

The Wrong Transformation of Doctor-Patient Relationship in Drug-Patient Relationship: From the Doctor Himself as A Drug to Doctor as Drug Dealer

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Received: October 06, 2018; **Published:** October 29, 2018

Keywords: *Physician-patient communication; Adherence; Pharmaceutical treatment; Therapeutic alliance; Inappropriate Prescribing; General Practice; Framework; Decision making; Polypharmacy*

Volume 3 Issue 1 October 2018

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“Measurable relationships, we find, have no monopoly on truth, and our notion of what is objective must be completely redefined” Sense and Non-sense. By Maurice Merleau-Ponty

Is the old doctor-patient relationship in general medicine changing? It is being lost? Are we witnessing the transformation of the physician-person as the main active drug, to the chemically active drug object, without the intervention of the doctor? Does the general practitioner (GP) only prescribe drugs and more drugs, becoming a drug dealer, and have himself become invisible as an active ingredient for the patient?

In order to understand the meaning and structure of clinical experience, it must be framed in the history of institutions and the relationships in which such experience has been organized and manifested.

Thus, we have to accept that the clinic is being transformed with the appearance of new pathologies, the medicalization of everyday life, the marketing of the pharmaceutical industry, and the diffusion and overvaluation of technology, including pharmaceuticals, by the media. On the other hand, the diagnosis is mediated by the type of therapeutic intervention that we plan to carry out (which is currently pharmacological almost exclusively) [1]. This process leads to “too much medicine”: over diagnosis, multimorbidity and Polypharmacy [2].

Of course, the pharmacological prescription is one of the main facets of the professional. Medicines have become an essential part of modern health care, and improve the health of the population. But, in the same way as the transformation of the clinic, there is a trend that leads to transform the medical relationship with patient. Until now, especially in general medicine, it was admitted that the doctor-patient relationship itself is the intervention that the general practitioner (GP) most frequently uses with the patient, considering the doctor in himself as a drug, the “drug”-doctor [3], but this scenario may be changing dramatically.

Citation: Jose Luis Turabian. “The Wrong Transformation of Doctor-Patient Relationship in Drug-Patient Relationship: From the Doctor Himself as A Drug to Doctor as Drug Dealer”. *Chronicle of Medicine and Surgery* 3.1 (2018): 298-301.

We attend to the medicalization of the natural circumstances of life, and in this situation, many of the drugs used in medicine are but symptoms of disconnections in society, and doctors are becoming “drug sellers” instead of listeners who work with human beings; so, doctors can be using drugs as a substitute for being with the patients. Consequently, the classic concept that the interview itself is therapeutic is modified, and it stops being this doctor-patient relationship the most active drug [4].

Until now it was accepted that the doctor-patient therapeutic relationship is the environment where the rest of the therapeutic instruments are housed, pharmacological or not [5], and that the chances of success in a treatment are directly proportional to the quality of the doctor-patient relationship [5], and that therefore, the interaction between patient and doctor was fundamental for the prescription process of drugs [6]. Since the doctor in himself was the “real drug”, so it could apply to himself the concepts of pharmacology of overdose, allergic reaction, side effects, etc., so that the most complex question regarding that doctor-patient relationship was what should be the optimal dose of “doctor” [7].

But, all these concepts and the scenarios where they were located, are changing in several levels:

1. In the use of drugs, the aspect related to pharmacology, completely eclipses the importance of the non-pharmacological aspects of medication, mainly the doctor-patient relationship, which are not considered anymore. The doses of “drug”-doctor are now extremely modest or they no longer exist. In addition, in the patient, the drug becomes the representation of “something” that needs, and therefore must be good and not modifiable, and it demands the repetition of its prescription [8]. The medicine is a relational object. From the manufacturing laboratory through the doctor’s office to the patient’s body, the medicine incorporates a world of social representations and symbols [9], from which the figure of the doctor disappears or vanishes to a large extent; patients accept the drug (without considering the effect of the doctor) as a symbol of something, and demand it as a right.

2. Interpersonal doctor-patient continuity is always difficult, but nowadays it is even more difficult, since it has become in a scenario of growing increasingly trivial demand on the part of the population that wishes to achieve the pseudo-advantages that are offered to them, through the consumption of pseudo-sanitary services. There is a lack of understanding on the part of the patient of what constitutes a good scientific-technical quality on the part of the doctor, and there is communication with the doctor inadequate and querulous on the part of the patient, and a cognitive and behavioural defines by part of the doctor, that have to face the hypertrophied claims of the patients. In this new context, the “interpersonal continuity” doctor-patient can be discontinuous, experienced as “moments”, or even disappear [10], and the patient’s intervention can be focused exclusively on getting the prescription of the drug (although patient later can not comply with the treatment), without a true interpersonal doctor-patient relationship.

And 3. The style of union between doctor and drug imposes a new doctor-patient relationship. In the previous theoretical framework, the doctor and the prescribed drug are united, stuck together, so the therapeutic alliance is an alliance of the patient-person with the doctor-person; it is an interpersonal alliance. But in the new style of super-priority to the pharmacological chemical product, it makes the doctor-patient relationship become exclusively a pharmacological relationship: patient-drug relationship, or doctor as drug dealer-patient relationship, where the prescriber is excluded, the doctor (at least, the doctor himself as a drug); the physician-person has been transformed into a chemical object (drug), and the therapeutic properties do not include the interpersonal aspects. It is a relationship that could be established equally between the patients a drug vending machine [11]. In addition, the doctor can accept this transformation willingly, because the drugs are used to avoid being with people; being a doctor as a drug dealer is easier than showing us human [12].

In this context where the “drug”-doctor disappears (the doctor himself as a drug) and where the communication between the professional and the patient is reduced to the minimum expression, it is where it appears, “to improve adherence to treatment” is the use of “poly-pills” (fixed-dose drug combinations) The experience available with this type of formulations seems to indicate that the tablets with different active ingredients that are used in individual units could significantly improve the pharmacological adherence in many

types of diseases, reduce the costs of production and distribution and improve the affordability of treatment [13, 14], and reduce the need for the doctor-patient relationship!

On the other hand, the prescription of medications has evolved to treat mainly chronic pathologies. In general medicine, it is currently prescribed repeatedly using computer or electronic means, which leads to problems if it is not done with proper control [15]. One of these problems is that this technological modality deepens and favours the lack of need of the doctor himself as a drug. Already in the consultations for the repetition of prescriptions, the doses of the “drug” -doctor tend to be lower than in the rest of the consultations. In the prescriptions repeated over the years tends to be a paralysis or “freezing” of the doctor-patient relationship, where doctor and patient are “defeated”, as disappointed or frustrated, they mean an unrealized achievement or unresolved fears –chronic-, although it also includes the peaceful or tranquil sense that this medication repeated for years was not entirely unfruitful [7], and the disease, although chronically present, is stabilized. This whole psychological or symbolic context is exacerbated in the electronic repeated or chronic prescriptions. In this environment of disappearing the doctor himself as a drug, the patient says: “I do not come to consultation, I do not come to see the doctor, and I just come to renew my prescriptions ... for another year”.

Of course, the multitude of processes treated in general medicine: infections of diverse localization without microbiological diagnosis, symptomatic processes, chronic processes without curative possibilities, preventive processes with long-term results, self-limited processes, etc., make that the therapeutic decision-making, and in particular the choice of a medicine, is a fundamental axis of medical reasoning. That is, the prescription of drugs is a central element of the GP, but despite the transformations of scenarios due to forces more powerful than the GP, against which we are at a disadvantage, we must try not to forget certain principles that are before prescription: making the treatment by listening and understanding the patient as a person asking for help, and not as an isolated and de-contextualized pathology that can be treated as one who changes a piece of a machine [3].

Despite the theoretical and rhetorical emphasis on patient-centred medicine, shared decision-making, and the bio-psycho-social approach, the truth is that the drug, in today’s world, is probably more powerful and tends to obscure the concept of doctor-patient relationship, both for the doctor and for the patient. However, science should not refuse en bloc the human experience, the interpersonal doctor-patient relationship, nor subject it to the only questions that can arise from the chemical experience of the drug, but there are other real relationships than measurable and chemical relationships and that finally, our notion of objective must be entirely redefined [16].

In summary, we are witnessing a dramatic and wrong transformation of interpersonal continuity in general medicine. A reflection and review of the doctor-patient relationship is necessary, but also of the concepts of over diagnosis, multimorbidity, overtreatment, and Polypharmacy [17,18], which are intertwined, and seem to be partly self-created scenarios by the vision of health/disease in the biomedical and medicalist framework, where the drug eclipses the person, and therefore, at least in part, these scenarios could be modifiable.

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