Drugs and Family Medicine: Form and Content

Jose Luis Turabian*

Specialist in Family and Community Medicine, Health Center Santa Maria de Benquerencia. Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain

*Correspondence should be addressed to Jose Luis Turabian; jturabianf@hotmail.com

Abstract

Choosing an individual medication for a particular patient is one of the most important clinical decisions in family medicine (FM). Prescription of drugs is currently the main tool of FM and that's the main source of prescription of drugs. The drugs are used by general practitioners (GPs) to manage a wide range of health problems that are addressed at this level of medical care have tangible results. But should the drug be the GP's main therapeutic resource? Drugs arrive to serve the purposes of the GP, but finally, the GP redefines its own goals according to the drugs. Prescription rates have increased and polypharmacy is very frequent, a new doctor-patient relationship has appeared: a "patient-drug relationship" where the GP is excluded, there is an increase in yatrogenesis because of high rate of adverse drug reactions and drug-drug-interactions, and the importance of the non-pharmacological aspects of the medication is completely forgotten. In the matter of drugs on FM it is necessary to take into account the opposition and relationship between "the content and the form." The "content" is not in the drugs; it is in conceptual foundations of FM and the GP must not forget the crucial elements on which his/her work is based: the use of a special clinical interview, continuity of care, knowledge of the context for the diagnosis and treatment, the wise use of drugs and technologies, and a permanent ability to critically reflect on the situation presented in the consultation.

Prescription of drugs is currently the main tool of family medicine (FM) and that's the main source of prescription of drugs. More than 75 percent of all visits to family physicians/general practitioners (GPs) result in the prescription of at least one medication [1]. The drugs are used by GPs to manage a wide range of health problems that are addressed at this level of medical care: bacterial infections, chronic diseases such as diabetes, hypertension, coronary heart disease, bronchial asthma, COPD, depression/anxiety, etc, as well as other daily needs such as contraception. On the other hand, innovative pharmacological therapies, such as new treatments for cancer, HIV/AIDS, vaccines or hepatitis C, also are directly or indirectly used by GPs. All of these drugs have tangible results: in some cases, they manage to eradicate a disease, and in others, to control it better, increase hope life or reduce the side effects of previous therapies.

But should the drug be the GP's main therapeutic resource? The ease and speed of incorporation and use of new drugs, the ease of maintaining and repeating legacy drug-prescribing patterns, and the resistance to abandonment of drugs of dubious efficacy by the GPs are striking [2,3].

Pharmacological advances have favored a mechanistic and medicalizing approach to health; with the advancement of biochemistry, success has been achieved in many medical interventions, as long as the problem is reduced to a biochemical phenomenon. An example of this "reductionist" approach is depression (it is a deficiency of serotonin) and we have a drug to act in the opposite direction (the selective serotonin reuptake inhibitor drugs).

In addition, prescription rates have increased, among other causes, due to the greater availability of effective medications, changes in patient expectations, and the

promotion of guidelines that increasingly recommend therapy with multiple medications to achieve intermediate results, such as blood pressure and glycemic control. These guidelines highlight that polypharmacy can be potentially problematic, but not that polypharmacy is always inappropriate [4]. Thus, in parallel, the rates of inadequate pharmacological prescription have increased. Many factors contribute to these decisions in FM, such as the failure of GPs to keep abreast of advances in pharmacology; over-promotion of medications, medical ignorance about costs; pressure from patients or relatives for a particular medication, the use of the prescription as a "termination strategy" of the consultation, etc. [4-7]. Furthermore, the drug is a relational object; drug incorporates social representations and symbols [8]. All of these factors can lead to a wide variety of prescription errors [7].

On the other hand, in the use of drugs the importance of the non-pharmacological aspects of the medication is completely forgotten, and which, however, acquire great importance: the therapeutic action is constituted by the sum of the pharmacological effect of the drug, the effect placebo and the environmental effect [9-11].

It must be borne in mind that the drugs arrive to serve the purposes of the GP, but finally, if there is no critical reflection on the drug, the GP redefines its own goals according to the drugs. In addition, we must not forget certain basic principles that lie before the pharmacological prescription: listen to and understand the patient as a person who asks for help and not as an isolated and decontextualized disease that can be treated as someone who changes a part of a machine [12]. Many of the drugs used in FM are symptoms that societal disconnects are increasing, and drug prescriptions can cause patients to be less human and more objects. In reality, the increase in pharmacological prescriptions in FM indicates that GPs are becoming "drug dealers" and ceasing to be doctors [13].

In this scenario of increased drug use, changes occur in many essential aspects of FM as it has been understood until now:

A New Doctor-patient Relationship

The probabilities of success in a treatment are directly proportional to the quality of the doctor-patient relationship. Thus, it is essential to know the pharmacology of the drugs used, but also the non-pharmacological aspects of these, such as non-specific adverse effects (nocebo), the placebo effect, non-compliance, cost, psychological meanings, ethical aspects, etc. In the use of drugs, the aspect related to pharmacology changes doctor-patient relationship: the effect that the doctor is the more important drug itself disappears [14,15]. The drug imposes a new doctor-patient relationship: the priority is for pharmacological chemical product (the drug), and the doctor-patient relationship becomes exclusively a pharmacological relationship: a "patient-drug relationship" where the GP is excluded [16-18].

An Increase in Yatrogenesis

There is an epidemic of diagnoses and treatments. The prevalence of the disease is growing rapidly in societies with high-tech medicine [19,20]. In this way, there is a "creation of new diseases", which result in giving pharmacological treatments for minor problems, the concern about future diseases in healthy populations is increased, and personal and social problems are converted into diagnosable health disorders and in need of drug treatment [21]. Multimorbidity, in a small but significant part, is created by the medical intervention itself [22]. So, polypharmacy appears. But polypharmacy does not depend exclusively on the multimorbidity; the main cause of polypharmacy (of excessive use of drugs) is the professional in itself. It is admitted that the prevalence general of polypharmacy is high, and could reach 20% (23-25). However, the presence of polypharmacy is an indicator of malpractice and poor quality of the FM: polypharmacy originates a series of facts that lead to medical malpractice, and this is a cumulative process [23,26].

One common consequence of polypharmacy is the high rate of adverse drug reactions (ADRs). Many ADRs are due to drug-drug-interactions (DDIs). The risk of a DDI in any particular patient increases with the number of co-existing diseases and the number of drugs prescribed. It should be noted that the frequency of ADRs is 6% when a patient takes two medications, 50% when he takes five and almost 100% when he takes eight or more medications [27,28]. ADRs complicate up to 20% of therapeutic drug courses [29].

In summary, choosing an individual medication for a particular patient is one of the most important clinical decisions in FM. Doctor's prescription decision is the result of the patient's contribution, commercial sources; professional colleagues, academic literature, lines of research, etc. [3,30-34].

In the matter of drugs on FM it is necessary to take into account the opposition and relationship between "the content and the form." Content is the main question, the essential, the conceptual basis, what underlies and survives more or less intact to external contingencies, that whose existence is presupposed but not seen. The form is the more or less contingent aspect, changing and adaptable to the circumstances that surround the fund; the ostensible manifestation of the form is by definition mutable. Thus, it is not only or mainly about attending to the "form": for example, the need for GPs training to make

precise decisions regarding new powerful and expensive drugs [7]. But it should also be borne in mind that drug training in general is oriented towards the description of its pharmacological characteristics without taking into account others that modify the doctor-patient encounter and may condition a change in attitude in the prescriptions of daily practice. Likewise, it is necessary to be aware that drug regimens are increasingly complex and potentially harmful [35], and GPs need to regularly review and optimize chronic medication [36] and clinical guidelines should also consider making recommendations on when to stop medications [35,37,38].

Real "content" of the matter of the drugs on FM is not in the drugs; it is in conceptual foundations of FM; it is that the GP must not forget the crucial elements on which his/her work is based: the use of a special clinical interview, continuity of care, knowledge of the context for the diagnosis and treatment, the wise use of drugs and technologies, and a permanent ability to critically reflect on the situation presented in the consultation [39].

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