# The denaturation of the medical consultation

## La desnaturalización de la consulta médica

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*Denaturalize:(RoyalSpanishAcademy*-RAE*)*
- *To altert he properties or conditions of something, denature something.*
-

*Consultation:(RoyalSpanishAcademy*-RAE*)*
- *Eitherwrittenororallypointofvieworopinionrequiredora-pproachedregarding something.*
- *Doctor'sactionofassistinghispatientsforadeterminedperio-doftime.*

The Argentine health system is made up of 352 private health insurance companies and 674 prepaid medical care entities; each one having a proper methodology of assistance to its affiliates, as well as an economic cost for the medical consultation.

As the document from the National Institute against the Discrimination, Xenophobia and Racism "***Towards a National Plan against Discrimination***", of the chapter devoted to the Heath, mentions in one of its paragraphs:

> "*In our country the Medical Assistance is structured in three subsectors: Public,Social Security and Private which, although they interact among each other in the microsystem, they create three independent systems that respond to proper logics in which they intervene, in diverse measure, eitherthe State orthe market. This provokes heterogeneity and fragmentation, with an unequal allocation of resources and strong differences at sectorial and territorial level, which in practice they imply an important social benefit lack for big sectors ofthe population. In this sense, forthe case of access to the health of poorpeople, we have reached a situation of absolute inequality: the poorest homes spend more on health regarding the relative income percentage than richer people1.*

The medical consultation is based on the dialogue between the patient and a trained medical professional. The patient's participation must be stimulated and each comment, indication or study requested must be justified, as the indication is not an order but a qualified recommendation. Besides, it is institutionally ruled and in almost every occasion it is able to be legally suited[2].

Just as an example: A patient who is discharged from a medical institution after an acute cardiovascular event with inter-consultations orders for the evolution evaluation and supplementary studies, as well as a minimum quantity of five specific medicines for his/her cardiovascular disease and approximately four for its concurrent pathologies. This is reflected on the report of the Argentinean Group for the Rational Usage of Medicines, where it is mentioned that in the health care providers for pensioners, half of its affiliated is poly-medicated and this conditions the adherence to the treatment, observing that the 70% fulfills the non-adherence criteria; apart from the economic impact for the patient, for more than the 20% of its pension is allocated to that purpose[3,4].

When this patient comes to the consultation office, the clinical history must be read in order to know his/her disease and the doctor must ask the patient questions about his/her symptoms and make a physical examination (blood pressure, cardiac frequency, cardiac and pulmonary auscultation, etc.). The doctor must explain what has been detected, how the evolution will be, the basics of secondary prevention are (diet, salt, physical exercise, giving up tobacco, etc.). In the same report of the Argentinean Group for the Rational Usage of Medicines the important patients' ignorance on the risk factors is outlined[3,4]. The doctor must register everything on the clinical history (legal requirement) and make orders of required studies and medicine prescriptions, remembering that each credential has as minimum 10 numbers, name, surname, health care provider, medicines (three per prescription and some health care providers only accept only 2 by prescription), signature and datewith the clarifying seal.

For the patients' assistance, the schedule of the working days must be organized. Is the parameter which must fix it the consultation duration time or the consultation economic cost?

We must take into account that the times of the consultation must suit the goals of each level of assistance. There is abundant bibliography about the average time devoted to a consultation. Just as an example, the consultation of primary assistance can take among 3 and 5 minutes long, whereas the consultations with specialists should last much more, between 30 and 40 minutes. On the **Figure 1** the average times of some countries are shown[6,8].

The times of the patients, of doctors and of the health ins-

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titutions require to be revised with the purpose of humanizing these processes oriented to dignify the professionals' work and the patients' assistance.
Besides, the time devoted to the medical consultation acts as an economic filter of expense contention: if the medical consultation is carried out accurately, it is supposed that there are efficiency profits with early diagnosis and due deviations to other assistance levels and reduction of supplementary studies.
What calls the attention in these studies is that 20% of the consultation time is dedicated to solve bureaucratic problems, the time devoted to the explanations of pain and treatment is two minutes long and the one devoted to the problem exposition takes 18.3 seconds. This shows the brief communication time, which suggests the need of enlarging the time of having an active dialogue[7].
The World Health Organization, an Agency of the United Nations, mentionsona report about the quality of assistance that:

*"The Goals of Sustainable Development underline that the quality is a keyelement of the universal health coverage. [...] Every year between 5.7 and 8.4 millions of deaths are attributed to the deficient quality assistance in countries whose people get low and medium income, which represents up to 15% of the countries in those countries. [...] It has been estimated that the high quality health systems could avoid 2.5 millions of deaths due to cardiovascular diseases, 900,000 deaths due to tuberculosis, 1 million of just born deaths and half of the mother deaths every year"*[8].

There is a trend that the patient's consultations with morbidity and mortality determinants last longer than those patients without suffering that condition. It is important to treat not only ill people, but also those who are exposed to multiple risky factors.
The consultation must have the accurate duration in order to allow doctors and the interested parties to have a precise time and related cost quantification[9].
As a publication of the Argentinean Medical Association concludes:

*"Although the doctor goes on having a social function, it is necessary to have in mind that the doctor's image has been deteriorated and devalued.*
*The doctor has lost the capacity to decide on the handling of the patients.*
*It is essential to accept quite simply that the medicine is no longer a liberal profession.*
*In the 98% of his/her activity the doctor depends on third parties who pay them, State, private health insurance, mutual associations, prepaid medical care and others, from whom he/she receives several professional compensations, not fees.*
*The medical trade union is at the mercy of the "market forces", of the "offer and demand", including from the State through the Institutions of Social Security.*
*The administered medicine abandoned the social solidarity spirit which generated it to start being integral part of the "health commercial-industrial complex"*[10].

A survey carried out in Mexico to patients of external consultation offices of several public and private assistance centers showed that "for the users of the social security, the main elements that define the bad quality of assistance are the long waiting times, the short times devoted to the consultation and the deficiency in the examination and diagnosis actions. And in Japan the patients use a phrase that describe, ironic but, dramatically, the conditions of medical assistance in that country: Japanese people say "you wait for three hours to be assisted in 3 minutes"[11].

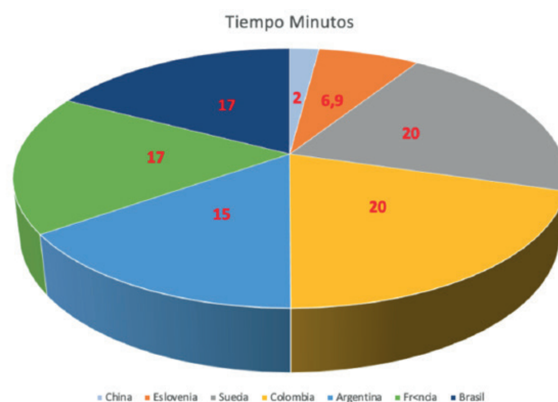


***Figure 1.*** *Average duration of medical consultations in some countries.*

The other point of view in the evaluation of results is what has been revealed in a survey carried out by the Argentine Society of Cardiology, where it was shown the growing doctors' frustration due to the disassociation that exists betweenthe tries to offer an ideal assistance and the restrictions that the system of medical assistance imposes which "*demanded to make the consultation in 10-15 minutes*" for a specialty with great prevalence alterations in the population, where the clinical control and the preventive indications are of vital importance and they take important time"[12].
As it is published on the report written by María Agustina Paternó Manavella "***State, attentionand preventive habits on health, heterogeneities and vulnerabilities in the human development 2010-2021"***, of the Observatory of the Argentine Social Debt from the Universidad Católica Argentina[13], the deficit of the medical consultation in people having healthy problems, in the population being 18 years old or more, was more marked during the last years; the first reason was the pandemic, but once it was over historical parameters have not been achieved.
As it could be advised in this brief, the medical consultation should be revalued, changing the parameters which currently fix the consultation duration, focusing on the patient andhis/her problem and the devoted time should depend on that. Besides, the medical consultation must fulfill with the requirement of setting a relationship based on reliability, knowing the patient, making a diagnosis, confirming it and instructing the patient on how to reduce the effect of risky factors, giving medicine or proposing therapies whose risks and benefits should be explained if they are not invasive. In order to do so, I propose:
• To unify the requisites in the studies requests, made by the Ministry of Health, through a pre-printed universal single form under the charge ofhealth care providers or prepaid health coverage with the name and number of the affilia-

ted person, writing the study requested and its foundations only.

• To unify the prescriptions through the Ministry of Health, preprinted by the health entity. A universal single prescription book let owned by each affiliated person where his/her name and affiliated number appear, which will reduce the time spent on making prescriptions being able to state everything requested on only one prescription.

And as it is publicly known due to the big quantity of articles written by the press lately, to fix a decent fee for the medical consultation that may be updated periodically and that it must be taken as a base of the medical fees of the different practices, as the doctor was some time ago.

## REFERENCES

1. *Maceira et al., Reporte del Banco Mundial AR26-144 de 2003.*
2. *Musso CG, Enz P. Comunicaciones médico-paciente: la matriz del acto médico. Rev. Hosp.Ital. B Aires Vol 26 Nº2, agosto 2006.*
3. *Mazzola R, Sandler E. Valoración de la adherencia al tratamiento farmacológico de los adultos mayores en la ciudad de Rosario. Santa Fe. Argentina. Facultad de Ciencias Medicas, Universidad Nacional de Rosario. e-mail: rosinamazzola@hotmail.com*
4. *XXVII Reunión de GAPURMed. GAPURJóvenes, Grupo Argentino para el Uso Racional de los Medicamentos: Innovación vs Novedades, 25, 26 y 27 de octubre: La Plata. - 1a ed. adaptada. - La Plata: Comisión de Investigaciones Científicas de la Provincia de Buenos Aires, 2019.*
5. *Gimena Buffo MD. Polimedicación y su impacto económico en los adultos mayores de la ciudad de Bella Vista, Tucumán. Cátedra de Farmacología. Facultad de Medicina. Universidad Nacional de Tucumán. XXVIII Reunión Nacional de GAPURMed.: situación actual de los medicamentos: entre el conocimiento científico y las políticas sanitarias / María Teresa Rocha; María Eugenia Horna ; Mirta Liliana Mierez; compilado por María Teresa Rocha. 1ª ed . San Luis: Nueva Editorial Universitaria - UNSL, 2020. Libro digital, iBook.*
6. *Rodríguez Torres A, Jarillo Soto EC, Casas Patiño D. Medical consultation, time and duration. Medwave 2018;18(5):e7264*
7. *Seguí MLP. Tiempos durante la visita médica en atención primaria. Aten Primaria. 2004;33(9):496-502.*
8. *Organización Mundial de la Salud. Servicios sanitarios de calidad. Informe 11 de agosto de 2020.*
9. *Tadeu ACR, e Silva Caetano IRC, de Figueiredo IJ, Santiago LM. Multimorbidity and consultation time: a systematic review. BMC Family Practice (2020) 21:152.*
10. *Hurtado Hoyo E, Galmés M, Iraola N, Dolcini HA, Yansenson J, Gutiérrez Zaldivar H. Remuneraciones profesionales médicas. Revista de la Asociación Médica Argentina, Vol. 122, Número 2 de 2009.*
11. *Outomuro D, Actis AM. Estimación del tiempo de consulta ambulatoria en clínica médica. Rev Med Chile 2013;141:361-6.*
12. *Doval HC. Malestar en la medicina. Insatisfacción y descontento en los médicos. Rev Arg Cardiol 2007;75(4):336-9.*
13. *Privaciones Estructurales en el Desarrollo Humano Argentina Urbana 2010-2020, bajo el escenario Covid-19. Desigualdades en recursos psicosociales, condiciones Sanitarias y representaciones ciudadanas frente al contexto de pandemia. Documento Estadístico 03/2021.Observatorio de la deuda social Argentina. Pontificia Universidad Católica Argentina.*