

Danger on Family Medicine

Today we clearly see that the system and its supporters are attempting to replace the doctor – patient relationship, as typical in general practice where the prevalence is for emphatic values and personalization of care, with a doctor structure relationship, based on illusion that sharing clinical informations through informatic instruments could replace the peculiar and intimate patient - family doctor relationship.

Also, it is strongly worrying the attempt to hospitalize the family medicine, applying to this dimension the elements and procedures that are typical for hospital medicine and sectorial specialised medicine. We can see that many administrators do ignore the clinical practice in family medicine, where diagnosis is instrumentally finalised and centred on patient, not really at all to get a codification.

This mystification on family medicine's practice, explains the obstinate will to try to exchange the specialistic medicine's categories where the prevalence is for technical standardized and codified elements, instead of the existing elements of listening, narrative, waiting and deciding inside the patient's dimension context.

Also it is worrying the will to change and simplify the communication between doctors, key element for the therapeutic process, to a different system just codifying nosographic entities only for bureaucratic and control purposes, and really not to transfer necessary informations to define diagnostic doubts and find agreed therapies. It is well known how ICD codification in its various editions is inadequate when we work in the family medicine's dimension, where we treat “ problems”, symptoms without diagnosis, diseases at early stage confused and not definable where frequently time itself is a diagnostic help, time where we prescribe provisional or symptomatic treatments, or we try to exclude diagnostic possibilities also less probable, or we use to do something just to contain uncertainty.

One matter is to produce documents, as prescriptions, directly for the patients who are free to use them as they consider the best for them, another matter is to pass directly sensitive data on a third party, not related to the therapeutic – assistance relationship.

These are for control logicals, also clearly useless, because passed data are not at all suitable for the governance: so they are not passed on citizens' own interest, because, according to the necessity's principle, personal data have to be treated only when such a treatment would be absolutely necessary to the pursued aim.

Also, consensus on passing data is crucial because it cannot be considered valid a unique consensus: it has to be put in the context during the time, based on different changes in the patient's life and believes.

Last but not least we must consider how the political body and health authorities are paradoxically spurring the pro-consumistic aspects in the access to family medicine services.

Increasing the offer according to the future estimated mega-structured-organization, it will increase greatly the inappropriate demand in such a context where we all should be asked to reduce a lot of interventions that are useless or anyway not supported by valid evidence on the field, so to grant the supportability in an universalistic health system.

Evidences supporting interventions, are not at all automatically exchangeable, also if they would be coming from studies or from literature's reviews, because these just never refer to populations as we meet in the common daily clinic practice, but to selected groups, free from the co-morbidity's complexity and strongly motivated to agree with protocols.

If we read carefully and with detachment at several recent scientific papers, we can see that in the family medicine's setting, mainly when concerning big “ chronic – social “ pathologies, it is rare to find interventions with convincing evidences on relevant clinic end points and with adequate temporal horizons.

By trivializing the access to family medicine and by replacing doctor – patients relationship with a doctor – structure relationship, will surely and greatly increase the demand coming from the 20 per cent of patients just today consuming the 80 per cent of resources, worsening efficiency and equity and increasing bureaucracy so withdrawing resources from clinic and assistance.

Francesco Carelli

**International Ambassador Association Health Care Professionals
EURACT Director of Communications**

Published on Synapse Magazine, 2009; 4:14.

(Reproduced with permission as advised by author)