

Pharmacological Non-Prescription, Doctor-Patient Relationship and Biopsychosocial Approach: Foreign Lands or Foreign Travelers?

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“There are no foreign lands. It is the traveler only who is foreign.

” Robert Louis Stevenson (13 November 1850 – 3 December 1894; was a Scottish novelist, poet, essayist, musician and travel writer)

In my opinion, pharmacological non-prescription and pharmacological de-prescription are one of the main factors that alter the doctor-patient relationship at present, especially in countries where there is a national public health care service with universal access, and the general practitioner (GP) has a role of gatekeeper, and his consultation is the beginning and end of all itineraries of health care of all patients. This place is where the vast majority of pharmacological prescriptions, including repetitions of prescriptions for chronic patients, are made, and these prescriptions are financed partially or totally by the health system.

The tendency of the increase in prescriptions and polypharmacy leads to a consequence of iatrogenesis. Although this problem has different levels of reflection, these comments focus on the micro level of the GP consultation. There is a technical and ethical need to rationalize pharmacological prescription, and that includes pharmacological non-prescription of drugs when they are not indicated (for example, antibiotics for viral infections) and pharmacological de-prescription when indicated (for example, opioid coincidence and benzodiazepines, or statins as

primary prevention in the elderly, etc.), which must be made by the GP, although there may be many difficulties, both with respect to the doctor, and to the possible pressures of the patient to have the drug.

However, both the pharmacological prescription and the pharmacological non-prescription influence and are influenced by the doctor-patient relationship. This doctor-patient relationship is the link that the doctor generates when creating certain contexts in his office, and the doctor-patient communication that is produced indicates the clinical direction for diagnosis and treatment (1). In addition, the doctor-patient relationship is a complex, multiple and heterogeneous concept, and several models have been described, but there are difficulties in the instruments for measuring the performance of this relationship due to all this complexity (2, 3).

For a long time, it has been established that having a referral doctor, can imply a powerful protection factor to circulate through the health system (4, 5).

And consequently the rupture or the problems in the dynamics of the doctor-patient relationship, along the continuity of care, supposes a risk factor for health. Although little is known about the factors that facilitate doctor-patient relationship continuity, numerous benefits are described (without knowing exactly why they occur). It is estimated that over time the patient’s confidence improves, and with it the quality of the information (6-8), including the continuity of pharmacological prescriptions (9).

However, the evolution of the health system with its tendency towards medicalization and polypharmacy may be modifying the concept of treatment in general

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medicine, by influencing doctors and patients. The GP is giving increasing importance to the biological dimension of the treatment (for example, antibiotics or surgery). But we must bear in mind that many drugs also act through the psychological dimension (placebo effect), and that they also modify the doctor-patient encounter (10).

Thus, both doctor and patient consider that the end of the consultation should be the prescription of one or several drugs. If that premise does not occur for some reason, both will feel insecure about the end of the consultation and the doctor-patient relationship in the future of continuity of care.

Pharmacological non-prescription and pharmacological de-prescription is usually guided by intuition. Although there are decision instruments that allow to indicate the drugs susceptible to withdrawal: Garfinkel algorithm, Hamdy questionnaire, Medication Appropriateness Index, Beers criteria, STOPP-START criteria, or serial therapeutic trials of prescribing and de-prescribing (11-13), the decision of pharmacological non-prescription or pharmacological de-prescription can be very difficult, and not only in its technical aspects.

Today society is more demanding. This makes it more frequent than a few years ago doctor-patient relationship of the “consumerist” type, where patients exercise more control than the doctor and understand that they “consume” health services. In this situation, the continuity of the doctor-patient relationship can be maintained without problems, especially if the GP framework is “narrowly biomedical” (14), but an increase in demands (for drugs, technology, etc.) can lead to deterioration and toward a social trend of de-professionalization.

Patients may show rejection if the consultation ends without a pharmacological prescription or on the reduction or withdrawal of a drug. The patient may experience this situation as a restriction or elimination of something of his property and to which he is entitled. The drug has become converted into the representation of “something” that is needed; in an object of consumption, and therefore the patient can demand the repetition of his medication or end the consultation with a pharmacological prescription as treatment to his reason for visiting the doctor. The patient can understand de-prescription and non-

prescription, not only as a deprivation of a good that belongs to him, but also as “affection deprivation” (15).

On the other hand, doctors also tend to feel uncomfortable at the end of the consultation without pharmacological prescription, or talk about pharmacological de-prescription with patients. The GP can understand it as being asked to intervene to “contain costs.” In addition, he may fear that patients may interpret the lack of pharmacological prescription as a sign that there is no medical treatment. In this way, the number of GPs that accept the “narrowly biomedical” framework (characterized by closed-ended medical questions and biomedical talk) or “expanded biomedical” (like the restricted pattern but with moderate levels of psychosocial discussion) tend to increase vs. “biopsychosocial” framework (reflecting a balance of psychosocial and biomedical topics) or “psychosocial” framework (characterized by psychosocial exchange) (14).

This GP insecure before the possibility of pharmacological non-prescription can accept polypharmacy and either to consider it right from its frame of reference, or accept it to preserve the continuity of the doctor-patient relationship. In addition, GPs with a biomedical orientation, although they may accept the technical need to not prescribe a drug, even unconsciously, transmit to the patient a verbal or non-verbal message of cognitive dissonance with the decision not to prescribe, which generates in the patient a nocebo effect, and can reinforce the interpretation that a necessary good is restricted to the one who is entitled to it. Probably, in this situation, this nocebo effect will give rise to certain symptoms that will “demonstrate” to the doctor and the patient that the pharmacological prescription was necessary, which will eventually be prescribed in subsequent visits. This same situation, but with a placebo effect, can occur in GP cases with a biopsychosocial orientation (16, 17).

However, whether there is a biomedical behavior and the pharmacological prescriptions are made, as well as if there is an assertive GP behavior denying a prescription requested by the patient, or performing a motivational interview with shared decisions, or within a biopsychosocial framework, in any case, the issue of pharmacological prescription or pharmacological

non-prescription implies a certain type of change in the doctor-patient relationship.

The motivational or patient-centered interview or shared or participatory decision-making has been established as a reference to help prescribe with greater patient awareness and participation, and it should be assumed that it could also help to pharmacological non-prescription. It is assumed that the number of drugs will be reduced through a communicative intervention and that this will not affect the quality of life related to the health of the patients. However, there is a lack of evidence for the association between the empirical shared decision-making measures and the patient's behavioral and health outcomes.

The pharmacological prescription and the interview for pharmacological non-prescription and pharmacological de-prescription can give rise to a certain model of doctor-patient relationship that is more focused on the drug than on other more significant aspects of the medical intervention. Somehow, polypharmacy, but also the attempt to avoid pharmacological prescriptions leads to "another communication or relationship only with the drug", where the doctor (and its effects: the "doctor in itself as a drug"), are absent (18).

In short, the phenomenon of polypharmacy and the low quality of the use of medications is due to a poor communication in the doctor-patient relationship. However, the doctor-patient relationship in pharmacological non-prescription also tends to focus the interview on the drug, forgetting other more significant aspects of the medical intervention.

In my opinion, the only option to break that vicious cycle is to go back to the basic concepts of general medicine, and recover the biopsychosocial approach. The GP with a biopsychosocial approach will focus on the highest possible levels of the systemic organization (family, community), rather than on the lowest levels (cells, organs). In this way, the treatment must be contextualized, and include the psychological and social dimension. The psychological dimension is mainly aimed at modifying feelings-emotions, the functional capacities, and the well-being of the patient, which is based especially on the doctor-patient relationship and its placebo effect; going from "the doctor as a drug dealer", to a classic relationship in which "the doctor is himself a drug." Social treatment is any intervention that involves some environmental,

contextual and interpersonal change of family, school and work relationship. Tal vez hay que decir como dijo Robert Louis Stevenson: "There are no foreign lands. It is the traveler only who is foreign." (19). There is not a doctor-patient relationship in the pharmacological non-prescription that is strange, but doctors and strange patients. In relation to "foreign" doctors in a "foreign" biopsychosocial country, evidently there are implications for research and training in general medicine.

REFERENCES

- [1] Turabian JL, Perez Franco B (2008) [The Effect of Seeing the Sea for the First Time. An Attempt at Defining the Family Medicine Law: The Interview is Clinical Medicine] [Article in Spanish]. *Aten Primaria*; 40(11): 565-6. <http://www.elsevier.es/es-revista-atencion-primaria-27-pdf-13128570>
- [2] Turabián JL, Pérez Franco B. *Actividades Comunitarias en Medicina de Familia y Atención Primaria* [Community Activities in Family Medicine and Primary Care]. Madrid: Díaz de Santos; 2001. <https://www.amazon.es/Actividades-comunitarias-medicina-atenci%C3%B3n-primaria/dp/8479784741>
- [3] Turabian JL, Pérez Franco B (2015) Observations, insights and anecdotes from the perspective of the physician, for a theory of the natural history of interpersonal continuity. The colors of time. *Rev Clin Med Fam*; 8(2): 125-136. <http://www.revclinmedfam.com/articulo.php?art=412>
- [4] Baker R, Streatfield J (1995) What type of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction. *Br J Gen Pract*; 45: 654-9. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1239467/>
- [5] Wasson JH, Sauvigne AE, Mogielnicki RP, Frey WG, Sox CH, Gaudette C, et al. (1984) Continuity of outpatient medical care in elderly men. A randomized trial. *JAMA*; 252: 2413-7. <https://www.ncbi.nlm.nih.gov/pubmed/6481927>
- [6] Nyweide DJ (2014) Concordance between continuity of care reported by patients and measured from administrative data. *Med Care Res Rev*; 71(2): 138-55. <http://mcr.sagepub.com/content/71/2/138.long>

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- [7] Stott NCH (1983) Primary health care. Bridging the gap between theory and practice. Ney York: Springer-Verlag.
- [8] Dobson R (2005) It's official: family doctors are good for your health. *BMJ*; 330:985. <http://bmj.com/cgi/content/full/330/7498/985-a?etoc>
- [9] Beadles CA, Voils CI, Crowley MJ, Farley JF, Maciejewski ML (2014) Continuity of medication management and continuity of care: Conceptual and operational considerations. *SAGE Open Med* 2014; 2. <https://www.ncbi.nlm.nih.gov/pubmed/26770750>
- [10] Turabian JL, Pérez Franco B (2010) [The concept of treatment in family medicine: A contextualised and contextual map of a city hardly seen]. [Article in Spanish]. *Aten Primaria*; 42(5): 253-4. <http://www.elsevier.es/es-revista-atencion-primaria-27-articulo-el-concepto-tratamiento-medicina-familia-S0212656710000259>
- [11] O'Mahony D, O'Sullivan D, Byrne S, O'Connor MN, Ryan C, Gallagher P (2015) STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age Ageing*; 44(2): 213-8. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4339726/>
- [12] Garfinkel D, Mangin D (2010) Feasibility study of a systematic approach for discontinuation of multiple medications in older adults: addressing polypharmacy. *Arch Intern Med*; 170(18):1648-54. <https://www.ncbi.nlm.nih.gov/pubmed/20937924>
- [13] Ouellet GM, Ouellet JA, Tinetti ME (2018) Principle of rational prescribing and deprescribing in older adults with multiple chronic conditions. *Therapeutic Advances in Drug Safety*; 9(11), 639-52. <https://doi.org/10.1177/2042098618791371>
- [14] Roter DL, Stewart M, Putnam SM, Lipkin M, Stiles W, Inui TS (1997) Communication Patterns of Primary Care Physicians. *JAMA*; 277(4):350-6. <https://jamanetwork.com/journals/jama/article-abstract/413647>
- [15] Hesse C, Rauscher EA (2018) The Relationships Between Doctor-Patient Affectionate Communication and Patient Perceptions and Outcomes. *Health Commun*; 1-11. <https://www.ncbi.nlm.nih.gov/pubmed/29461101>
- [16] Benedetti F (2018) *L'effeto placebo. Breve viaggio tra mente e Corpo*. Roma: Carocci editore.
- [17] Turabián JL, Ruiz SM (2016) The fable of the pine and the palm tree: the two extremes. Strategies to maximize the placebo effect and minimize the nocebo effect in primary health care. *Ment Health Addict Res*; 1. <https://www.oatext.com/pdf/MHAR-1-111.pdf>
- [18] Balint M, Hunt J, Joyce D, Marinker M, Woodcock J (1984) *Treatment or diagnosis. A study of repeat prescriptions in general practice*. London: Tavistock Publications.
- [19] Stevenson RL. *The Silverado Squatters by, Fiction, Historical, Literary*. [Homepage in Internet]. <https://www.goodreads.com/work/quotes/1985507-the-silverado-squatters>

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