Changing Doctor-Patient Interaction from Paternalistic to Consumer-Driven

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ABSTRACT

The trend in healthcare is personalized medicine, which includes personalization, prediction, prevention, and participation. Doctor-patient relationships are crucial for personalized medicine. This article analyzes research on the topic. The doctor-patient system is changing due to shifts in medical practice and social reality, particularly driven by information technologies. This has led to a move away from the traditional paternalistic approach towards a more consumerist model. This trend is mixed - while personal responsibility for health may increase, consumerism in medicine also rises. The future of personalized medicine requires both expanding medical knowledge and educating individuals responsible for health.

Keywords: social reality, prediction, prevention, participation, personalized medicine, consumerism, molecular, health risks

At present, the notion of personalized medicine represents a predominant trend in the advancement of national healthcare. As expounded upon in the accompanying material to the «National Technology Initiative» personalized medicine entails the utilization of a novel modality in the prevention and treatment of ailments founded on data that has been objectively derived from biomarkers. The distinctive feature of the novel approach lies in the identification of an individual's susceptibility to developing illnesses through the identification of molecular genetic markers, and subsequently, the utilization of suitable cellular products for remediation and mitigation of the underlying ailments.

As per the esteemed scholar, M.A. Palsev, who is a member of the Russian Academy of Sciences, the latest methodology incorporates the element of personalization. This refers to the concept of tailoring the approach to suit an individual's specific needs and requirements. The utilization of an individualized approach in conjunction with the practice of prediction. This suggests that... The formulation of a prognostic framework utilizing probabilistic methods aimed at forecasting health outcomes, and the implementation of preventive measures to avert potential health risks, can be regarded as key components of an effective healthcare system. The prevention of disease occurrence and participation, denoting active involvement of the patients throughout the entire process, have been identified as crucial elements in the healthcare landscape [1.48]. The doctor-patient relationship holds significant importance for the effective functioning of personalized medicine as a priority model of modern healthcare, despite the scientific component being equally vital.

The subject matter at hand has been previously explored within the realm of sociology. The concept of medicine as a social institution with the doctor and patient as central actors in social interactions were initially addressed in the field of sociology. Notably, T. Parsons, an American sociologist,

presented such perspectives in his published work titled «The Social System.» In this context, the relations were viewed through the concept of «the role of the patient,» as documented in the literature [2]. The crux of the matter lies in the premise that a patient, incapacitated due to illness, is granted exemption from certain social obligations on the condition that they undertake a proactive role in their recuperation. The medical practitioner assumes the role of a social control agent and a professional community representative by conferring formal recognition of an individual's new transient status and expediting their rehabilitation to a complete social existence. Nonetheless, the conceptualization of the doctor-patient relationship introduced by T. Parsons during the mid-twentieth century remains an inherently theoretical construct that inadequately represents the practical realities within medical settings.

In the year 1956, T. Sasa and M. Hollender, American specialists, published an article titled «Contribution to the Philosophy of Medicine: Basic Models of the Relationship between Doctor and Patient» in an academic context. The inquiry surrounding the intricate structure of interactions between individuals representing the medical sphere and broader society is, for the first time, being broached [3]. The authors assert that the essence of their work ought not to be confined solely to its utilitarian significance. To obtain meaningful outcomes, it is imperative to thoroughly consider the unique characteristics and idiosyncrasies of all parties involved. The given text is already written in a fairly academic tone, but here is one possible way to revise it: The preceding passage exhibits an academic style, but several potential opportunities for clarification and precision exist. Accordingly, the subsequent rendition endeavors to refine the prose in adherence to customary conventions of scholarly writing. Revised text: The preceding excerpt evinces a scholarly tone, though certain areas for greater elucidation and exactitude may be identified. Consequently, the following iteration strives to enhance the language by customary norms of academic discourse. T. Sas and M. Hollender posited that the dynamic between a doctor and a patient varies depending on the type and nature of the illness. To illustrate such variances, the authors put forward three distinct models: an active-passive model, guided cooperation, and partnership or mutual participation. Academic Revision: The passage in question, 586, needs academic rephrasing. The initial model can be characterized as paternalistic, as posited by the authors. In this paradigm, the dynamics of the doctor-patient interaction can be likened to that of a caregiver and an infant, where the patient looks to the physician for guidance and assumes complete reliance on the latter for their well-being and sustenance. Thus, it is evident that the doctor holds a prominent position while the patient's involvement in the healthcare decision-making process is largely limited to passive adherence to medical directives. This highlights the subordinate nature of the patient's role within the healthcare system. Researchers regard this form of association as conventional in the historical context of medical progress. Currently, the prevailing practice within the field of emergency medicine is to adopt this approach [4]. According to the taxonomy proposed by T. Sasa and M. Hollender, the second model posits patient involvement in healthcare decision-making. However, the physician's role in this modality of interaction is still largely predominant. The discrepant factor pertains to the patient's cognizant concurrence with the authoritative viewpoint of the medical agent. Within this context, he assumes the role of an engaged participant, as he deliberately seeks medical assistance and autonomously relinquishes accountability for his well-being to the physician. The third model postulates an equitable partnership-oriented relationship, where both entities hold equal status and responsibility. Simultaneously, the involved parties must demonstrate a vested interest in the attainment of the primary objective of these interactions, namely the restoration of the patient's health and reinstatement into customary societal routines.

According to the authors T. Sas and M. Hollender, it can be observed that every model possesses inherent advantages and

disadvantages. Paternalism is deemed a favorable mode of interaction within the realm of medical practice. Simultaneously, the aforementioned type of relationship confers substantial ethical responsibilities upon the physician. This is due to the presumption that he or she will fulfill professional duties with utmost consideration for the patient's well-being, regardless of any personal biases or idiosyncrasies. Furthermore, a physician should prioritize the welfare of their patient when rendering medical aid, refraining from exploiting their position for personal gain. The empirical data analysis has led scientists to conclude that the restricted usage of such a model in medicinal applications often presents a conundrum wherein conflicts of interest stem from the subjective motives of all participants involved in such interactions. When assessing the third model, T. Sas, and M. Hollender emphasize that partnerships in medical practice are not commonplace. They argue that this form of interaction entails a significant degree of mutual empathy, often predicated on interpersonal friendships, which may prove difficult to envision within the contemporary landscape of healthcare organization and delivery. The numerical value of the given quantity is five hundred and eighty-eight.

The interpretative model presents notable divergences from the aforementioned frameworks, while simultaneously sharing some similarities with them. The responsibility of the physician entails the provision of comprehensive information regarding the patient's medical status, treatment modalities, and potential hazards. The crucial distinction associated with this particular approach lies in the recognition of the significance of the patient's subjective value orientations, in seeking to facilitate decision-making processes. This involves ensuring that patients are empowered to make independent choices, rather than being unduly influenced by professional authority. Indeed, irrespective of their area of specialization, a physician who operates within the confines of this paradigm functions as a psychotherapist, aiding the patient in comprehending their ailment, as well as adjusting to the treatment and potential ramifications thereof. According to the proponents of the concept, the realization of patient autonomy within the characterized model is predicated on the patient's self-awareness. Specifically, patients gain a clearer understanding of their identity and how different medical interventions may impact their psychosocial constitution.

The fourth model, which is advisory, exhibits proximity with the aforementioned approach. The responsibility of the physician involves providing complete and comprehensive information to the patient, thereby aiding in the process of making informed decisions. Notwithstanding, it denotes a more profound influence on the patient's value system, as the healthcare provider not only assists the patient in comprehending their condition and selecting the safest modality of treatment but also in altering their subjective perspective on health by engendering an awareness of its significance in the patient's existence.

The selection of an appropriate model is contingent upon the unique circumstances of a given scenario, as indicated by expert researchers. In the realm of medical practice, the consulting model is deemed to be more fitting. Additionally, the protection of patients' autonomy rights is imperative for the advancement of public health systems. In pragmatic applications, the manifestation of the aforementioned concept occurs using utilizing the mechanism of informed voluntary consent. The roots of this concept can be traced to the Nuremberg Code of 1947, which stipulated that any medical procedure must exclusively be performed with the explicit permission of the individual in question [5]. Consequently, this provision has been incorporated into several international treaties and conventions, along with domestic statutes regarding matters about healthcare.

The notion of informed consent encompasses two pivotal elements: the dispensation of pertinent information and the attainment of consent. The criteria of thoroughness and comprehensibility play crucial roles in apprehending the information provided by the physician regarding the

patient's medical state and the recommended course of treatment, as well as acknowledging the patient's autonomy in the decision-making process concerning planned medical interventions. Simultaneously, the implementation of the informed consent principle, which lies at the core of the contemporary healthcare paradigm, denotes not only the legal confirmation of patient rights autonomy. The fundamental components of the informed consent method encompass three key dimensions, namely the lawful, moral, and managerial aspects. From a legal standpoint, the act of obtaining informed consent serves as a means for patients to exercise their right to make decisions regarding their chosen treatment modalities. The administration's goal is evident in the process of legitimizing the treatment protocol through legal means. The ethical principle holds paramount significance in healthcare as it underscores the essential requirement of obtaining the informed and voluntary consent of the patient who is sufficiently apprised of the treatment plan and its potential ramifications. In contemporary medicine, the discernible shift away from the paternalistic doctor-patient social interaction model is readily apparent. The current shift can be ascribed to the modification of medical practices and the progression of the health biomedical model, alongside the transformation of society in its entirety. This phenomenon is recognized as one of the defining attributes of contemporary society, as articulated by sociologists D. Bell, M. Castels, and E. Toffler, who emphasize the pervasive role of knowledge transformation in all aspects of social life [6]. According to G. Behmann's analysis of contemporary social theorists, it can be deduced that in the case of industrial societies, the approach towards. The distinguishing attributes of the subject under examination are such that they exhibit notable traits which set them apart from other entities in their domain. In post-industrial societies, the generation and management of information and knowledge have emerged as crucial aspects, supplanting machine production and private property, as posited by scholarly arguments. As the foremost agents of advancement, they not only dictate the present trajectory of development but also exert substantial influence on governmental bodies, resulting in their metamorphosis. Consequently, novel structural configurations and models of social exchanges emerge, and their evolution is contingent upon their efficacy and utility for both the social institution and broader society.

The advent of communication technologies marked a seminal shift in the field of medicine. In particular, the dissemination of medical knowledge underwent a transformative change, as it moved away from being considered secret information that granted doctors an aura of mysticism and miraculous power, towards becoming widely accessible information that was readily available on popular websites and television programs dedicated to health and disease. The distribution of roles and statuses between the doctor and the patient has transformed, with the doctor moving away from a dominant position as a «patron» towards assuming a role as an advisor and informant. On the other hand, the patient has transitioned from a passive participant to a more active one, adopting the position of a «customer and consumer of medical services.» Consequently, a discernible shift towards a patient behavior model grounded on consumerist beliefs occurs when health evolves from being a fundamental societal tenet to a commercialized product, subject to consumption. This phenomenon exhibits ambivalence in its effects, with one aspect resulting in an increased emphasis on individual health responsibility, while the other promotes commercialization through a heightened consumerist culture within the medical industry. This is compounded by the inherent relationship between consumption and price escalation, thereby amplifying the linkage between consumption and product demand. This scenario results in an elevated level of inequity in the domain of health, in conjunction with the permissiveness of customers' extravagant preferences. The future of personalized medicine necessitates a concerted focus on augmenting the current bounds of medical knowledge whilst also

inculcating in each individual a sense of responsibility towards their health.

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