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Opinion

Polypharmacy and Doctor-Patient Relationship: A Round Trip

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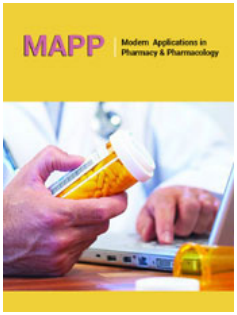

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Abstract

Multimorbidity often implies polypharmacy in chronic and complex patients, who have multifaceted care needs and require integrated and collaborative care from healthcare professionals and families. The doctor-patient relationship can have a therapeutic effect in itself. However, any drug prescription modifies the doctor-patient relationship. Polypharmacy distorts the doctor-patient relationship, transforming it into a "drug-patient relationship." Understanding the psychosocial effects of prescribing on the doctor-patient relationship is as important, if not more so, than understanding pharmacology. The act of prescribing is always charged with human and magical resonances. The patient's relationship with their favorite medications is much stronger than their relationship with any other person, including their doctor and pharmacist. Caring for complex patients with polypharmacy involves creating a different doctor-patient relationship and avoiding polypharmacy. People living with polypharmacy and complex chronic conditions need care from primary care physicians who avoid the "drug-patient relationship" as a substitute for the doctor-patient relationship and, in this context, recognize and address their multimorbidity as an integral disease that is constantly embedded in the life and context of a whole person. A priority for future research should be the development of new models of care that better serve these patients with polypharmacy.

Keywords: Polypharmacy; Multimorbidity; Physician-patient relations; General practice

Opinion

Complex patients (in the medical literature, the terms comorbidity, multimorbidity, frailty, or complexity are often used indiscriminately), understood as presenting with two or more chronic conditions and/or mental health issues, limited education, low socioeconomic status, and/or advanced age, and/or polypharmacy, have multifaceted care needs that require integrated and collaborative care by healthcare professionals and families. For example, polypharmacy is a major health problem for older adults and is entangled with several geriatric syndromes, including frailty, falls, and cognitive decline, as well as a high risk of medication noncompliance [1-3].

Multimorbidity often implies polypharmacy in these chronic and complex patients [4]. However, the benefits of numerous simultaneous pharmacological treatments are uncertain, and the potential worsening of one disease by treating a coexisting disease or the pharmacological impact of following clinical guidelines for individual pathologies is unknown [4].

General Practitioners (GPs) are increasingly required to care for people with complex health problems [5] and often have poor clinical outcomes, particularly among the lower socioeconomic groups; furthermore, multimorbidity and polypharmacy have an adverse effect on health outcomes [6-8]. A limitation of service delivery in primary care is that services are often organized to manage discrete long-term conditions, using guidelines related to single conditions, and managed in clinics organized around single conditions [9]. The high prevalence of multimorbidity, numerous combinations of conditions, and polypharmacy

suggests that single, disease-oriented management programs may be less effective or efficient tools for high-quality care compared to person-centered approaches [10-12].

In daily work, GPs, and other direct care professionals, must develop therapeutic relationships with patients and their families, as well as professional relationships with members of the healthcare team to ensure effective integrated care [13]. It is within the doctor-patient relationship where, very often, the decision to prescribe a drug occurs. It is classically accepted that the general practitioner is itself a drug. So, the doctor-patient relationship itself can have a therapeutic action. The consultation relational context that the doctor creates in his patient care can function as a drug. This therapeutic context induces biomedical processes in the patient's brain that may enhance or reduce the effects of chosen interventions. In this way, when the general practitioner prescribes a drug, he should modify his "psychotherapy" or his advice according to the pharmacological treatment of the patient [14].

The fact that General Practitioner (GP) or psychiatrist understands the psychosocial effects of prescribing on the doctor-patient relationship is as important, if not more so, than knowing pharmacology. Any prescription of drugs modifies the doctor-patient relationship [15]. The drugs act on the symptoms and change thoughts, feelings and behaviors (not only the psychotropic drugs; any drug); they can create both physical and psychological dependence, whose effect can be mediated by biochemical and/or psychosocial factors; they can discourage a deep search for real solutions, both by the doctor and the patient; they can affect general practitioner access on the patient and the problem will be out of reach of him.

Drugs can make the effect of the "doctor itself as a drug" can be more difficult, favouring a relational context that is not significant or that be problematic or not very human [14], with lack of cooperation of the doctor and the patient, and paradoxically with over-compliance or therapeutic discontinuity and the lack of pharmacological adherence, absences to appointments or delays or cancellations of visits, and the denial of responsibility of both the doctor and the patient [14].

A priority for future research should be on the development of new models of care that better cater for these patients with polypharmacy [9]. Understanding multimorbidity/polypharmacy can be facilitated by considering the relationship between adversity (in this case multi-morbidity/polypharmacy), resilience and social connectedness within a life [16]. The importance of establishing trusting relationships between persons and their GPs in order to truly provide assistance [17]. better patient-doctor communication is required to overcome the challenges of managing multiple chronic conditions with polypharmacy [18].

The doctor-patient relationship is a complex phenomenon comprised of several aspects, among which we can highlight doctor-patient communication, patient participation in decision-making, and patient satisfaction [19-21]. Therefore, caring for complex patients with polypharmacy involves creating a different type of doctor-patient relationship and avoiding polypharmacy by the GP, which entails drug withdrawal. All these factors lead to the development of a special type of doctor-patient relationship. In this relationship underscores the importance of the doctor-patient therapeutic alliance, which initially will constitute the first element of strengthening the patient's compliance with the medical recommendation and, by both, will have a considerable influence on the therapeutic process and the final results of treatment. Without an adequate alliance from the beginning of therapy, adherence is less likely to subsist [22-25].

Giving a medication is the tangible expression of attending and giving help. Thus, the prescription is a complex issue; It is a ritual. There are many elements in this exchange: promise and expectation of giving and receiving, of instructing, of evolving, of caring for and accepting care, and others, that are not within the active ingredients of pharmacology. The prescription indicates relationship.

It is not easy to find a solution to the polypharmacy of the complex patient and its effects on the doctor-patient relationship. The complex patient with multimorbidity is almost never free of symptoms, real or imaginary: they can make a long list of them. And the list of symptoms is confronted by a list of drugs that constitute their polypharmacy. Dissociated medical care (polypharmacy is associated with the number of specialists the patient consults, in addition to the general practitioner who usually treats them) tends to increase drug consumption [26].

Furthermore, few drugs are permanently abandoned by the complex patient: they keep them, alternate them, combine them, add new ones recommended by other patients, etc. The result is an anarchic polypharmacy, in which the problems of incompatibilities and unwanted effects grow in proportion to the possibilities of drug interactions. Moreover, the act of prescribing is always charged with human and magical resonances. A patient's relationship with their beloved medications is much stronger than the relationship they have with any other person, including their doctor and pharmacist. GPs need to gradually eliminate the superfluous, but just as important is not adding anything new for trivial symptoms that can be overcome with a little asceticism; not giving nonspecific medications for nonspecific symptoms [27].

In short, polypharmacy has a bidirectional association with the doctor-patient relationship: it is both a result of that relationship and a modifying cause of it. Thus, 1) Physician behaviour and their doctor-patient relationship (training, biomedical framework, fragmented care with several professionals who do not communicate, fear of withdrawal of drugs prescribed by another professional, overwhelm due to demand, lack of listening and shared decision-making, lack of empathy and assertiveness, etc.) are a greater cause of polypharmacy than multimorbidity itself [28]. And 2) Patient behaviour is often one of valuing the drug as magical and the end of each medical consultation, and its absence or withdrawal as an act of depriving a right or a help [29].

This scenario favors a certain type of paternalistic doctor-patient relationship that generates polypharmacy, or tensions in the relationship may arise if the doctor tries to avoid polypharmacy. Polypharmacy distorts the doctor-patient relationship,

transforming it into a "drug-patient relationship". The doctor is no longer the "drug"; the doctor and the human interpersonal relationship lose their value as "drug."

A buffering or inhibiting element in the creation of this "drug-patient relationship" is the long-standing doctor-patient relationship with a complex chronic condition, which could allow for a more comprehensive management of their multiple problems. GP practices should actively identify patients with complex multimorbidity and adopt a continuity of care policy for these patients by assigning them to a designated physician.

We propose an interpretation of decision-making as a continuous process of integration of disease and life: open, cumulative, and relational. Our understanding of decision-making suggests that people living with polypharmacy and complex chronic conditions need to receive care from GPs who avoid the "drug-patient relationship" as a substitute for the doctor-patient relationship, and who, in this setting, recognize and address their multimorbidity as an integral disease that is constantly inserted into the life and context of a whole person.

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