

Construction tools of human being. The medical report

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Abstract. In Italy, and in general in western society, there is an official certification for almost every event of our life. The national administrative machinery provides a specific form/document for significative events such as birth, immigration, come of age, permission to drive, getting married, beginning and continuing the school career. The citizens health state is also included in this machinery. Apart from the health cards, concerning the health state and “connecting” them to a general practitioner, the citizens can have use of a series of health services provided by the national health institutions and therefore, can be in possession of one or more medical reports. With this work my aim is to contribute from an anthropologic perspective to the investigation on how human being-patient is created within the medical and administrative boundaries. To do so I will briefly analyse in anthropopoietic terms some aspects of Medical Report structuration history.

Keywords: medical anthropology, medical report, anthropopoiesis, patients, users.

Cure systems

The access to the cure processes implies a long path through elaborated nets of symbolic meanings, connected to social institutions and to personal interaction ways (1). Inside human groups there is an elaboration process that, starting from specific definitions of what “sickness” and “disorder” mean, indicates a possible responses to these statuses, indicates the persons who can be affected, as well as those who will undergo the cure. It also indicates the social institutions that will be involved in the cure (1). The relations that will take place between the patients and the carers, and the reciprocal expectations, are set within these nets of meaning. Therefore the elaboration of cure systems, the selection of resources and of techniques to apply when needed, contribute to determine the limits in which disorder or sickness will be manifested in a social group. Piero Coppo states that culture gives a form to suffering, elaborating and legitimating containers – models of sickness ready to wear. This function is called “pathoplastic” – giving a form to a pathology (2).

In his work of form-definition that can be given to the suffering, culture inevitably provides also an in-

dications to what is connected to health. Therefore, it provides indications regarding the causes of sickness and disorder, the rules that guide the choice and the evaluation of the cure, the roles, the power relationships, the interaction modalities and the social institutions that are legitimated to intervene. This already complex net of factors, is further enriched by the multiple therapeutic approaches that co-exist in every social group and the various levels of access to them. As noted by Arthur Kleinman (3), in most medical systems analyzed with anthropologic theoretical approach, there are various levels of sickness management that often intervene in the cure scenario before the “professional” ones. One of those are the family, inside which the person who is regarded sick firstly undergoes a do-it-yourself treatment concerning diets, and ways of behavior. Another is the level of “social” management, through which the community members surrounding the sick person express opinions and give advice on possible ways of treatment, often indicating as the first solution “traditional” circuits.

But when the situation is no longer manageable within the family resources there is a request for help to those (persons or institutions) who, inside their cultural

contest, are concerned with curing actions. They, being experts on therapeutic treatments, authorized by their surrounding social contest, will be asked to read the signs and symptoms of the patient. They will proceed to the modeling of specific *human being-patients* following the parameters given by their experience, their discipline practice, the existing social-political conditions in the area in which they practice and in relation to the curing subject. With the resources provided to them they will analyze, knowing it or not, wanting it or not, the same places, languages, groups, objects and systems of thoughts which the human beings they have to deal with but also themselves are introduced to by the surrounding community. This is the proposal brought forward by the nathanian ethnopsychiatry: persons can only be considered according to their belonging to multiple vital group organizations that provide their identity and dimension of existence; therefore, a person is affiliated, put together, grouped according to specific differential matrixes (4, 5).

The above mentioned affiliations are defined by Bruno Latour as *attachments* (6), that is cultural bonds vital to one person, since they literally keep them in life. The necessity of being culturally “attached” to the world is a characteristic of the *human being* and it is the mechanism of the anthropopoietic action of social groups to newborns, with the purpose to overcome the biologic insufficiency by which the *Homo* is characterized and to lead them to the adult age under the form of human beings. Therefore, humanity is configured as the result of a continuous modeling action through which the human beings are culturally attached to the world by means of bonds that sustain, hold and bind them (7).

Having set the frames of this, medical anthropology refers to sickness, that is “ways of expression of some kind of uneasiness”, and to the cure systems as expressions of a specific historic-social-environmental background.

Embodiment and historic background of the suffering expression

The anthropopoietic project every group of human beings is put through is obviously characterized by a deep absorption that gets to model the incomplete biology of the *Homo*.

The *sick-human being* cannot be intended in exclusively natural terms, as an entity outside its process of social production and of cultural construction. It

represents a real social product and construction processes are to be investigated. That is because the specific culture absorbed and that rendered the human being appropriate to the expectations of the group in which he entered, is expressed indicating the ways through which the sickness with its pathoplastic function is shaped.

In these (social) terms cultural categories of the suffering and of the sickness are not simple categories through which human beings describe, by means of culture, a universal contest. These representations literally form the embodiment and the sickness as forms of social experience.

The historic images through which suffering and sickness are interpreted organize the ways in which human beings experience these particular states of being. Nancy Sheper Hughes and Margaret Lock (8) suggest that the symbology of the body that anthropology traces through its analysis should therefore be seen as a means of the construction of corporeality itself, of its reality as well as its historically subjective experience.

The human being is not simply made up of and through social practices, it is also the living of these topics and practices and therefore, the identity adventure is not exclusively socially produced, it produces also knowledge, meanings, culture.

Sickness can be conceived as a particular body technique, as a language requiring an interpretation able to unravel the thick tangle of personal experiences, cultural processes and sociopolitical forces that are lived in the immediateness of the experience. Therefore, sickness is something that human beings do not only through the categories with which one’s uneasiness is interpreted; not only through the political and social forces that produce specific discursive means that make up regimes of truth; but also through their incorporate experience. Sickness can be also interpreted as a real cultural practice itself, in which the human beings express themselves through historic repertoires of their cultural construction.

The impossibility to pin out naturally sick persons, that is outside a social contest, leads us to the conclusion that *patients*, just like sick persons, are nothing else than the local and historically defined product of the use of terms of specific theoretical and technical means elaborated within specific cure systems. These means developed within a society are given to all those who are accredited as “human beings in charge of the cure”, that is *therapists*.

Anthropopoesis in sanitary archive

Medical anthropology has long ago set its eyes on the products of the medical-scientific knowledge within the boundaries of which it is culturally included. This movement towards the inside has allowed the treatment of a so called corpus at the same level of every other knowledge concerning the cure, and above all the focus to the kind of human beings that has produced and continues to produce such knowledge.

The sanitary archive becomes the observation place of a peculiar moment in the human being's "identity adventure". This adventure, together with the health institution or assistance is enriched by categories through which persons can identify themselves or can be identified by their social group (diagnostic or identifying categories of various titles ie. "calm", "restless"...)(9).

There was and there still is a production of a huge number of documents and letters for the admission of a person in a cure facility. As the person's stay is prolonged or their returns to these facilities are repeated, the number of these documents and letters increases. The clinical files are therefore a meeting point of a number of applications, organized and conserved by an administrative machinery that shapes, together with some contemporary medical science representatives, the "form" of the documents. It is therefore possible to consider the medical report as an object *that is shaped and that shapes*. It actually represents a composed artifact that acts on the shaping of other artifacts, the human beings (physicians and patients/sick people).

The charm a researcher undergoes while reading life stories that come out of *memorabilia (especially in psychiatric archives)*, correspondence and newspaper articles makes the application of a careful, interested and not focus even more difficult. This is actually a problem that we clearly face during historical and social researches, conducted since the Medical Report started to be considered a resource equal to other documents (10).

The medical report is a symbol of western physician's knowledge that, in its structuring, is representative of one of the various ways to conceive the cure action. The structural lack of homogeneity that characterizes the clinical documentations, requires the presentation of a specific cultural production contest in order to set the historic, social and discipline boundaries. This considerations will be held after the examination of report file formats taken from the Sanitary Archive of O. P. of Quarto dei Mille in Genova (1888-1998) (11).

Shaping tools

Pierre Jean Georges Cabanis in 1798, trying to fulfill the need for "certainty" of the medical knowledge concerning a disease, assigns to the medical report a complex mission stating that the most important thing that has to be done is fill it with the exact description of a disease. Not only should be describe its outbreak, its development, its state, its decline, its convalescence; not only the physician will indicate the principles from which he was lead to his decision for the drug administration; and which were the consequences of this: he/she will also have to mention the age of the sick person, their temperament, the country they live in, their job, the diseases they have already had, their tastes, their customs (12).

The mentioning of the theoretic backgrounds that guide the physician's work, according to which he/she shapes the patients and their sickness, was therefore, an important condition for the production of a document valid for clinical and research purposes. Through the adoption of such a work tool, medical science was attempting to pick up, in the same levels as other positive sciences, the characteristics, the features, the rules that run sickness itself so that it could manage it, control it. And in this process, the possibility to write down and be able to read again in the form of a diary the observations and the drug administration was the main way to achieve the desired result. Clinical medicine was therefore focused in a research process aiming to localize the sickness in more and more precise anatomic structures. We should remember though that the idea of this tool under the *standardized* form took place in a historic contest of architectonic and administrative renewal of the cure and internment facilities. The information exchange for the medical use and of data useful to the public administration, connotes the structuring of the document until nowadays. This is where also the control function of this document derives from; very powerful and non exclusively aiming to investigate social and personal aspects of the patient. When filled in, the medical report actually represents a control tool and a test to the physician's work. This was so when it first started to be used, and also nowadays, inside an innovative health contest.

From an anthropopoeitic perspective the oldest personal dossier of Quarto dei Mille Asylum are representative of their function in guiding and structuring of the "medical look". Until 1925/26 inside personal dossiers we find *Tabella Nosografica*, and *Modula informativa* (13), that constitute a very detailed and

well completed corpus of personal, social, physical and medical annotations. Every possible aspects of patients lives is taken in consideration in a specific field of the forms and some aspects concerning the patient patient. The process of patient shaping is clear as much as the shaping functions of the medical point of view. Is a bidirectional actions that shapes and is simultaneously shaped. In this patient has not yet many chance to “use” to have “agency” through Medical Report, he is a patient suffer and waits for diagnosis, treatment and cure but is not very often a social actor for the institution.

From patient to user

With the “Institution of the national health service” in Italy, How does the *shaping* of the patient evolve in this new reformed health contest? Formally, always through the use of a medical record, actually through the filling in of more records. In the documentation consulted in the Quarto dei Mille Archive, in the personal *files* of those who at the moment of the psychiatric reform were still internees, we actually find that the files of Mental Health Departments, through which the territorial psychiatric assistance has contacts of cure and rehabilitation, are accompanied by nurse and social record files (14).

The retrieval of information continues with the definition of the vital statistics identity of the subject: surname and name, gender, marital status, residence and domicile specifying the corresponding phone number. A great anthropopoietic difference is in the absences of parents data, evoked just in a field called “contact in case of need”. Data concerning the professional or retired condition of the patient follow, which represent an interesting evolution of the information “profession” which appeared in 1895. Today, in fact, apart from the possibility to have an old-age pension, there is also the possibility for the patient to have a social pension, a disability pension, a widower’s pension or a pension for carers, apart from the pension funds of specific categories of workers. The economic situation of the patient has become more and more complex. The chart of information goes on asking for data referring to the patient’s general practitioner, the data of the beginning of the treatment and the number of regional register.

Then there is a mapping of the subjects and their entrance in the health institution, so that it will be possible to have eventual access, to useful for the diagnos-

tic path or for the assistance information concerning them.

The page provides though two more parts of compilation and a signature of the document. From the moment that it is supposed that the operators are able to change the diagnostic response about their patient’s disorder, or that its definition might evolve in time, about a quarter of the page is dedicated to the annotation of the diagnosis. This is preferably expressed following a classification on a statistic base, such as WHO’s International Classification of Diseases (ICD) or APA’s Diagnostic and Statistical Manual of Mental Disorders (DSM), so that it will be possible to process data regarding the access, the dismissal, and to develop the use of medicine related to the diagnostic categories. The last area is the “D.R.G.”, Diagnosis-related group, a system for the classification of the patients that are dismissed from the health amenities. Such a system is actually based on the cataloging of the sicknesses, associated to a progressive number and grouped in homogeneous diagnosis macro categories. The grouping in macro categories is made on the base of the resource consumption, of the duration of the hospitalization and the clinical profile that the single diseases require, so that it will be possible to predict the quantity and the type of resources employed for the assistance of the patients.

The page concludes with the signature of the responsible manager of the service. This is the only signature that appears in the basic module and it is a proof of the value that today is given to the document: it has a legal value and in collecting the information regarding the patient, it keeps a record of the job of the physicians, and consequently, also of the amenity efficiency. In art. 221 the *Cassazione Penale* describes it as a public act of advantaged faith the content of which is confutable only with the proof of the contrary. Moreover, once dismissed, the patients, as with every other administration document, have the right to consult it or ask a copy of their medical record, according to law 241 of 1990 (15). The medical record can therefore, be interpreted as a claim tool, both towards the amenity that has offered the service but also with the aim to obtain specific goals, such as a disability pension, an insurance reimbursement, a visa for humanity reasons, etc.

The patient’s figure enclosed in the Medical records is not only treated as a user of the health service or as a diagnosis to transform in a statistic data. Through this compiled instrument, the patient can make requests or claims. The stigmatizing value of the

diagnosis loses a part of its power, since it is disputable by the patients themselves, in an action of acceptance or refusal of the diagnosis, that becomes concrete with the request of a copy of the documentation, or in serious situations, in a legal action.

Prospects

The future, already partially in action, of the medical record is in the computerization and, even more, in the integration of the entire documentation coming from the simultaneous observation of the patient performed by physicians, nurses, social assistants together with the reports and exams that every therapeutic course produces.

This process, as it has already been said, derives from the budget calculation needs of the amenities and of the cures to provide to the users of the health services, from the strong connotation of medical-legal ascertainment that the health documentation has taken up, from the necessity to provide directly for the uses and their claims the dispensed cure process. The social role of the medical record is enlarged, as well as of those who can use it, for the most various reasons.

Definitely we cannot put aside the enormous diffusion of the medical information (diseases, therapies, research, etc) that through the online publication, becomes useful for the interested categories that, at their time and with the same system, can expose the personal experiences and communicate with all those persons who have the same pathology or disturb.

From the anthropopoietic point of view, the medical report creates *human-patients* that, more and more often, far from being passive receivers of stigmatizing diagnostic categories, are organized in associations and communities to share their sickness experience. So, on tv, printed media and in (e-)mailbox we can daily verify the growing space dedicated to prevention campaigns, cure and assistance, towards persons affected by specific diseases. This visibility is surely due to the activation of national, European, world policies that have produced, among many visible results, also the establishment of World Days with the title of the agenda pathologies. Within this scenario quite important are the associations that define themselves as “patients” and “sick people” that mainly operate on the territory to guarantee always major rights for their members. These often work on a local or national basis but aim to extend on a world scale the number of persons who can benefit from their fights (16).

The mass association movement represents, from a historic-anthropologic point of view, a really interesting phenomenon. We actually refer to the collective associations of “sick persons” or “not sick anymore” that identify themselves with a pathologic label. Also this is a form of identity claim. The requests made by this community are the most various ones: from the extension of the sick person’s rights inside the health amenities, to the request of more or better assistance for who faces the suffering in their own home bed; from the request for funds to attribute to the families of the sick persons so that they can hire carers for their dear ones, up to much more difficult requests such as the possibility to use medicine which is not in the market or in an experimental phase. Then there are initiatives aimed to fight and eliminate the consequences that the stigmatization of certain pathologies has on the everyday life of who feels to belong at the group of people who are affected from such pathologies.

As Mikkel Borch Jacobsen sustains, from isolated and passive patients the sick persons-patients have been transformed in social actors, who act within the public space and who participate as citizens to the debates and the controversies concerning them (17). The word written inside a medical record can be disputed in an activist form that puts this category of users of the health services against the health practitioners and the health institutions. Borch Jacobsen also highlights the generated lack of satisfaction in these patients from the knowledge verdict of the specialists; from here derives the decision to make their knowledge and their experience on the sickness count (18). Getting together in group organizations represents a form of *empowerment* that gets sometimes a therapeutic value. Therefore, “De bénéficiaire de soins, le malade devient usager de thérapie, un consommateur éclairé qui s’informe sur ses options, réclame la transparence de la part des professionnels et des autorités, demande à comparer les résultats pour pouvoir décider librement et en toute connaissance de cause” (18).

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