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Strengthen the doctor-patient relationship and avoid administrative stifling

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Abstract

The acquisition of private medical practices by large health-care corporations is transforming clinical practice in many Western countries. The growing influence of health administration on medical practice is increasingly perceived as a danger by the public and health professionals. Health-care administrators should not replace doctors or invade their competencies. Back to principles, the patient-doctor relationship must be funded in trust. Representing society, governments must try to ensure health care to all citizens, serving one of the fundamental human rights. Using the principle of subsidiarity, administrators should fill gaps in the provision of health care to all patients by doctors.

Keywords

Medical ethics. Patient-doctor relationship. Subsidiarity. Vertical medicine. Medical humanism.

Introduction

The growing influence of health administration on medical practice is increasingly perceived as a danger by the public and health professionals. Concern exists about an intrusion by health managers to the detriment of the doctor-patient relationship. The perversion consists in the fact that management is no longer at the service of the citizen and becomes the power that instrumentalizes it. In health care, illness becomes the exchange currency: the administration tries to replace the doctor. Sensitive to this problem, one of the most prestigious medical journals, the New England Journal of Medicine, has begun to publish a series of articles on medical ethics[1,2].

Back to principles, the patient-doctor relationship must be funded in trust (Fig. 1). Representing society, governments must try to ensure health care to all citizens, as a service to one of the basic goods. Using the principle of subsidiarity, administrators should fill gaps in the provision of health care by doctors to all patients.

The risks of "vertical medicine"

The acquisition of private medical practices by large health-care corporations has transformed clinical practice in the United States[3,4]. In this new "vertical medicine," the doctor has become a provider of health services, so the responsibility for the patient has been assumed by an administrative entity. The doctor has become a salaried employee within a health services company. In this way, the doctor-patient relationship has become one more variable under the umbrella of the portfolio of services of an insurer or a health corporation. As a result, the laws of mercantilism have replaced the traditional norms of the medical encounter, that exclusive moment that until recently had dimensioned the medical vocation[5].

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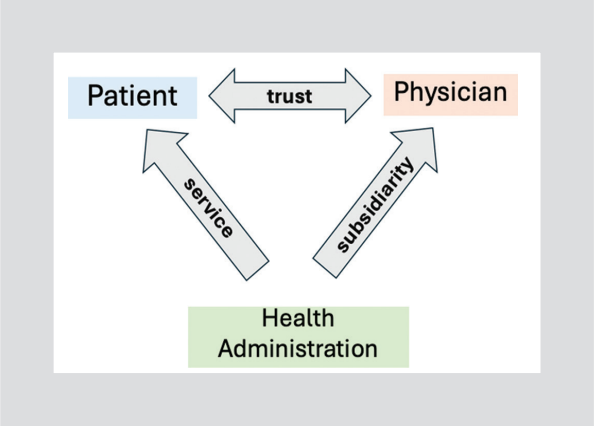

Figure 1. *Crossroad in medicine. Protagonists and interrelationships.*

In this new scenario, the medical act has come to be evaluated in terms of the degree of patient satisfaction, as in other commercial activities. The score given by patients with respect to nurse and physician's cordiality, delay in diagnostic tests, cleanliness, and comfort at the meeting place are considerations that distract from what is really important. The unique content of the encounter, in which the sick person puts his or her health (and his or her life) in the hands of the doctor is putting aside[6].

There is no doubt that this paradigm shift in professional practice contributes to the high rate of burnout among physicians. Six years of undergraduate study and as many years of residence training to be a specialist provide expertise and desire to assume responsibilities in the health of citizens. It is hard to adapt to do less than that. In the new health-care scenario, of a mercantile nature, there is a high risk that doctors feel alienated. For many professionals, it is like becoming just another link in a chain of health services and, ultimately, the health business.

Administrative intrusion impoverishes medicine

Totipotent health management has discovered that it can do without the doctor committed to the ultimate goal of patient care[7]. It is enough to attend the health request made by the citizen, the "client." This makes the doctor feel insignificant. In this scenario, the conversation with the patient and the personalization of the medical act are often replaced by greater medicalization: more diagnostic tests and more referrals to other colleagues, all full of anonymity.

In vertical medicine, public and private, clinicians attend orders and protocols that they often do not share. Medical disease guidelines dictate the way to care for and treat an anonymous and average patient[8]. The general has prevailed over the individual; illness to the sick patient. The doctor's commitment to search for the good of the sick person progressively fades[9].

The doctor is only expected to conform to the protocol. Moreover, the risk can occur precisely when he expresses his opinion, which in reality constitutes the art of medicine. Moreover, in this way, defensive medicine and litigation promote a profile of the doctor away from personal contact with the patient. Forcing diagnostic and/or treatment practices with administrative rules may violate the physician's conscience and break the necessary patient-doctor trust[10].

Health is somewhat richer than health care[11]. We like our profession; we endure it all. However, we are dragged down by a *"society of tiredness"* –as the South Korean philosopher Byung-Chul Han points out–[12] and we doctors are at risk of self-alienation. Our work no longer reward with the gratification that the healing of the sick entails. Moreover, frustration occurs because our work is suboptimal to fulfilling our preparation and expectations. In this way, we limit the purpose of our tasks to satisfy leisure, with trips and all kinds of extra-work plans.

Back to humanist medicine by subsidiarity

Sensitive to the transformation of medicine into cold technological attention, the administration has created units and counseling departments for humanizing medicine. What nonsense! More regulations and regulations for doctors. What we doctors need is more subsidiarity, to regain the initiative, to be able to have more time for our patients, and to personalize our care.

The recent law of the current Spanish government to supervise the codes of ethics of professional associations by the central administration (RD 435/2024) is another example of administrative intrusion. The Official College of Physicians of Madrid has already spoken out (*ICOMEM 2024*) on this abuse[13]. If we want good doctors and medicine of excellence, we must respect and support our good professionals, instead of ignoring them.

Recovering the profile of the doctor in the 21st century

One would expect medical education to be a source of inspiration for the profession. However, it has been

observed that the expectations of dedication to the patient that students expect to find in the Faculty of Medicine are frustrated when they carry out their clinical practices. They are then confronted with the pragmatism and lack of empathy of many disenchanted medical tutors, who quench the vocational thirst for the sick[14]. How far it is from "*The Country Doctor"* (Honoré Balzac, 1833), where the protagonist's commitment to his most vulnerable patients was extolled.

In this scenario, the emergence of at least two new variables in clinical medicine of the 21st century could transform the medical profession even more. The first concerns the growing participation of women in medicine, which is undoubtedly changing the profile of the profession. Overall, it is easy to recognize different ways of dealing with and doing things with patients.

A second variable is the rapid introduction of artificial intelligence (AI) in medicine. Data collection (i.e., electronic medical records) has been a great effort for many doctors, to the detriment of dedication to patients. Filling medical histories in the way that an administrative officer does has taken time and confidence away from the doctor-patient relationship. A computer screen has gotten in the way and not looking at each other patient and doctor while asking questions, has depersonalized the medical act itself. There is no doubt that digitalization has contributed to increase *burnout* among clinicians[15].

Experts are calling for a revulsive, second wave of AI in medicine, that will allow to recover the time dedicated to patients. Eric Topol has expressed it clearly and distinctly: AI is to help us in our work and never to subdue us[16]. AI should allow us to be more accurate in diagnoses and treatments while being more empathetic and compassionate with our patients[17]. Only in this way will technology allow doctors to spend more time with patients, which is their most genuine task[18].

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Conflicts of interest

None.

Ethical disclosures

Protection of human and animal subjects. The authors declare that no experiments were performed on humans or animals for this study.

Confidentiality of data. The authors declare that no patient data appear in this article. Furthermore, they have acknowledged and followed the recommendations as per the SAGER guidelines depending on the type and nature of the study.

Right to privacy and informed consent. The authors declare that no patient data appear in this article.

Use of artificial intelligence for generating text. The authors declare that they have not used any type of generative artificial intelligence for the writing of this manuscript, nor for the creation of images, graphics, tables, or their corresponding captions.

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