

EDITORIAL

From the *impatient* doctor to the *patient*-doctor

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Over the last century, we have witnessed the transformation of the *paternalistic* doctor-patient relational model – which had characterized the existence of medicine in its first two millennia of activity – into a *shared* model. A model, that is centred on the patient (*patient centred medicine*), and no longer on the disease (*disease centred medicine*) [1-4] – as Ludolf Krehl and Viktor von Weizsäcker had already argued at the beginning of the 20th century [5, 6]; a model based on the recognition, to the actors, of equal powers and responsibilities. The shared model, which inaugurates a form of new therapeutic alliance between doctor and patient, risks, however, to assume, within a health apparatus that moves in the triangulation economy/technology/politics [7], the appearance of a pact, of a contract, which hides a model of defensive medicine (*information* model). The practices of informed consent [8, 9], if on the one hand have represented a way to make the patient aware and responsible for therapeutic choices, on the other hand they channel the doctor-patient relationship through the tracks of the formal, legal and contractual relationship. An all-out information hides, in fact, an *autonomist* model [10], in which it is fundamental to inform, not to communicate. This transfer of communication procedures that are valid among strangers, to the intimate and trustworthy dimension [11], determines a passage not so much to good medicine, but to safe medicine. Distrust, however, reigns in it.

The increase in disputes, *malpractices* and attacks against doctors (according to the Federation of Associations of Doctors, 1420 only in 2017 in Italy) [12] is a sign of an epoch-making crisis: the end of a hierarchical, paternalistic relationship and the need for a new *hierarchy to be negotiated*. This reconsideration of roles and functions puts both the doctor and the patient in crisis, both of whom are now forced to reconsider their own and other people’s roles. The loss of an exclusive top position on the part of the doctor, and the need for a continuous (sometimes exhausting) coming to terms with the patient, can induce the doctor to retreat in the name of scientific knowledge and of objective knowledge. This attempt to recover the summit, bypassing the relational need of the therapeutic alliance, feeds the figure of an “impatient doctor”, not very inclined to negotiate. On the other hand, the sick person appears to

be increasingly freed from a privileged relationship; in particular, the growing specialization and technologization of medicine, the affirmation of a business model of care, a nomadism which makes the patient itinerant, in search of the best services where they are offered, the interference of the *mass media* (which heavily affects the communication between doctor and patient) [13], interrupt the bond of trust. The “patient-doctor”, who knows, who undermines the authority of the doctor and of medicine, who proposes the various therapeutic options, in fact overturns the traditional paternalistic model into an extreme autonomous model.

However, this overturning seems to duplicate rather than undo the error of perspective of paternalism; it is rebutted to subject with subject, to preeminence with preeminence, to hegemony with hegemony. With the difference that, in an age of “moral foreigners” [14] the primacy seems to belong to the freedom (of the patient), rather than to the truth.

This difficulty in re-establishing a new balance between the protagonists has its philosophical roots in modernity and in the subject/object separation it entails. Both these options (impatient doctor and patient-doctor), in fact, are based on a hard, drastic reading of modern subjectivity. The Evidence-Based Medicine revolution has as its premise the Cartesian dualism between *res extensa* and *res cogitans*, the experimental method, specialization, a certain form of reductionism, the distance from one’s own research object, which in medicine becomes “therapeutic distance”. This brings with it, in addition to immeasurable benefits, the risk of a “removal of the patient” [15, 16].

This is even more evident with the advent of technology, that is, with the affirmation of the indissoluble union between science and technology. As Hans Jonas clearly pointed out in his *Technique, Medicine and Ethics*, the exponential development of technology over the last century has brought about a qualitative leap: once something becomes technically possible, feasible, it is inevitable that it will be done [17]. Action, in other words, is no longer dictated by the object in front of us, but by action itself as “feasible”. However, to the doctor «the purpose is given by the internal purpose of its object, the “raw material” is already the last and the whole, that is the patient, and the doctor must identify himself

with the purpose proper to the latter» [18]. This submission of the object (the patient) to the technician (the doctor) has considerable repercussions on the medicine: the patient and the anthropological dimension of the relationship and of the care are lost, or completely overshadowed. This, however, means forgetting the deeply dialogical dimension of medicine [19]. In fact, it is born keeping together the need for healing with the need for care, the need for a therapeutic distance with that of a humanitarian *ethos* [20, 21]. The *seduction of the technique*, instead, has traced a deep furrow, whose effects are tangible in the changed relationship between doctor and patient. On the one hand, there is the need to recover a relationship of trust with the patient, of esteem, which, however, is mainly established by virtue of taking care, of taking charge of the sick man, even and in particular in chronic diseases, in unfortunate events; on the other hand, the union between science and technology

feeds the opposite tendency, to remove from the priority tasks of the doctor precisely these functions [22]. Usually delegated to third parties.

This short circuit risks stiffening the doctor/patient relationship in a relationship between self-sufficient subjects, who claim their rights (to know and to decide). On the contrary, medical anthropology, medical humanities, narrative medicine, each from its own specific perspective, move precisely in the attempt to recover the *dialogical* dimension of medicine. This does not mean limiting the rights of the doctor by claiming those of the patient (which is closer to the war of position, to the “role play”), but promoting a *circular hierarchy*, in which the recovery of a «logic of care» by the doctor plays an essential part. A medicine that cures, that does not renounce to being medical art [23], does not put aside the clothes of science, but guarantees, even in an age of hyper-subjects, an open confrontation between doctor and patient.

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