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The Generation of Nameless Doctors and the End of the Doctor-Patient Relationship

How institutional mass production turns the physician into a product without identity

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ABSTRACT

The author examines how contemporary medicine, in both its socialized and its capitalized forms, tends to anonymize the physician, draining the value from the doctor-patient relationship. He argues that the entry of unvalidated professionals under a discourse of equal service, together with the building of strong institutional brands, reduces the physician to an interchangeable part, judged by rigid protocols, targets, and app ratings. The text holds that patients no longer seek a particular physician but a health service, converting the doctor-patient relationship into a hospital-patient or intermediary-patient relationship, even in the midst of the social media era. It criticizes physicians' own passivity, as they accept abusive clauses and give thanks for opportunities without realizing they will be replaced. It closes by calling on the profession to examine its mistakes critically and to actively plan the future it desires.

KEYWORDS: *doctor-patient relationship; socialized medicine; protocols; mass production; physician autonomy; healthcare institutions*

For different reasons, both socialized and capitalized medicine seek to anonymize the provider of medicine's most noble part: the doctor-patient encounter. We have recently seen the entry of unvalidated physicians to make up for the country's scarce and poorly distributed services, in a socialized strategy in which medicine is (theoretically) the same regardless of who practices it and of the infrastructure available. This view is notoriously distorted, yet it has found its adherents, whether for electoral motives or for personal, un-republican benefit. But even under capitalism, where the demand for institutional monopoly likewise requires the mass production of medicine, anonymizing the provider and building a strong institutional brand causes the physician to gradually lose his name. His craft ceases to matter, giving way to the acceptance of and adherence to institutional protocols and contracts with insurers. It no longer matters whether the physician on the front line is an excellent doctor, but rather whether he faithfully follows the fixed and immutable protocols of this science of transient truths turned into dogmas for teaching purposes and, I would add, for commercial ones. And when the physician refuses to assume his full position as an autonomous professional, he becomes a piece in a larger puzzle, manipulated by larger interests.

The previous generation of physicians still in practice watches this transition open-mouthed, as smartphone apps or strong-name institutions recommend their best "product" for a given problem, and that product is now a nameless physician under a brand. Momentarily, this physician feels his importance in the system as he is referred to and recognized by his patient, but just as the patient did not find him by name, in the slightest variation of the "product" delivered he will realize that the patient is not his, for the patient will be redirected to another

problem-solving "product." And that product is chosen on the basis of "little stars" in an app or some target metric measured to the millimeter by the system in which it is embedded. Let us be honest: the resolution rate is just one measured variable; financial return to the institution is another. Between the two, which matters most to the intermediary?

The traditional doctor-patient relationship is becoming a hospital-patient relationship (or any other intermediary-patient relationship, an app-patient relationship, for example): patients no longer seek a particular physician, but a particular health service. And the most remarkable thing is that this is happening right in the middle of the social media revolution, which theoretically puts people in contact... with other people... or does it? And worst of all, physicians are not merely letting this happen; by failing to consider what lies hidden in the proposals they receive, they end up thanking others for the opportunity, without realizing that they will be summarily replaced by the next one who hits the metrics that happen to be of interest at the moment.

With the curtailing of medical communication, which occurs in various ways, from severe restrictions imposed on physicians to lax ones on the services of non-physicians, many refrain from any public presence for fear of outside judgment, though others, admittedly, take advantage. They isolate themselves from the problem by placing themselves contractually under abusive clauses (written or not). They accept the situation, thank others for the opportunity, but complain about the circumstances.

Accepting this *status quo* will inexorably lead to the end of the doctor-patient relationship and of the art of medicine, and to the massification and transformation of medical service into an encapsulated, readily saleable product. The maxims "clinical judgment is sovereign" and "each patient is a patient" grow weak in the face of mass-produced protocols and the financial power of institutions.

It is long past time for us, physicians, to look critically at our past and understand where we went wrong. And to plan the future we want, not the one imposed on us.