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The end of medicine. Part 3. The patient's perspective, the unwelcome disease and the cure-heal duality

El fin de la medicina. Parte 3. La perspectiva del paciente, la enfermedad inoportuna y la dualidad curar-sanar

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ABSTRACT

This work discusses the end of medicine from the patient's perspective facing disease and suffering as conflicts of interest with a stranger, the physician. It also analyzes the concept of 'scientific medicine' as an imitation of a dystopian model ill-suited to the social reality of this country. Besides, it considers the curing-healing duality as a conflict of subjectivities incompatible with the scientific model. Finally, it discusses the confusion of ends and the role of the physician before the patient's suffering.

RESUMEN

En este trabajo se discute el fin de la medicina desde la perspectiva del paciente ante la enfermedad. Se discuten la enfermedad y el sufrimiento como conflictos de intereses y codependencia entre extraños, médico y paciente. Se analizan el concepto 'medicina científica' como imitación de un modelo distópico mal adaptado a la realidad social de este país y la dualidad curar-sanar como un conflicto de subjetividades incompatibles con ese modelo. Finalmente se discuten la confusión de fines y el papel del médico ante el sufrimiento del paciente.

ILLNESS, THE UNWELCOME CHANGE

Before getting into the subject, it is important to differentiate terms that we take for synonyms. This will allow us to better understand the patient's perspective. When we read international publications we tend to translate disease, sickness, and illness as synonyms. It is worth noting that in English their meanings are confused and interchangeable. While disease corresponds to illness, sickness refers to an unpleasant sensation that can be physical or emotional. The Dictionary of the Spanish Language of the Royal Spanish Academy, a government institution that standardizes Spanish, defines 'disease' very vaguely as "more or less serious alteration of health," a condition of impairment of normal function. 'Malaise' is also described vaguely as "uneasiness, indefinable discomfort".[1] According to the Dorland's Illustrated Medical Dictionary, the term 'illness' can be defined as "any deviation or disruption of the normal structure or function of a body part, organ, or system, manifested by characteristic signs and symptoms". When it defines illness, it does so circularly as "disease" and ill, simply as "not well, sick".[2] The Dorland's omits that 'discomfort' implies that the disturbed functions produce sensations and feelings so that the person perceives that something is not right.

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Illness and malaise change the patients' perception of the world. They interpret each sensation from the history of their illness. Patients change their interaction with their social world and also their relationship with themselves. They try to comply with social standards considered external. Their demands to comply with these standards are internal, their own, reinforced and interpreted in the light of others in order to escape from categories such as 'sick' 'chronic' 'disabled' 'crippled' or 'handicapped' and comply with others such as 'normal' 'productive' and 'provider' to name a few. The sick person's conflict is personal and permanent. The untimely illness forces them to suffer both physically and emotionally.

The conflicts that arise from disease, alien to 'scientific medicine' threaten the integrity of the person. Why? Because conflicts between the persons and their body cannot be solved. Their ill body is not only unreliable, but they are also trapped in it. Western medicine maintains the dichotomy between the scientifically constructed term 'disease' and the lived distress. And while for the physician the body is a dysfunctional object the patient is both object and subject.[3] One sees it in the third person; the other in the first. In the face of illness, their body fails them when they need it most, disrupts their image, and embarrasses them, particularly in case of chronic diseases or treatments that make them feel uncomfortable or unpleasant before the eyes of others. For example, deforming or metabolic diseases, and complications of adjuvant cancer treatments. Besides weakness, dyspnea, anorexia, and emaciation, there are mutilations, alopecia, incontinence, halitosis, foul body odor, and much more.

Even if intellectually they can understand a good part of their illness, patients struggle and suffer to understand something very different, what will happen to their life. Their concern is not they as the anatomopathological substrate of a disease, an otherwise natural process. Their afflictions are now poor performance and failure, losing control, dependence, scrutiny, shame for lack of value before those *normal*. Fear of anticipation of the future, of a total loss, death, and dissolution of their person, unless they can overcome this inner conflict, which is not always the case. Fear and uncertainty are primary components of the patients, who introduce a "teleological order" in which they use their discomfort as a source of information, understanding, and perhaps knowledge; by telling their stories, they accept their ills and use them as a gain from the experience.[3]

On the other hand, the disease has secondary benefits for stress management. Patients may not desire to be cured but to get attention from others, avoid commitments, and evade responsibilities. They may get used to illness, to a greater or lesser degree. They may not be sick but disabled persons, adapted to their disability or limitation and healthy in other respects, so they are neither sick nor patients. The definitions of health, disease, disability, and their correlates healthy, sick, disabled, patient, made by doctors or dictionaries, do not correspond to the concepts people have of themselves, definitions written but not lived. The disease can be a coercive mechanism, facilitating a co-dependent relationship with the physician and with others. The problem is that physicians may accept this relationship, willingly or unwillingly, which will ultimately affect their professional satisfaction and performance. They may detest their patients, but they will have to live off them. If they accept it, their professional relationship will become unhealthy.

THE PHYSICIAN AS STRANGER AND THE RECIPROCITY OF STRANGENESS

To understand the strangeness between doctor and patient from a relationship of convenience, we can turn to some classics and realize this concern dates several centuries back. Let us first recall Shakespeare's *The Tempest,* in which Trinculo, the jester of Alonso King of Naples, lost on an island, meets Caliban, a wild deformed foul-smelling aborigine lying on the ground covered with a cloak to shelter himself from the coming storm. Trinculo, much to his regret in the face of the storm that threatens again, gets under Caliban's cloak and says: "misery acquaints a man with strange bedfellows."[4] In situations of misery, and suffering is one, very heterogeneous people with different interests

will force themselves to share the same space. They will do what they would not normally do, associate. Doctor and patient are strange consorts. They need each other. The patient depends on the doctor to live, and the doctor depends on the patient to make a living. These strange consorts may no longer be friends but co-dependent spouses.

This also brings to mind one of Plato's earliest dialogues, Lysis. It precedes the Banquet (Symposium). The Banquet deals with love as erotic desire *(eros)*. Lysis treats friendship (philia) in a general and somewhat skeptical way.[5] Friendship in Lysis is a product of necessity, even of dependence. Put in Socrates' mouth, the sick person goes to the doctor because of his will to cure. "For example", says Socrates, "we only have to consider a healthy body to see that it needs no doctor nor help: it is well as it is. No healthy man is a friend of a doctor because of his health [...] but the sick man is, I imagine, because of sickness [...] which *compels* the body to welcome and love medicine".[6] (*Italics* are mine). Another classic, the Hippocratic author of *The Precepts*, a physician, treats that relationship from a more positive point of view. He says, "where there is love of man (philanthropíe), there is also love of the art (philotekhníe). For some patients, though conscious that their condition is perilous, recover their health *simply through their contentment with the goodness of the physician*."[7] (*Italics* are mine). Two of the late writings of the *Corpus Hippocraticum*, *from the third century B.C., The Physician and On Decorum*, attracted by a strong Stoic morality, describe how the physician should conduct himself. The clinical etiquette to win the trust of the sick and not be strange to him. "The dignity of a physician requires that he should look healthy [...] for the common crowd consider those who are not of this excellent bodily condition to be unable to take care of others. Then he must be clean in person, well dressed, and anointed with sweet-smelling unguents that are not in any way suspicious."[8] This pleases his patients. [...] The prudent man must also be careful of certain moral considerations-not only to be silent, but also of a great regularity of life, since thereby his reputation will be greatly enhanced."[8,9] (*Italics* are mine).

FROM IMITATION TO CONFLICT OF INTERESTS

Technology and "scientific medicine" heritage from the positivism of the 19th and 20th centuries have relegated the humanism of the Art. This paradigm makes us believe, uncritically, that "scientific medicine" is the same for every person. Nevertheless, medicine has pressing fundamental problems. These cannot be understood out of the social context of the country in which it is practiced, as in ours. Technocratic Medicine has dissolved the conflict of interest by leaving out patients and their relationship to physicians. The conflictive tension remains; patients have to resort to strange consorts, not recommended by their qualities as physicians, reputation and decorum, impeccable dress, and proper speech. Insurance consortiums and hospitals designate those physicians they have on their payroll with a low deductible.

In this country, with a bankrupt public health system, the patient chooses a stranger because of the price. The "service provider" doctor no longer sees patients but "users". Nothing is stranger to the Art than the term 'user'; a poor substitute for 'consumer'. When a failed state and this country is one, cannot guarantee even what it promises constitutionally, and I will discuss this below, health, like many other things, becomes every man for himself. The service provider knows, the user does not. Physicians can self-diagnose and self-medicate; they have friends and colleagues in hospitals. Patients do not; everything is strange for them. Only that, in this every man for himself, physicians will at some point be patients. Perhaps they will be able to overcome illness, but not old age, and disagreements dating back to the classics, about old age as an "insanabilis morbus", an incurable disease, or as the punishment of the usury of time, "prolonged for those who reach it" have importance no more.[10,11] Physicians will be users and consumers in this system, and they will

wish, with or without luck, to be someone's patient.

And amid such "insurmountable circumstance", and I quote Ortega y Gasset, I have already said that physicians dissolve the conflict of interests by doing scientific medicine, not personal medicine. So let's go on. Since the beginning of the 20th century, and the problem has become only more acute, one can witness "an incredible spectacle: that of the peculiar brutality and aggressive stupidity with which a man behaves when he knows a lot about one thing and ignores the roots of all the others." Why did Ortega say this as early as 1930? Because "to pretend that the average student is a scientist is a ridiculous pretension that has only been able to harbor the vice of utopianism characteristic of previous generations" of imitating paradigms of first world universities with the pretension of training a large number of scientists when those who have those qualities are a minority.[12] Therefore, the average student has to learn to cure and care, and "the mission of the university is to train researchers, but professionals dedicated to the care of the sick."[13] (*Italics* are mine)

And what has happened to the curriculum that relegates the teaching of ethics? Shortly after the end of the 18th century, the conversations between philosophy and medicine separated. Medicine became a field in which many small areas with a large amount of knowledge had to be mastered by younger and younger students. With positivism, physicians then became isolated, without the benefit of philosophical and religious moral debates. For their part, humanists also withdrew and lost the benefit of interaction with those who cared for the sick and made the decisions.[14]

In the Flexnerian model, which bases medical education on research, the patient was gradually left out. The report Medical Education in the United States and Canada, written by Abraham Flexner in 1910, is not exempt from exaggerations that have been taken at face value by contemporary universities. True, the model was justified because "very seldom, under existing conditions, does the patient receive the best possible help in the present state of medicine, owing mainly to the fact that a vast number of persons untrained in the sciences fundamental to the profession and without sufficient experience with the disease are admitted to medical practice."[15] It is also true that "a hospital under complete educational control is as necessary to a medical school as is a laboratory of chemistry or pathology."[15] But it does not follow, as has been interpreted, that every physician must also be a researcher in this or that discipline. Flexner spoke of three stages in the development of medical education in the United States, "the preceptorship, the didactic school, and the scientific discipline"[16] and considered the latter to be superior and to have transcended the senses and experience of the preceptor to differentiate and interpret phenomena. The Flexnerian result a hundred years later is that a good part of physicians, during and after their specialty, have little contact with patients and with the clinic.

Let's see what is happening in Mexico. After an analysis of the results of the National Examination for Medical Residency Applicants (Examen Nacional de Aspirantes a Residencias Médicas, ENARM) between 2001 and 2016, Manuel Ramiro et al. from the Research, Education and Health Policies Unit of the Mexican Social Security Institute, comment that "something is wrong in the training of physicians, given that most of them are not allowed to develop successfully in the general market conditions, despite having completed their studies, and fulfilled the requirements to obtain their degree".[17] In the opinion of Ramiro et al. the whole career "is equivalent to a propedeutic course" for specialization. A system with "few academic incentives, limited development prospects, and low salaries". "It would seem that one of the main motivations of the various medical schools and faculties is to create successful applicants to pass the exam for medical specialties, so they enter different programs and become specialists." The ENARM and the selection percentages of its graduates "are indicators of efficiency and a reason for prestige and even propaganda. It would seem that teaching, and its results, lose importance."[17] The whole academic flow, the entire self-esteem of a school, points to the ENARM.

If general practitioners, despite good grades, do not pass the ENARM, they have little chance of a successful, well-paid career with relative job security. That implicit promise is a bias in a country lacking in professional and competent general practitioners dedicated to the care of the sick. Failure to pass the ENARM, even after several attempts, means losing the incentive to practice the profession decently, always at a disadvantage with specialists, no matter how bad they may be, given the quality of training is not uniform in the different institutional venues. It, therefore, means that the sick will have access to general practitioners with diluted motivations and quality, who will rarely pick up a book, let alone an article. The scientific advancement of these physicians will have remained in the year of their graduation despite having passed the General Examination for Graduation from the Bachelor's Degree in General Medicine (Examen General para Egreso de la Licenciatura en Medicina General, EGEL) of the National Evaluation Center for Higher Education (Centro Nacional de Evaluación para la Educación Superior, A.C., CENEVAL). Even assuming that the EGEL evaluation "makes it possible to identify whether the undergraduates have the necessary knowledge and skills to start effectively in the professional practice."[18]

However, a dystopian model adopted by the imitation of paradigms from developed countries insists on curricula to train "scientific doctors". Competition against other medical schools for preeminence, reputation, and annual ranking. A catalog in which those universities that achieve the accreditation by the Mexican Council for the Accreditation of Medical Education (Consejo Mexicano para la Acreditación de la Educación Médica, COMAEM)[19] advertise as the Mexican Ivy League. Just as Flexner wanted to explicitly imitate the European models of the end of the 19th century, Mexico imitates the North American model of the 20th century, by the way, in crisis. Only the Mexican disaster is far worse. In a country with fewer resources for health and education, poor distribution of whatever there is, greater poverty, and illiteracy, the Flexnerian model is even more dystopian.

Now, if in agreement to science no fact is properly scientific until measured, then human phenomena such as pain and suffering would not be facts since they cannot be measured, only estimated. In such a case, physicians take refuge in what Francisco González Crussí calls metromania, a contradiction. By trying to escape subjective interpretation, the physician "is reduced either to the shameful admission that they are not interested in the human being as a whole, but only in the organic aspects, or else they must accept that their field is not scientific [...] since it deals with what is not measurable".[20]

The fact is that in a medical practice becoming more and more quantitative, more scientific, the patient is more and more alone. In metromania, patients often lose out. They must interpret all this atomized, overwhelming information to make validly informed decisions for which they are not prepared. Thus, leaving the decision to the patient's autonomy is a form of abandonment. In this excess of "tropicalized" North American contractarianism in Mexico, the paternalistic authoritarianism of physicians has been reduced, as their role as guides. Quack pseudoscience accessible online challenges textbooks, medical articles, and office lectures. Legitimate authority no longer derives either from knowledge or from experience, nor from agreement, let alone from the ability to advise. Now it's every man for himself. In addition, there is another loser in metromania; a physician with no proper clinical training who has to practice in an environment lacking technological sophistication no longer knows how to interpret the patient.

It is easy to see that speaking of scientific medicine and scientific physicians is to resort to sophistry. According to the testimony of Sextus Empiricus, quoted here by Ricardo Salles, a sophism is a false argument; "whose premises are not all true or its conclusion does not follow validly from its premises, even if they are all true".[21] Salles goes on to say that "they are convincing but deceptive arguments, [that] have

an apparent verisimilitude that makes their conclusion acceptable despite being unacceptable, and [that] their purpose is to deceive the adversary, to defeat him in an argument".[21] Speaking of sophisms, in Mexico, Ortega's criticism is fulfilled as a prediction. In the last 50 years, emphasis has been on the pathophysiological bases of medical practice, to the detriment of a broader perspective. The physician sees processes down to the organic level, but no longer of the patient, let alone the person. I am not saying that we should not aim at the preparation of excellence. I am saying that resorting to sophistry is also resorting to self-deception; a medical school in a country such as ours should train the good general practitioners needed. That is the social mission of universities, public or private. The scientists and specialists that emanate from them will be selected on their own, by affinities and qualities, and will always be a numerical minority. Good general practitioners will be a majority, not less important or less valuable, but much needed in this country.

SUFFERING AND STRANGENESS IN THE FACE OF SUFFERING

'Suffering' comes from the Latin súfferre,[22] from sufferire, in turn from the verb fero, to bear, to tolerate, to endure, and the prefix sub, underneath. To suffer is then to tolerate, to hiddenly put up with something. Suffering is carried inside, not always patent. The hasty physician does not perceive it. They hear that a patient refers pain of some kind and notice their facies by some exploratory maneuver. Then, they consign it with confusing eponyms so frequent in medicine, Giordano, Blumberg, Rovsing, and quasi-infinite others. What is the eponym of suffering? The Hippocratic facies is not of wisdom but agony.

The alleviation of suffering is not a predominant theme in the discourse of contemporary technocratic faculties. What matters now is the accurate diagnosis and the treatments that evidence shows to be best. The dictum "there are no diseases but sick people" is no longer but that, a saying repeated without further reflection to young and healthy students. It would seem that the Cartesian mind-body dualism persists and that the physician treats the dysfunctions of the latter, forgetting the effects on the former. In this sense, observation cannot resort to a system of measurements capable of quantifying pain and suffering. Emphasis has been placed on training physicians to express the problems in a structured and standardized format called the clinical history.[23] This is not necessarily bad. On the contrary, it facilitates capturing the quantifiable part of reality and transform it into objective and ready to process information. But the human, subjective aspect and the physician's tolerance are thereby suppressed. It would then be better to say "there are diseases in patients" since the qualitative conception of the individuation of the symptomatic picture is more satisfactory, the methodical and scientific reference of everything observed and systematized to the singular person of that patient, all without denying the validity of both criteria, the quantitative and the qualitative.[24]

In light of technologies and how the sciences themselves have shaped educational programs, diseases have become isolated objects of study, as if they were entities rather than processes in people. The laboratory, imaging, and others have taken precedence over the *ars medica* so that physicians determine *the abnormal* by figures and images. Occupied with this pragmatic vision, they relate suffering to pain, and when the latter does not exist, they assume that the former does not exist either. Only suffering and pain are not synonymous. Pain can be a sign or a symptom, suffering not necessarily so. Pain engenders suffering, but this latter can occur even in the absence of pain. Already in the *Precepts*, the Hippocratic asclepiad said that "indulgence also helps to put a man back on his feet, if one pays the necessary attention to him who is blind to what is good for him".[25] Clinical diagnosis and the doctor-patient relationship require time to be exercised and cultivated, time that the contemporary physician is not always

willing to invest in the face of the advantages of techniques.

What is the nature of the dual relationship between the patient and the physician? Pedro Laín Entralgo asks in Theory and Reality of the Other (Teoría y realidad del otro)[26] and later in Marañón and the Sick (Marañón y el enfermo)[27] where he speaks of a "personal ourness" in the doctor-patient relationship, distinguishes between the duo and the dyad. According to him, "[t]he duo is an *objectifying* linkage with another for something that matters to both of us, outside of him and outside of me, for example, a business with profit sharing, which arises as a consequence of what living in the world offers us or imposes on us." In contrast, the dyad is "an i*nterpersonal bonding* with another for something that is in him and in me, that belongs to our *personal intimacy*." (*Italics* in original).

For Laín, the cognitive relationship between doctor and patient could evolve into a personal dyad or stagnate in a purely objective duo similar to what, half a century later, resembles a business model. The problem in question, which seems to be misunderstood or obscured by techniques, "scientific medicine" and statistical and meta-analytical evidence, is not only to detect abnormal parameters and correct them but "to know the patient as such [...], to know what the patient has".[27] This is how suffering can be detected and alleviated or alleviated, but all this is alien to the contemporary physician.

Patients continue trying to narrate their ailments to us while we physicians observe and intervene in their illnesses. Skills such as listening, appreciating, and interpreting patient narratives are rarely valued as such, even less so than the once-famous clinical eye. Caring for the sick requires unhurried conversations, which occur when neither internal pressures from either are allowed nor external ones from the expectations of the system, in which physician and patient collaborate to solve the patient's problems, to establish or renew relationships that return after the disappointments of complications and failure.[28] The patient would determine the pace under the careful moderation of the physician and not by standards external to the purpose of the patient-physician relationship.

The physician should place himself at a level above the underestimation of the patient because of his vulnerability and suffering, which would then lead to paternalism, and below the overestimation and the ability granted to him, condescendingly and comfortably, to make decisions based on the often-used autonomy, in vogue in a medicine that is no longer altruistic but contractarianist.

As long as the physicians' interest remains only the diagnosis of the disease and its treatment, they will not understand the patients' interests or avoid their suffering. Moreover, by an excess of diligence and treatment, they may inadvertently cause it, partly because of how they conceive the disease rather than the patient. Partly because they are no longer trained for the primary task, to alleviate. Suffering is not cured by opioids prescription, now a health problem, up to dependence. Moreover, physicians are not trained to deal with sorrow. Apart from the dictum "there are no diseases but sick people" and a medical psychology course at the beginning of the career, again, with some unlikely luck, they will receive advice from a teacher during residency. Faced with patients' fears and social expectations -to which they are objects and prey-physicians shelter and become hermetic. Hence their objective coldness can be very subjective. It is part of the collective imaginary fed in large part by physicians themselves. However, physicians do not deal with objects but with subjects. Their subjectivities confront the subjectivities of patients. In this case, physicians' distancing is a defense mechanism against suffering, which has other reasons and other circumstances.

RHETORIC AND THE CURING-HEALING DUALITY

Health systems focus on the organic causes and the much-brought up but little-attended social determinants of disease, simply because of their use to make budgets and health policies, even if not applied. These determinants and

organic causes are quantifiable. But even if applied, patients would not feel better right away. Once their disease cured, even treated with all the efficiency and humanitarianism that our health system is capable of guaranteeing and providing, the institutional hospital carriage would again turn into a pumpkin, as they would return to their social environment full of shortages.

By way of example, a digression: what good is the ominous result of a Papanicolaou stain when the woman must obtain blood donors as a necessary condition for surgery in a public hospital (the policy is often coercive on the part of institutional personnel), when she must raise a minimum of cash for a family member to accompany her and, in addition, buy medicines and supplies out of pocket because the failed health system does not provide them, as is her right? The first and second articles of the Mexican General Health Law are utopian, and article 4 of the Constitution is, *de facto*, rhetorical (everyone has the right to nutritious, sufficient and quality food [...] the right to health protection [...] the right to a healthy environment for their development and wellbeing. The State shall guarantee respect for this right). Since the wording of the law does not by itself change the reality of the world, the woman in question will continue her farm or domestic work in someone else's house until her pelvis freezes.

Back from my trip. Most Mexican citizens do not enjoy the right to health. The patients' perspective in the face of untimely illness is the impossibility of being cured. They will seek to cure their ailments with whatever they have. With what intellectual credentials could a physician criticize the different healing practices to which, in the absence of services, some of these patients resort? Such criticism would be valid as an academic-intellectual exercise in a classroom or seminar, but it has not been successful as a critique of the health policy of this country. On the other hand, it is also fair to say that, frequently, the only thing well-intentioned institutional physicians can do is *what they can with what they have*, and leave the rest to the fate of patients, to the determinants of their life according to the place and family environment where they were born and which do not change with the rhetoric of the State. The sick will then resort to heal their ailments with whatever they have, their physical reserves, emotional, social, and spiritual circumstances, even miracles.

The contemporary physician (almost) no longer participates in these other processes of being sick. One cause is the imitation of paradigms of first-world universities. Just as Flexner imitated the European models of his time, Mexico mimics the American model. Not only, as González Crussí rightly says, because of "the undeniable leadership that the United States exercises in world medicine, its proximity to Mexico and the fact that many of the best Mexican specialists take professional training north of the border" but also because of the tendency of American medicine to actively intervene rather than remain expectant.

The implicit rule that proclaims that "it will always be better to do something than to do nothing, [with] a bellicose and combative turn [manifested by] 'blatant' examples of American medical aggressiveness not hard to find, [such as] aggressively pursuing this policy [...] the war on cancer [and speaking] in frankly military language [...] of disease or death as the enemy."[20] (Quotation marks and italics in the original).

A distressing example is "prophylactic" bilateral mastectomy with bilateral oophorectomy for the presence of a BRCA1 or BRCA2 gene mutation, even in young women, only because of family history and without any evidence of tumor. In this case, let us ask what is being cured. And let us answer with all irony that American medicine has come to what the popular Mexican saying goes, "curarse en salud" that is, to cure oneself in health. Moreover, it is this medicine that we imitate.

The Mexican case imitates the imitation of the model, albeit it does not include adaptation to the Mexican environment, one of extreme poverty and lack of resources that only increases the dystopia and makes it difficult for doctors of excellence, whether trained inside or outside, to adapt to a reality that ends up inhibiting and frustrating them.

Their professional determinants, specialization, the quantitative, evidence

and objectivity, the economic determinants of their profession, their business model in private practice, the third-party payers, the punished fees and the tax system, and their own social determinants, family, free time, and rest hinder their professional practice. Either they make extraordinary efforts or become tropicalized and survive in mediocrity.

To cure is to eradicate or correct. To heal involves giving meaning to life and helping to cope with the suffering of illness. While curing is restorative of a state, healing is transformative; it changes attitudes.[29] To heal is to give a sense of wholeness and a place in the world, to provide maximum enjoyment of even the smallest joys and comfort when death approaches. Curing and healing are, thus, a duality, two aspects of medical care. Their epistemologies are also different. The basis of curing is scientific, requiring data and evidence. The basis of healing is the relationship between people. It depends on the physicians' gifts and their qualities of empathy to patients. Healing is more art and intuition than science.[30] It has no structured or standardized procedure, no formulas. Rather than taught, it is learned.

EPILOGUE. THE CONFUSION OF THE ENDS AND THE END

Let us not confuse ends and end. I have written in the two previous installments that there are different ends.[31,32] Social medicine aims to understand the effects of adverse environments on the health of populations to modify them. But so-called social medicine is not medicine in the strict sense, but one of several health sciences, epidemiology, public health, and others, such as medical informatics or biomedical engineering.

On the other hand, the goals of social medicine should not be confused with socially constructed ends, such as lifestyles, conditioned by marketing as illusions against uncertainty. Certainly not to be confused with the goals of a contractarianism which invokes the autonomy of those who cannot decide as a false alternative; one which allows lax, defensive physicians to escape responsibility as guides and caregivers of the patient, with all the complexities it entails in a multiple and complex society.

Medicine is a conflict of subjectivities between doctor and patient in which neither can morally oblige the other with their own beliefs and decencies that clash or elude. Without *being a servant of the art*[33] as *Epidemics I says*, it must be exercised with mastery and prudence. The purpose of medicine takes place in the setting of life. Patients are the protagonists of their own lives, not physicians, who can be agonists or antagonists of those biographies, even with the best intentions.

While reading these lines, the question naturally arises: who has time for the biography of the other when one's own is more than enough? The physician. With all his social and personal determinants, subjectivities and conflicts, either he gives himself the time or he will not be a physician. He will be a service provider, a network doctor, a white coat worker, a hospital bureaucrat and all the pejoratives that come from our contemporary national context in which he has lost respect, often with his consent, circumstantial or not. But he will not be a doctor. No epithets.

The role of the physician is not only to cure but to care. And I am not saying that we should not seek healing. The very term *mědicus* comes from *meděor, meděri* meaning curing, caring; also meditating, reflecting, advising.[34,35] All of these are part of the set of our functions towards patients, whom we once swore not to harm, especially with our excesses, however well-intentioned they might be.

Patients are not interested in terms as 'Evidence-Based Medicine', 'statistically significant', and others. They are not interested in where remedies come from, East or West, nor in where or how these syncretisms arose. The patient is neither a historian nor a philosopher, neither of medicine nor religions. They are interested in personal, subjective treatment, certainly with results, if not measurable, sensitive. Above all, they are not interested in theories but in feeling well, and being relieved from suffering, sometimes by death itself.

Thus, it will be more important to alleviate suffering than to cure at all costs,

even more so if we practice in a State that does not fulfill its social contract, and countercurrent with unreflective physicians, some of whom are even our teachers, insisting on scientific paradigms, mirages of the promised medicine.

Life is not saved, as we were once taught, but lived. The patient wants to live it well, and it is necessary to interpret what living well is like for each patient. In this sense, inaction is also an action and, when a patient no longer wants to, it is necessary to understand, even against our deepest beliefs, that they no longer want to. There, in this feeling well, in this relief of suffering, lies the end of medicine.

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