire during medical school training, in respect of those, of course, the latter often introduce contradictory elements. As far as the specifically professional level is concerned, what we must bear in mind is that the position single doctors hold is actually of extreme structural asymmetry with respect to the patient's position, because of their competence to solve people's health problems (Lupo, in press). Nevertheless, they are also strongly bound by the contractual power the patient possesses today, even more than in the past, and which physicians must contend with every day in a constant negotiation of their own role.

However, thanks to the ethnography inside the consulting rooms the need also emerged to critically review some theoretical references, calibrating and reciprocally integrating them to better reflect reality, and to drop prejudices and preconceptions [12].

With this idea, I decided to use the relationship between local physicians and immigrant patients as a privileged observation field and a prompt for conversations. It seemed to be a very important revelatory instrument: such an encounter, in fact, assumes the form of a "limit" situation, in which the heterogeneity of the cultural patterns held by the two protagonists acquires evident and sometimes extreme features. This allows some of the prejudices and devices I discussed above to emerge, rendering them visi-

ble, whereas in the case of local patients they remain concealed under reciprocal expectations of behavioural response, standardised and interiorized by both parties. For example, if a somehow paternalistic attitude seems so subtle as to be, at times, almost imperceptible or at least appreciated by the patients, in the case of migrant patients it often assumes great and glaring proportions. During one of my stays in a young lady doctor waiting-room, I realised at once that the patient she was dealing with at that moment was not Italian, because she was talking to him with a particular voice tone articulated in an almost grotesque way and loud enough to be clearly audible even from where I was. Because she seemed to take for granted that what she was saying would be unintelligible to him. And because the communication register she adopted would have been fit for a conversation with a young child rather than with an adult, even though he was Ecuadorian (and the answers the man gave showed a perfect control of Italian!).

An analogous situation occurred while I was in another consulting room. It involved an Albanian man in his forties. The doctor received him with a very kind attitude at first but, suddenly, he became irritatingly paternalistic and sarcastic as soon as the patient ingenuously "confessed" that he preventively had recourse to self-help care with domestic remedies from the Albanian tradition. It is not difficult in these situations to recognise in physicians the co-presence of values and concepts imbued by medical academies that clash with a broad set of other patterns acquired, more generally, in the course of life [13]. Also evident is the conflict that many physicians experience between the need to be detached, impassive, unaffected and uninvolved with patients' problems, and the wish to participate, alleviate and understand sufferings. This is the case of most physicians who have undergone medical operations, and who thus find themselves in the hospitalised patient's shoes. Two years ago, at the age of 47, one of the doctors I work with had a heart attack. He learned then, to his cost, the significance of the "cold" and detached attitudes of physicians, which caused him a great inner struggle between what he still considers the "right way" to practice medicine, learnt at school (he once said: «*You must be detached, you cannot be overwhelmed, or else you're dead*!») and the uneasy feeling he experiences every time he identifies with his patients' pain, being aware of what one feels in a similar position. He told me:

> «*I'm more careful now. The first impacts of people feeling sick, the first time they get in touch with the medical structure and so on, I'm aware about what it is to feel lost, bewildered, to feel, I mean, tossed up and down... Because I remember how I felt in those three or four days in the hospital, I mean. During the hospitalisation, the worst thing was my colleagues' coldness. Even if you're a doctor you can feel a very strong*

> *sensation of powerlessness. What I felt was the physicians' will to avoid any emotional contact with me, although I would have appreciated [the opposite]...all my friends and colleagues that came to visit me were reassured about what the physicians had done to me, they told them everything but I was told nothing! The paternalistic attitude is the most irritatingly to me. I can't stand it.»*

In its most extreme and disabling cases, the experience of being sick can have the power to damage, once and for all, the real foundations of the doctor's image as a superman, invincible and therefore powerful against "evil" dangers. This is the image that is responsible for the asymmetrical axis he establishes in the relation with patients. The sole strategy he can use to recover a role of "authority" and to preserve the "divine" features threatened by the "offending" illness, seems to be the assumption of a new identity, which we could define as the "survivor" identity: because he has come back from the "realms of death", he is now invested with a new power, the power of participating and sharing patients' experiences (GODEAU, E. 1993). In other words, this kind of investiture seems to legitimate the "fall" from a dominant position, which merely leads to another immediate position of power, even though it is dissimulated by a rhetorical closeness to the patient. It is, however, an inauthentic approach: physicians' gestures, attitudes and words, though often only undertones, express, to a level that goes beyond appearances, a total empathic incapability.

4.

A widely spread opinion is that the growing discontent with certain kinds of patient-physician relationships is basically due to a few, somehow still stereotyped, elements: brief and heedless consultations, the coldness and indifference of physicians, and so on. It is quite clear now that the question should be posed at a deeper level, even if the contradictions internal to the complex dynamics involved seem to make an exhaustive analysis of all the elements very difficult. However, by their very nature, contradictions possess the great implicit power of "revealing". They destroy, in fact, the schemes of what is given, through a mechanism which interrupts the circular and self-regenerating flux of the logic from which contradictions themselves originate: they introduce discontinuous elements which make the constitutive structures and functioning procedures of such logic visible.

Therefore, to look more thoroughly at the patient-physician relational dynamics, the way in which patients themselves often express needs and requests at times incoherent and ambiguous, for instance, should be pointed out. They are in fact hardly solvable with a mere increase in dialogue and

a more profound "humanisation" of the relationship [14]. Many difficulties are rather mostly connected to the ever-growing technological presence in sanitary needs – in its turn produced by the ceaseless technological development of diagnostic-therapeutic methods – and linked to the availability of immediate information that the recent advances in telecommunication systems can guarantee. All this, together with the spreading of a "scientific mass culture", actually responds to what is natural and partly auspicated for the development of a medical system rooted in a context of liberal-democratic tradition [15]. Nevertheless, the process of democratisation that in recent years has been investing biomedicine as a medical system has also roused that wide set of distorting effects and complex troubles which any process of structural transformation inevitably carries.

The professional routine seems at times to suppress physicians' passions and motivations. They appear "cold" and indifferent to the human history of their patients. However, the role of Italian general practitioners within the welfare state has recently undergone changes and they have had to assume functions that are increasingly bureaucratic [16]. This has increased their frustration levels and their awareness of being just little pawns in an enormous sanitary apparatus [17].

> *«When prescribing a drug the doctor is guided by his own scientific knowledge and therefore... that's that! Moreover, he is responsible for what he prescribes, obviously! [...] But in this way [with these bureaucratic complications] they take away from me the freedom to prescribe "in science and consciousness"! Because I have to follow bureaucratic norms that someone else has set for me! [...] One feels almost "castrated", because... just the problem of remembering the numbers is enormous! In daily practice you just have to remember the name of the drugs, their instructions, their side effects, how they interfere with other drugs... and these are rightful things, and they have to be remembered! But what about remembering the number of the prescription, having to sign it, having to sign the exemptions... there are exemptions classified per pathology… than you must remember the number of each exemption... it has become an obsession! [...] When you live a profession you must also accept your responsibility: eh, I'm aware of this and I'm happy about it! But when they make me assume responsibilities just for bureaucratic acts, that's the end! [...] And it has two clearly negative effects: it takes up a lot of time, time that should be spent on other things, particularly on conversation with patients; second, it causes friction with the patients!»* (Doctor P.G., 54 years old)

If we cannot but consider a certain portion of administrative-bureaucratic engagement as a constituent and unavoidable part of the same medical practice, the idealization to the limit of the physician as a figure almost external to the economy's dimensions, just working for pure vocation, with a nearly supernatural inspiration, plays a decisive role in the perception of his professional practice as alienating and in the consideration of some requests as illegitimate and deviant.

Another critical point – even if it is a fundamental democratic achievement – is that due to the efforts of patients' rights organisations and a more pervasive scientific mass-culture, patients have today greater contractual power. This patients' empowerment is often perceived by physicians as a kind of blackmail (and frequently it actually seems to be), which they try to avoid by entrenching themselves behind a rigorous face of impeccable professionalism, thus lacking in empathy.

> *«It is very fastidious to think that today general practice in medicine is perceived on a commercial base. Because all doctors constantly fish for patients! [...] The patient's attitude is one of blackmail! He demands certain things of you and if you don't satisfy him, he goes to one of your colleagues, who is much more easy-going and at his own risk and danger he finally concedes those things. So the patient says: "If you don't give me that, I will go to another doctor and sign myself on!". These are the realities of today, and that's the worst aspect of the general practitioner's profession, because it doesn't permit you to be really authentic, or at least it is very difficult to be so, it is very difficult not to be "polluted" in that sense!»* (Lady doctor, A.R., 37 years old).

Moreover, the increasing medicalisation of daily life spaces in recently industrialised countries (among other factors) drives patients to look to doctors for answers to all kinds of questions, such as solutions to existential matters that he is not always able to provide. In addition, most doctors can no longer count on the "support" of people who, until a short time ago, especially in a rural reality such as Umbria, were covering similar roles: priests, neighbours and other social circles.

> *«I think there should be other characters, you know, because today everything is referred to the doctor... whereas we need to have other figures! I mean, once there were those figures, there was the priest, the village, the neighbours, I don't know... anyway, there were other roles, now it is absurd but everything is demanded from the doctor!»* (Lady doctor P.B., 48 years old).

Neither do the patients themselves really appreciate deeper conversations and examinations, it doesn't matter if they are Italian or immigrant (although apparently for different reasons) [18]. They both sometimes express "closed" attitudes towards a relationship that tends to go beyond mere "drug shopping": they often identify general practitioners as mere distributors of medicines, tests and specialist check ups, which, even when superfluous, physicians end up conceding only in order to satisfy patients. In one of the consulting rooms I attend, people often come in and say: *«I am out of bird seed, I am dry!»*. They stand in front of the desk, showing that they are in a hurry, and they reluctantly answer the questions about their state of health, as if their answers could somehow negatively influence their right to benefit from what they are asking for.

Some physicians told me about people turning to them, even though they belonged to another doctor, because the high confidentiality level and the

strong emotional involvement that links them with their doctors prevents them from speaking about problems that they prefer to share with someone who is an "outsider".

> *«Sometimes it turns out that patients tell you things and not their own doctor! [...] Or maybe the reason is that in the first-aid station [where I'm working too] they don't know you, understand? Therefore maybe they feel easier telling you their problems, you know? [...] Maybe they feel freer talking with you, an unknown person!»* (Lady doctor P.B., 48 years old)

5.

To balance out the questions discussed above, it would seem that the complex dynamics of the patient-physician relationship and the entangled contradictions that emerge can be traced back to the fact that the whole biomedical paradigm is being transformed and reshuffled. Medical knowledge is undergoing a process of democratisation and, far from being an exclusive and "initiated" knowledge, it is now turning out to be more and more comprehensible (at least in its less specialist fields) to a larger part of the population [(19)]. As a consequence of this phenomenon, deep internal conflicts have been generated in those who have for centuries been the privileged bearers of this knowledge. What is more, these effects seem to have made themselves felt in general practitioners, whose cognitive store – by its very nature wide and "generalised" – is the first to have been drawn away not only by broader general social changes, but also by the partial "collectivisation" of medical knowledge. Therefore, even more noticeable are the "self-defence" mechanisms generated in such physicians, whose response pattern to the current critical phase seems to be summarised in their attempt to construct a new "identity", perceived as a guarantee of a revitalisation/demand of their role within the medical system.

> *«The effort we have been making these years has been to give a connotation and a worthy image, a role, tasks and functions (codified and acknowledged) to the general practitioners... [...] The battle that we're all fighting is the emancipation battle of general practitioners against all other doctors: it has been the battle of women against men!»* (Doctor P.G., 54 years old).

The reference points of the recent past have little by little been falling to pieces (the classic character of the local medical officer, for instance) and the perspectives and new values that a medicine which is still undergoing changes can provide to general practitioners are still not clear. They are currently hanging on in a marginal zone characterised by confusion and

uncertainty, and therefore sometimes by frustration and dissatisfaction. Thus, on the one hand, physicians can no longer recognise themselves in the traditional clichés but, on the other, they are not clear how they must adapt to the new requirements. This lack of definition of the general practitioners' identity seems to be reflected in how they perceive the attitudes of their patients [20], in the discursive strategies that many of them use, and in the identity that they construct by means of "opposition". The recurring rhetorical games that they use to define their own role are based on the differences and contrasts with the so-called "traditional doctor" and with what they perceive as negative features of other medical identities, above all clinicians and specialists. Positive and negative aspects of what the old panel doctor was and of what contemporary medicine can offer seem to alternatively stand out from their words. A new pattern is thus going to be constructed by chaotically capturing elements from an idealised past, cleaned of perceived negative aspects, and enriching them with the perceived positive elements of a "modern" present. In this way they will be softened and somehow legitimated by rooted historic precedents.

It is interesting to note, to conclude, how the discursive elements that physicians used during the interviews often reused concepts and arguments produced by the social sciences in their criticism of biomedicine: de-personalisation of relationships, high specialisation of competencies, dehumanising hyper-technicality, and so on. In other words, doctors seem strategically escape from these criticisms becoming themselves the bearers of such criticisms. Thus, as often happens, the results produced by the research, if still with sometimes ambiguous and deforming effects, turn to the experiences and discourses to whom the research were been directed. They slip out of the direct control and the purposes of the research itself, to be called upon and used in other directions and for other objects.

Notes

[1] This fieldwork periode constitutes the first part of my PhD project in "Methodologies of Ethnoanthropological research" [*Metodologie della ricerca etnoantropologica*], University of Siena (administrative office) – University of Cagliari and Perugia (associated offices), 2000-2001 academic year.

[2] Already in 1880 Cesare Musatti, pediatrician, coeval colleague of Giuseppe Pitrè, wrote about the necessity to "keep in great consideration" concepts, expressions and practices of popular medicine, in order to guarantee the correct outcome of the treatment (see Musatti, C. 1998 [1880]:

243). From then there are a lot of disciplinary approaches working on this topic, each one emphasising different aspects of the question: the psychological dynamics generated by the patient/physician interaction; the ways and the purposes with which every social system fixes the "role" functions of them both; the linguistic-semiotic aspects of the relationship; the symbolic contents conveyed by places, objects and proxemical registers with which doctors "familiarise" since their first years of medical school training; and so on. Despite their undeniable scientific value, these contributions sketch out a very fragmented picture, in which interconnected and interdependent factors have been managed in separate way by quite separate fields, with scleroting effects, which hampered for a long time the effective and necessary overall view on the patient/physician relationship question.

(3) Translation is mine. About the same theme, see also Balint, M. (1961).

(4) See again Seppilli, T. (1996). He reminds us, how: «this "question", this problematic horizon that anchors us to the *here* and *now*, cannot be tackled with the simple terms of an operation of "applied anthropology", as the answers to the crisis from which we start cannot be found in mere "touch-ups" *internal* to the existent medical structure, but rather in a conscientious and organic rediscussion of its own paradigm and of its own operative results» (p. 19).

(5) Margaret Lock, in the introduction to *Biomedicine revisited* quotes: «what is being demonstrated in research of this kind is not that medicine is "unscientific" because it is permeated by social forces: but, in contrast, that both medicine and science are essentially social enterprises» (cfr. Lock, M.; Gordon, D.R. (eds.) 1988: 6).

(6) In a 1976 paper, *Crisis de un modelo en la medicina?*, Foucault wrote: «What is diabolic in the present situation is that when we want to refer to a field we believe external to medicine, we realize that it has been medicalized. And when one wants to question medicine and its weaknesses, snags and injurious effects, it is done in the name of a more complete, refined and widespread medical knowledge» (translation is mine). See Dal Lago (ed.) (1997).

(7) «In the realm of medicine, the body is transformed into an object. It is inspected, touched, poked, cut. The body changes from the home of an ego to an object to be examined» [translation is mine] (see Young, K. 1999 [1997]: XVII). With regards to the same theme, see also Godeau, E. (1993) and Bertolini, G.; Massa, R. (eds.) (1997).

(8) «In the context of medical training, the ritual language is important (as are other, more general, forms of communication) in the combined constituent dispositions of the medical *habitus* [...]. And a specialist language must form part of any professional cognitive identity, in medicine, all examinations that medial students must pass are written or spoken in specialized scientific language. Learning the knowledge to pass exams is dependent on learning the language in which that knowledge is expressed and, indeed, exams are just as much tests of the use of the language that medical knowledge is expressed in as of the knowledge itself». (See Sinclair, S. 1997: 22-23).

(9) «[Dispositions are] structured structures predisposed to function as structuring structures, […] without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor» (see Bourdieu, P. 1977 [1972]: 72).

(10) See Kleinman, A. (1995) («Learning medicine is learning to reconstruct the world anew, medically», p. 243 / «Seeing, writing, and talking "medically", the student is authorized to be a participant in a Wittgensteinian "language game" that in turn creates a "way of life": an ontology of being medical», p. 245) and Good, B.J. (1999 [1994]) («[...] to learn medicine is not simply to incorporate new cognitive notions or new ways of solving problems and new skills for problems, but rather joining in a new world [...]. To learn medicine is to increase the knowledge about this distinct life world and it requires entering a separate reality system», p. 110 [translation is mine]).

(11) However, even though there have been a few recent openings in this direction, the same scholastic training of medicine students seems to be still poorly calibrated with regards to the importance of psychic and cultural aspects of the patient-physician relationship, and on the objective weight of subjectivity in health/sickness dynamics. More in general, what emerges is a difficulty to critically

assume the epistemological basis and the whole paradigm of contemporary biomedicine. One of the doctors I personally interviewed said: *«We are set in a particular way, that is to find just what we can measure! They taught us, I mean, to diagnose what we can measure: so we got into crisis! General practitioners are the ones who most frequently burn out in a crisis! Then a wide set of other psychological problems also plays a role...»* (doctor T.S., 49 years old).

(12) See note 2.

(13) Inclinations to tolerance and equality hit head on with prejudices about the value of other medical approaches and about the presumed inability of immigrants to understand complex technical-scientific truths.

(14) If we read the incommunicability between patient and physician exclusively in that key, the perfect *compliance* many traditional curers obtain with very short consultation, uttering a very few words or even being totally silent, closed in a solipsistic dialogue with the patron gods shouldn't be intelligible. In these cases, in fact, it is probably the intensity or the symbolic-emotional mood of the contact, which plays a fundamental role. These elements have little space in the relationship between patient and physician, such as it is set up at present in accordance with the biomedical paradigm.

(15) In that sense, the role of health training campaigns and, more in general, the educational policies of prevention has been fundamental, but above all a great impulse has come from the ever growing space dedicated to health topics by television programmes and, more generally, by the mass media.

(16) «Because of its long development under the powerful regimen of industrial capitalism, biomedicine is the most institutionalized of the forms of medicine. [...] Now, at the close of the century, biomedicine is practiced in bureaucracies, whose effect is profound [...]. The rule of efficiency governs the lived time of the patient-practitioner encounter, regulations control practice, transforming the doctor into the 'provider' of a 'product' that is advertised, marketed, and sold. [...] The physician is a bureaucrat; the patient is a user, a consumer of the institution's services. The very imagery of care constructs an industrial logic to its delivery and evaluation, reducing the moral space of the career of illness and of the work of doctoring to a minimum» (cfr. Kleinman, A. 1995: 37-38).

(17) «The physician as a man has an important role to play in the great system of the technology of health, but in general his position, the same as that of the patient, tends to be swallowed up by the monster of public sanitary organizations, as much as to create a relationship problem between the physician himself and the medical institution. [...] He has the power not only to influence health but also the same life of the patient, and nevertheless he lives the frustration to feel that he is only an infinitesimal part of an apparatus bigger than himself, that tends to inhibit his creativity and humanity, and complicates more and more the concrete difficulty to understand the patient and to make himself understood by him» (see Valdré, L. 1995: 94).

(18) One of the lady doctors I interviewed talked at length about the trouble to which the patient himself will go to request a "reductionist" approach to the illness, and therefore a kind of relationship that is not "holistic" at all: *«I mean, if you ask a patient, even if you're a specialist, which other illnesses have occurred to him, how he feels, he tends to not... he says: "But, what do you care about that?"»* (Lady doctor L.B. 43 years old).

(19) For further information, see Spinsanti, S. (2001).

(20) *«Because if you could just look at the [traditional doctor's] bag, what would you think to find?! He didn't have anything! All things considered, he only accompanied patients, he accompanied them in their death, in their illnesses... eh, today patients request this too, they would like it, but at the same time they would like something technical too! And it is so difficult to steer a middle course between the two things... [...] So, they always say: they don't want any more queues, so you need a secretary! They want you to answer to the phone 24 hours a day, but when they are sitting in front of you they hate to hear the phone ring! And if you take a secretary, they say it is no more the old patient-physician relationship! Sometimes you hear on TV: 'The doctors of the past were so...', it's just like if the old physicians were doing miracles! But it's not true... [...] And on the other hand they want the modern technologies, they want a context for the general practice in medicine worthy of the third millennium!»* (Doctor T. S., 49 years old).

References

Balint, Michael (1961) *Medico, paziente e malattia*. Milano: Edizioni Feltrinelli. Orig. ed.: *The doctor, his patient and the illness*.

Beagan, Brenda L. (2000) "Neutralizing differences: producing neutral doctors for (almost) neutral patients". *Social Science & Medicine*, vol. 51, num. 8, p. 1253-1265.

Bertolini, Guido and Riccardo Massa (eds.) (1997) *Clinica della formazione medica*. Milano: Franco Angeli.

Bottaccioli, Francesco (1995) *Psiconeuroimmunologia*. Como: R.E.D.; Studio Redazionale Edizioni.

Bourdieu, Pierre (1977) *Outline of a theory of practice*. Trans. from French by Richard Nice. Cambridge: Cambridge University Press. Orig. ed.: *Esquisse d'une théorie de la pratique*. Genève: Droz, 1974.

Cosmacini, Giorgio (1995 [1987]) *La qualità del tuo medico. Per una filosofia della medicina*. Roma; Bari: Editori Laterza.

Dal Lago, Alessandro (ed.) (1997) *Archivio Foucault. Interventi, colloqui, interviste. 2. 1971-1977. Poteri, saperi, strategie*. Milano: Feltrinelli., p. 187-240. Orig. ed.: Ewald, François and Daniel Defert (eds.) *Dits et écrits*. Paris: Gallimard, 1994.

Foucault, Michel (1969) *Nascita della clinica. Il ruolo della medicina nella costituzione delle scienze umane*. Trans. from French by A. Fontana. Torino: Einaudi. Orig. ed.: *Naissance de la clinique. Une archéologie du regard médical*. Paris: Presses Universitaires de France, 1963.

Freud, Sigmund (1967) "Trattamento psichico (trattamento dell'anima)". In Freud, S. *Opere. I. 1886-1895. Studi sull'isteria e altri scritti*. Torino: Boringhieri, p. 93-111. Orig. ed.: *Psychische ehandlung (Seelenbehandlung)*, 1890.

Godeau, Emmanuelle (1993) "'Dans un amphithéâtre…'. La fréquentation des morts dans la formation des médecins". Terrain, num. 20, p. 82-96.

Godeau, Emmanuelle (1998) "Il paradosso del medico malato". *Etnosistemi. Processi e dinamiche culturali*, vol. 5, num. 5, p. 9-18. Tit. num.: "Figure della corporeità in Europa", edited by Giovanni Pizza.

Good, Byron J. (1999) *Narrare la malattia. Lo sguardo antropologico sul rapporto medico-paziente*. Trans. from English by Silvio Ferraresi. Torino: Edizioni di Comunità. Orig. ed.: *Medicine, rationality and experience: an anthropological perspective*. Cambridge: Cambridge University Press, 1994.

Hahn, Robert and Atwood A. Gaines (eds.) (1985) *Physicians of Western medicine. Anthropological approaches to theory and practice*. Dordrecht: D. Reidel Publishing Company.

Kleinman, Arthur (1995) *Writing at the margin. Discourse between anthropology and medicine*. Berkeley: University of California Press.

Lindenbaum, Shirley and Margaret Lock (eds.) (1993) *Knowledge, power, and practice. The anthropology of medicine and everyday life*. Berkeley: University of California Press, p. 77-144.

Lock, Margaret and Deborah R. Gordon (eds.) (1988) *Biomedicine examined*. Dordrecht: Kluwer Academic Publishers.

Lupo, Alessandro (1999) "Capire è un po' guarire: il rapporto paziente-terapeuta tra dialogo e azione". *AM. Rivista della Società italiana di antropologia medica*, num. 7-8, p. 53-92.

Lupton, Deborah (1994) *Medicine as culture: illness, disease and the body in Western societies*. London: Sage.

Mauss, Marcel (1926) «Effet physique chez l'individu de l'idée de mort suggérée par la collectivité». *Journal de Psychologie Normale et Pathologique*, vol. 23, p. 653-669.

Musatti, Cesare (1998) "Il linguaggio delle sensazioni nella bocca del popolo". *AM. Rivista della Società italiana di antropologia medica*, num. 5-6, p. 239-243. Introduction by Paolo Bartoli.

Seppilli, Tullio (1996) "Antropologia medica: fondamenti per una strategia". *AM. Rivista della Società italiana di antropologia medica*, num. 1-2, p. 7-22.

Shorter, Edward (1986) *La tormentata storia del rapporto medico/paziente*. Trans. from English by

Raffaele Petrillo. Milano: Feltrinelli. Orig. ed.: *Bedside manners. The troubled history of doctors and patients*. New York: Simon and Schuster, 1985.

SINCLAIR, Simon (1997) *Making doctors. An institutional apprenticeship*. Oxford: Berg.

SPINSANTI, Sandro (2001) "Guaritori da guarire". *Prospettive Sociali e Sanitarie*, vol. 31, num. 7, p. 1-2.

VALDRÉ, Lido (1995) *Medicina muta. Che lingua parla la medicina scientifica. Che cosa capisce il paziente*. Milano: Rusconi Editore, 93-117.

WRIGHT, Peter W.G. and Andrew TREACHER (eds.) (1982) *The problem of medical knowledge: examining the social construction of medicine*. Edinburgh: University of Edinburgh Press.

YOUNG, Katharine (1999) *L'io assente. L'oggettivazione del corpo in medicina*. Trans. by Daniela Di Bella. Milano: McGraw-Hill Libri Italia. Orig. ed.: *Presence in the flesh*. London: Harvard University Press, 1997.