



Future Lines on Epiagnostics: Applications to Neuropsychiatry, Neuropsychiatric Epistemologies & the Nosographic Technologicalisation.

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Introducing Plural, Perspective, Situated Epistemic Frames for the Epiagnostic Characterisation of Pain Experiences.

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QIV, Chapter §2

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. Introduction

Neurophilosophy has approached along 21st-century scholarly works with medical and therapeutical interests the epistemology of pathologies through multiple sides, and with the shift of the technological rhythms into deeper and broader information systems, neuropsychiatric fields can open as well to critical studies, alternatives and historiographical and analogical-comparative inquiries on pathologisation, beyond solely biological schemata. Cultural, social, economical, gender and race studies on the mater have and will develop into new forms of understanding what pathological accounts are, classifications, evaluations and epidemiological claims on diseases appointed to specific patients, instantiated by their conditions, emerged from their interactions with their changing environments.

Ascription claims (definitional tagging schemas) inform through categorial structures different mereologies, ontologies, identifications on pathological dispositions, thus about diagnostic possibilities: ascriptions, in being abstractions, remain artifactual, socially and conveniently decided by communities of research and clinical practitioners. It starts to be the case for categorial claims in contemporary evaluation that fixed point paradigms provide not as medically profitable and theoretically solvable solutions as dynamic, interactive, interoperative, multifactorial and prognostic-related strategies. This conclusion, involving those characteristics as foundational traits of epidiagnostics as proposed by this thesis, makes space for new alternatives in diagnostic recognition, not just for the case selected (neuropsychiatry) but for internal medicine as a whole in coming years.

In the lapse from 2020's to 2040's the fields related to diagnostic evaluation will see profound changes affecting the technologisation of the practice with fruitful promises for casting better decision making processes, assisted by

Artificial Intelligence, cross-cultural, cross-comparative, multivalue situational assessment and case behaving strategies for measuring private experiences like pain.

It is to note that diagnostic intervention, as appointed from contemporary professional activism, must be ontologically separated from treatment intervention in the sense offered by the duality 'diagnosis-farmacotherapy': a progressively larger and increasingly overflowing diagnostic scenario of classificatory plausible pathological clusters, to be called 'nosographical inflation', does not provide for, and has no necessity of, inducing immediate or appointed therapeutical intervention. Nosographical inflation can be thought of, and is argued to be informed as so, informational compounds that will progressively evolve into facilitation factors for building modern computerised assistants performing hyper-contextualised and tendency-specific descriptive pathological systems. Examples in international classifications for internal medicine (eg, ICD10v) serve for understanding this suggestion: the possibility of claiming 'domestic cat scrape' does not identify treatment intervention, but a more comprehensive assessment and contextualised attachment that may be of much help if tracked along patients's anamnesis for future developments of, for instance, infections—for in knowing the attacker's species and the patient's situation at the event will make better informed differential diagnoses given the case of poor prognosis, in this way providing of a more educated guess assisting decision making routines for practitioners—. 20th-century 'medicalisation of ordinary life' has not much to do with 21st-century 'pathologisation of possible health problems of ordinary life'. The first perspective approached biomedical instructions, which has been highly criticised, especially in psychiatric ambiances, involving acutely inefficient medicaments pos-

ology decision making, framing pharmacological adherence and resistance, secondary-gain emergence (legitimation of affective problems masking deeper societal problems affecting the individual), and comorbid implications of iatrogenic origin, providing reductionist and centralised medical results —however endorsing multiple economical benefits for certain industries—. The second modernised perspective approaches an overall paradigm of intervention, generating medical diagnostic produce on account of heterogeneity and complexity, of personalisation of the practice, by enabling a better space for human contact in a decentralised institutionalisation of healthcare, internationally contrasted and disposed to understand the problems of the patient as a person in his or her contextual contact with a shifting environment of stressors that may be characterised broadly, descriptively and prognostically. Pathologisation of ordinary possibilities may be, in this sense via nosographical inflation, a big hope in attaining better healthcare systems aided by expert software, in an era where physicians are shifting from private memory and research study, individual decision making processes, and personal skills, to cooperation, globalisation of power, interpersonalisation of authority, indetermination of unitary singularised index diseases, and multiple drafts theory making, recognising the human value before the organic, biological immediacy, and putting to work plural dynamic resources for extracting well-ordered and epidemiologically compared suit-to-the-patient diagnostic values that integrate his or her authority, personality, character traits, ordinary behaviours, life preferences, interpersonal accounts, general skills and specific abilities, with further involvement of how societal, cultural, economic, laboural and familiar-friendship-kindred multifactors appear affecting his or her pathological niche in a medical sense. Diagnostic recognition has today's opportunity to rethink and reinvent clinical epidemiology, patient evaluation, social,

cultural, economical, interpersonal problems framing, and to re-read the societal changes that are, in many ways, provoking and aggravating such pathologies.

Diagnostic contrast and thick-&-thin Big Data comparison, Smart Comparison and further strategies have the power to translate those problems that have a basically societal emergence point, and empowering the individual suffering from them through interpersonal and intimate descriptive forms of diagnosis that could make patients reunite, focus their problems in a natural and social manner, de-taching diagnostic stigma, and favouring spaces for cooperation within institutional and associational grounds (proposals that walk across diagnostic evaluation from a first instance medical intervention, and that come in very common terms with the postpsychiatric and critic psychiatric movements, which would work in similar ways as in mental medicine as for those applications currently installed in oncology, kidney diseases, hepatic diseases, orthopaedics, paediatrics and viral infections with familiar, laboural, scholar and further social impacts).

In this writing, the following three parts will consider the developmental space of what is understood by this research to be the lines needed and programmable through future works as for addressing the problems in today's evolution of diagnostics, with especial attention to neuropsychiatry in the study of patients's affection and experience, but with direct application to internal medicine. Part I considers some of the aspects the present epidiagnostic turn to complexity faces, seeks and looks forward to provide in 6 points. Part II sounds the 8 major traits concluded in the transformation towards a future diagnostic practice. Part III finishes the text exposing the orientation to future work opened by the present thesis, continuing with the development of a research basis for theoretically underpinning epidiagnostic projects in current views, as applied in clinical ergonomics too.

I — *Aspects of an Epi-diagnostic Turn*

(1) *Decision Making Routines & Fragility:*

In a close future characterised by an overflow clinical nosography, with an inflationary offer of clinical and medical data from interfield origin, current decision making routines will straightforwardly come vague into diagnostic human-follow-oriented precision algorithms, showing non-exhaustive in defining proper-to-the-case divisions of polythetic pathological classes (generally in need of application of diffuse and abductive logic of difficult performance without technical assistance). This scenario worries the common application and understanding of clinical paradigms: should the collateral effects of nosographical inflation occur to perpetuate rough decision making, hindering clinical identification, solely human routines will show fragile in detection, characterisation and determination of pathologies —as so for theoretical-comparative and alternative shifting paradigms in progressive movements towards interfield re-classifications. This fragility can be attuned to the time and era of contemporary identifications through assisted comparison, in the sense epi-diagnostic precision algorithms for polythetic detection would end up helping practitioners to better determine pathological clusters and niches via new adaptive software and epi-diagnostic nosographers.

(2) *Barriers of Biomedical Modelling & General Reductionism:* As appointed in QIII, §3 and §4, the need of anatomophysiological accounts in neuropsychiatry (and internal medicine in general practice) is irrevocable: the diagnostic horizon cannot escape from material alibis in current times —the amount of causal critique and counter critique, of experimental data and interpretations, of correlations and multi-causal models implying material expositions of events is increasingly been modified and morphed into more complex views that shall not be re-

viewed but thoroughly. Psychiatric nosography and decision makers along the way cannot obviate as an article of float scholarly optionalism the effects of vascular breakage (eg, encephalic hypertension, aneurisms, ictuses), of hormonal equilibrium (eg, thyroidal stability, hypophysis, metabolic balance), of immune coalescence with nervous system (as exposed by the RIF Interpretation in QIII, §4), or more directly tumours, internal oedemas, glio-neural fields dynamic and structural dysfunctionalities, of exo-substances's effects on cognition, of neural reactivity after nervous disability via exercising and sports, of cell migration, and of functional plasticity.

The problem is not presented by material alibis as such, but with stating that these are ontologically responsible for overall clinical reactivity and personal agency, which is an argument involving highly discutible propositions and fallacies. To the extent of this summary, as approached beforehand, nosography could expand its views through materiality nonetheless accepting and endorsing an instrumental skepticism overriding suggestions recalling, as studied by 'Niche A' in this work, ancient 17th-18th-19th-century partial and reductive inclinations on material reasoning.

Description and explanation as revealed by trusting conventionalism can be separated from epistemological analysis, and it is the case that through the second one, three modernised anatomophysiological aspects might get extracted: the significance of (a) adopting an intersystemic disposition (a coral work among organic systems), of (b) claiming through a metasystemic perspective (overflowing integrative agencies over singular systems, pluralising specific agencies through the whole organism, and distributing partialised agencies among the interactions of the organism with its changing environments), and of (c) making arguments participate of an epiphenomenal assumption (this implies conceiving of experiences in differ-

ent scales of complexity as the basis of self-ascriptions, and not as ‘a product of the brain’, but of the interactive evaluation of the contextual circumstance the person, in the medical case, is induced as a whole and exposed to interoperate with, in a situated scheme, socially, culturally, economically, familiarly... appointed). These aspects make the case for using material claims of agency as ‘facilitators’ or ‘orchestrators’ of further agency charges proper to the person in his or her interaction with the involving medium, for thus enhancing the way clinical evaluation of experiences through complex multifactorial stressors affecting such facilitators changes overall action and interaction from the person.

The biomedical roles associated with modern practices do not need to be associated with strong materialism, nor the cultural implications of capitalism in the anthropological sense that historically this way of thinking medicine approaches the patient as an organic machinery in a process of dysfunctionality. In its stead, modern interfield theory making can supply better assumptions for understanding the person — and his or her circumstantial disposition to the surrounding multifactorial schemata— in need of medical assistance as a proper human niche for factors aggravating or impeding his or her personal and interpersonal realisation in life.

In this sense, integrative medicine and modernised understanding of values, beliefs, narratives and their emergency as epiphenomenal developments would be able to help to make biological, medical, psychiatric and behavioural tenets convive in mutual understanding, without neglective argumentation, fallacious selection problems, or pseudo-explanations based on a purely unneat, metaphorical, unrealistic, mono-field, biased or interested and unbalanced reduction of complex scenarios.

(3) *Increasing Need of Memory, Contrasting and Epidemiological Facilitation Strategies to the Clinician:* The epistemic overflow on the

amount of data and perspectives reunited for generating standards, contrast tools and for finally delivering on diagnostic values exposes contemporary and future physicians in a problematic situation proper to human finite sets of skills. Modern technology can drive powerful softwares to act as facilitators to clinicians, as nosographers readapting immediately, contextually and internationally, tendencies of pathologies situating patients in personalised and interpersonalised niches, thus responding the necessity of Memory Facilitation Strategies (smart and expert search engines), of Contrasting Facilitation Strategies (through massive data cross-referentialised comparison), and of Epidemiological Facilitation Strategies (helping to apply global statistical background knowledge to case-behaving personalised requirements that may not respond to statistical claims). It is hoped these tools may set clinicians during diagnostic phases free from anxiety-driven decision making routines and de-installing them from individual biases in a more approachable and patient-oriented humane service, leaving to machinery skills that show programmatic, repetitive, time-consuming and about contrasting immense quantity of information from an up to date schema; and to humans skills that require interpretative, integrative, emergent, imaginative and contactual, interoperative and interpersonal performance.

(4) *Promotion of Democratic or Educated Participatory Trust Protocols of Conventionality for Deciding Changes in Pathological Registration and Ascription:* Promotion of such would require to adapt to contemporary requirements the way epistemic communities trust on conventions, and the style of discussions they have. Through adaptive nosographers (more specifically, via artificially guided trend-seekers and query responders) a different form of participatory and integrative re-distribution of trust into newer nosological claims shall emerge,

favouring a deeper, progressive, contextualised and descriptive pathology. One significant aspect of this shift comes with the identification of the notion of 'pathologies in nosographies' and 'pathologies in patients', being the second ones instantiations of the former with multiple variables proper to the person at case, that also affect his or her environment and gathers stressors that may function outside the material niche of the proper patient (eg, reinforcement of pathologies derived from economic crises, multiple-class conflicts —post traumatic stress, fear, anxiety—, familiar unbalance, scholar or laboural asymmetries, interpersonal dysfunctions...), forming a scene that reclaims modern nosographies and diagnostic interpretations to re-value the weight of how epistemic communities decide upon the division and classification of pathologies.

(5) *De-Stigmatisation via Nosographical Inflation*: The terms 'pathological trait' informing 'pathological architectures' have been introduced here in this sense for capturing the shift from disease-like, syndromic, disorderly or condition-like ascriptions: pathological traits via recognition of specific stressors do affect, this way, overflowing those concepts, and ascribing multifactorially, prognostically, personally and interpersonally multiple drafts characterisations of affections and evaluations of health 'in the scenario of the patient', meaning, de-stigmatised from a category, and reassumed as a person involving specific stress and responses developed against it affecting from multiple focuses his or her life performance which, assessed, identified and suggested for a treatment, would be medically approachable, involving as well therapeutical behavioural patterns that the patient may follow with prevention ends (the benefit of equilibrium in diet, socialisation, sports and physical activities, open stays rebalancing the amount of time spent in closed spaces, and so forth), and the reduction and specialisation of

medication for dealing with pathological alterations that may be solved with a non-pharmacological interaction. A more plural, contrasted, integrative, abundant and broader claim on pathological traits can be projected with contemporary and future software assistance. The diagnostic direction shifts, from solely attributing a disease to a patient, to identifying pathologies in the scenario of the person, extracting and interpreting (abducting) a problematisation described in medical and clinical terms. Epiagnostics make the effort of using multifactorial expansive and descriptive nosographies using traits in deep comparison and characterisation from the patient's scenario, instead of assigning the patient a reduced nosography approachable from a finite trusted conventional recount.

The inflational effect in nosographical accounts initially brakes the limits of specific determinations of diseases stigmatising categorically a particular patient, moving the clinical narrative into terms like 'pathological traits and architectures' inscribed as heterogeneous 'instantiations in-the-patient-scenario', being such instances of pathology the different variations approached by the patient in his or her individual and interpersonal resolution of specific pathologies. The need of claiming on the necessity of names for diseases will end up coming standardly unnecessary should the epiagnostic project achieves enough cross-comparative inflational satisfaction of assessment resources so that descriptive pathology could present more approachable through interoperative diagnostics based on conceiving the patient as a person in a particular circumstance, completing their focus work with more complex and broader ascriptions and characterisations for the pathological scenarios of a patient.

(6) *Naturalisation of the Relationships among the Institution, the Clinician (diagnoser), the Patient and the Patient's Environment*: The naturalisation of patient-physician relationships

occurs more clearly in 21st-century forms of attention, care and assistance —in comparison with 17th-18th-19th-century authority, oppression, violence, etc. as a significant number of historical and epistemological critiques have been appointed, and studied by the present work in QII, §1 and QIII, §8—. This naturalisation is present in pragmatic and linguistic accounts on what the patient says and informs about, and what the physician through specific measurement instruments and strategies understands from such speech. The relevance of text and qualitative analysis makes the case for adopting an inflationary perspective on this specific topic, as for choosing to provide broader resolution feeds (Cf. QIII, §8), situating the patient in the context of presentation of multiple plausible pathologies via a multiple drafts methodology, and contextualising his or her experiences through acknowledging the pragmatic accounts and narratives used (helping in case of communicative and executive patients: self-beliefs, self-narratives; Cf. QIII, §9 and §10) or performing advanced clinical diagnostics through pathological traits trend recognition (helping in case of non-communicative or dysexecutive patients).

II — *On the Lines of Transformation towards a Future Epidiagnostic Practice*

(1) *Incorporating Framing and Diffamation to Professional Activism & Research Practices*: One specific task in the prosecution of a more complex, dynamic, responsive and bilateral (patient-physician) future practice comes with incorporating historiographical and epistemic reasoning about linear-to-non-linear theoretical developments, ‘difformations’, as exposed by Lambert Williams in 2012 and studied in the present work in QIII, §1-4, in application to discerning how theories move convention from certain locus of attention to another, both in research and practicing clinical work.

This process will help to understand the underpinning ideas contributing in maintaining historical diachronic conventions as trusted or debunked in a democratic, contemporary, debating formulation of scientific acceptance. As informed in QII, §1, framing strategies expose a descriptive and explanatory analogy to theory making in diagnostics with the introduction of trust protocols, their interpretation, re-distribution of authority and enrichment of data. Incorporating those two traits to common scientific practices would also imply the usage of cultural critique, epistemic analysis and social inquiry in everyday decision making processes on diagnostic calibre, empowering critical and skeptical ideation and, thus, contrasting styles of producing valuable data.

(2) *Incorporating Personalised Attention by Calibrating Abstraction from Epidemiological Accounts to Clinical Accounts*: Epidemiological accounts, statistically defined, populationally-driven, niche-accurate, gender-race-ethnicity-age-specific and cross-culturally, economically, politically and internationally compared, offer abstract standards that may serve as background data for actively informing upon pathological architectures and pathological traits exposure and instantiation in a demographical sense. When transcribed into the clinical realm for a specific patient, as approached in QIII, §7, many studies have claimed background data to coalesce with personal and interpersonal information to properly arrive to conclusions on pathological attributions: in future years new software would be able to direct —through broad resolution feeds from the patient and even broader massively fed standards uploaded to decentralised open case-reported, research-reported, institutionally-reported and agency-policy reported networks— highly cross-comparison strategies towards determining kin resemblances among specific contextualised patient-specific symptoms with broad

knowledge pathological traits. This extraction will calibrate the way epidemiological abstraction ends up clinically applied into personalised diagnostic accounts, manifesting the significance of personal variations in the processes of instantiating pathological architectures through individual polymorphisms, thus gathering the necessary information for educating better decisions on the extraction of diagnostic values, prognostic factors and in the application of treatment interventions.

(3) *Informing New Trust Protocols and New Forms of Agreement: Refilling the Gap Between Diachronic & Synchronic Convention*: New forms of protocols will emerge, where different and decentralised stakeholders manage decision making dynamics. There a shift phase appears transitioning from previous processes of deciding —away from patient zones, and among scientific communities, what patients can suffer from, providing a standard and a name corresponding to the presentation of a specific disease structure and development— to modern forms of deciding trust, involving scenarios where many (clinicians, patients, patients's environment) argue, decide and collaborate in providing broad reference marks, describing presentational and circumstantial whole-scale symptomatology, that will end up in delivering assistance before intervention, helped by software protocols that will aid in determining descriptive architectures opened to possible treatments based upon material, test and analytical basis, but as well on self-reporting beliefs and narratives from the patient, and global standards functioning in decentralised fashions contextualising diagnostics to the patient, in his or her niche, and in his or her interpersonal interaction with the shifting environment. These new trust protocols will also make clearer the way information is managed, exchanged, modified, written and analysed, and whose is the owner of such, the patient, legally protected, authori-

tatively empowered, and disposed to collaboration with clinicians and institutions, which will also have a significant part of legal ownership of detailed reports on specific patients —in an evidently different modular scheme in comparison with patients—. Informatisation and deployment of value data upon networks and platforms (specifically with the development of blockchain resources and value-oriented exchange networking internet plazas) will redistribute power, enhance privacy, and encourage self-awareness of the value of personal data in medical and clinical realms, for better informing diagnostic schemas, and for controlling the protocols that will run what people share, how they do it and why they need to do it.

(4) *Reassuring Qualitative Scenarios: The Significance of 'Contextual Evaluation' in Clinical Assessment of Pain Experience*: Broad resolution feeds expose the case for qualitiveness in a world of quantities and measurements. Tests or material analyses based on biological sample extraction and pathological comparison will jump in future years with the development of micro- and nanorobotic agents, which may need to develop in close relationship with other forms of data gathering in metasystemic disciplines, where experiences, narratives, beliefs, speech, behaviour, interpersonal values and complex social and cultural vectors determine multifactorially important diagnostic values. The example of psychiatry, and neuropsychiatry as an interfield, in the clinical diagnostic assessment of experiences (as it is the case of pain) frames a magnificent example for interpreting how measurement strategies would work in a plausible future epidiagnostic flow: the incorporation of contextual evaluation through scenarios that assess the patient's resolution skills, collaborative performance, decision making, interpersonal sense in task solving, risk-taking and emotional narratives during performance are suggested (Cf. QIII, §8) to benefit the ex-

traction of broad resolution feeds, that will orient better comparison, and bring personalisation of evaluation to the clinical field.

(5) *Design and Incorporation of Artificial Intelligence Assisted Diagnostics*: The incorporation of Assisted Diagnosis in neuropsychiatric and internal medicine through Artificial Intelligence will contribute to make manifest the actual utility and international, decentralised controllability of the pathological overflow proper to nosographical inflation. Several lines of research and design are to be noticed: (a) Text & Qualitative Analysis (T&QA), with especial utility for enabling cross-comparison of patient symptoms with standards, and for extracting stressor-tensors in patients's speech and self-narratives through word-managing and analysis. (b) Thick-&-Thin Big Data, contrasting massive volumes of data in thick epidemiological blocks and abducting thin clinical applicable clusters through probabilistic multiple drafts methodology sorting. (c) Probabilistic-Frequentist Analysis, in the articulation of diagnosis and prognosis of pathologies, morbidities and co-/multi-morbidities as tendencies, where hypercomorbid and hypocorbid scenarios might be extracted through accidental vs. reciprocal/causal coexistence of multiple pathological architectures. (d) Blockchain technologies, in clinical application to systems of organisation, distribution, monitoring, encryption and communication of clinical value data in doctor-patient and doctor-doctor inter-operational relationships. And finally (e) Micro- and Nanorobotics diagnosing from the inside-outside macro-tissular, cellular, molecular and metabolic proteinic processes characteristic of pathological accounts ascribable from the patient's scenario.

(6) *From Pain Experience Evaluation to Contemporary Interdisciplinary Algology & Pain Units*: Algology, as the medical overall study of

pain experiences, has the opportunity to frame itself in 21st-century research practices as an interfield collaborative ground for theory making and clinical practice in a much needed impulse regarding the impressively high prevalence of pain and comorbid pain bearing scenarios in today's societies, and the opioid epidemic suffered by a big part of the world, involved, in psychiatric claims, as an overcoming compensatory strategy towards a non-realisational space where people can develop and health can be maintained and assorted. Algology, through pain units in hospitals with assistance-oriented value as introduced by P Wall and reinvented in the current century internationally, can play a good role in recovering clinical processes, as well as in enhancing an interdisciplinary complex collaboration in research theory making that, as the different grouping niches of the present thesis show in synthetic, polyhedron-like collaboration, with an integrative spirit, may structure the heterogeneous dynamics that favour pain debuting and continuity.

Another important topic this work wants to address is the lack of specific interfield development in 'Algology' as a medical speciality. This comes to the requirements of medico-clinical specialists on pain spectrum diseases, aetiology, morbidity, comorbidities, pathology, internal assistance, prevention, prognosis, kindred copathological scenarios, along with their needed intervention and treatment should it be applicable. Why is there not such a thing as algology for a medical student to become a specialist algologist? Why there is no academical specialty, before scholarly research, such as algology providing education on assistance, guidance, direction and caring beyond the also required and well executed for the most of cases pain units. A relational, inter-systemic, meta-systemic approach in algology is claimed here to be necessary, concluding with a specific interfield, a medical discipline in research and a clinical practice in direct intervention and healthcare systems.

(7) *Nosography Responding to Contemporary Complexity in Standards*: Nosographies may get transformed in the next decades of this century in highly useful, adaptive, cooperative and decentralised software technology tools. New forms of conceiving of previous static book-edited nosographies that can shift towards modernised plural, interactive, processing, instantly responsive and immediately updated nosographers, pieces of software dedicated to smart massive data searching and contrasting, personalisation and multifactorial value extracting engines that will facilitate the diagnostic recognition of pathological traits and architectures all around the globe, bringing first-quality healthcare protocols and diagnostic assistance to everywhere with an internet connection, that will connect patients, patients's environments, clinicians and healthcare operators and institutions in an international fashion, regulated by new legal waves of civilisational technologisation (as can be seen in the Canadian case in Toronto, Vancouver and Quebec, in China and Singapore, or in the European cases with Estonia's programme for a digitalised nation, with the fruitful Swiss blockchain legal social projects in the Zug Crypto Valley, with Sweden's Node Pole in Stockholm, or in the UK in London), and controlled by adaptive standards informing clinicians of multiple drafts plausible options in their developing characterisation of pathological accounts. The question being, thus: how will respond nosographies to the risks, challenges and opportunities this new form of 'trusting' offers? Which are the measures that we, as societal intervenors and contributors, need to approach for evolving theory making and clinical practice in a neat, controllable (at least not to form a malfunctioning corruptive disequilibrium), serviceable, opener and globalised tool?

(8) *Platforms, Queries, Decentralisations: New Era for Nosographers*: Not claiming this new point as an answer, but as a collateral im-

portant topic, it is to mention that nosographies have these risks and opportunities just in the sense they are being created, designed, decided, morphed, cared upon: diagnostic facilitation and nosographical inflation, through its technologisation, are starting to be new 'forms of convention', of trust, of identification with a decision, and the big difference may strike in that this new form of making decisions comes with plural, alternative, provisional, globalised and interpersonal factors that were before just handled by personal, individual, historical convictions, and with much more probability, fallaciously biased monofield strategies.

The new forms of trusting conventionality will now provide of more space for debating, contrasting and enriching data through social and interconnected epistemic communities, accessible, professional and guided. Two values have the key in this process: Open Data Platforms and Policy Networking. Open data platforms can redistribute clinical knowledge through new types of nosographers that make probabilistic-frequentist analyses based on human work, research, case-reports and directions. Nosographers, in this sense, will deploy as the needed filter of massive information presented by a human query, information that needs be assessed and calibrated through decision on conventions from those to whom filtering will affect: patients, patients's ambiances, clinicians, institutions... Open data platforms, thus, need to work in relation with political, debatable, openly democratic (meaning, educated participatory trustworthy decision protocols), transparent and honest boundaries, where policies and policy-makers come to play in a scenario set for developing fruitful, beneficial and humane lines of evolution. Instead of running across the lines (minding the corruptive and thus socially demanded refurbishing of political, economical, financial, stabilising infrastructures underpinning societal endeavours), we need to arrive to 'new deals' appealing to so-

cial interests in the hands of clinical institutions (recovering the sense of cultural institutions for clinicians too, associations and patient communities), whose main goal should be to provide with compulsory and progressive agendas, in much need in mental healthcare for tomorrow's depiction of what is to be sufferable.

III — *On Future Work on
Epidiagnostics Opened by the Present Thesis*

The present thesis on epidiagnostic assessment opens multiple research vectors, of which three major directions are to be depicted: (1) the introduction and enhancement of an Epidiagnostic Mindset for all stakeholders in healthcare, along the educational and divulgative actions showing the significance of developing a broad assisted evaluatory practice, which helps clinicians to better understand the role of multifactorial, prognostic and inflationary pathologisation of common current health problems. This especially affects to neuropsychiatric spaces, the selected interfield as case study (for it being one interfield where comorbidities and indetermination of pathology occurs more often), as to internal medicine (for overall diagnostic practices); (2) the introduction of Clinical Ergonomics in application to Clinical Assessment, and its impact in designing systems for epidiagnostic identification of pathological instantiations through Artificial Intelligence Assisted Diagnostics; and (3) the introduction of the study and development of Adaptive Nosographers building the new forms of trust and conventionality in decision making routines addressing selection, characterisation, clustering, contrast and identification of pathological traits and architectures as disposed in the previous pages.

The continuation of those three lines of research in immediate years will set the framework of my personal future research, in the hope that modern advancements in clinical interfields could build a better understanding

of pathology, experiences and healthcare interaction with those who suffer in pain and need of care.



~ The End ~