Family Medicine and Care

Review Article

ISSN: 2516-824X

Doctor-patient relationship in the de-prescription of pharmacological treatment

Jose Luis Turabian*

Specialist in Family and Community Medicine, Health Center Santa Maria de Benquerencia. Regional Health Service of Castilla la Mancha [SESCAM], Toledo, Spain

Abstract

Patients and doctors may be uncomfortable in the relationship that includes de-prescription: the patient may refuse withdrawal of the drug, which is lived as taking away something of his, to which he is entitled, and needs, signifying an "affection deprivation" and can produce a nocebo effect. Doctors also tend to be uncomfortable discussing de-prescribing with patients. He may feel that the problem has been created externally, but he is asked to intervene to "contain costs", on the other hand he fears that patients may interpret de-prescription as a sign that they have to give up their medical care. In this way, the general practitioner can accept polypharmacy to preserve the relationship, or perform a motivational Interviewing to help de-prescribe, or maintain his assertiveness and de-prescribe. Further, the style and content of the conversations can be different depending on the drug to de-prescribing. In any case, there are changes in the doctor-patient relationship, which is focused more on the drug than on other aspects more significant of the medical intervention. There is a lack of evidence on the appropriate model of relationship for de-prescription, but the phenomenon of polypharmacy is substantially due to mis-communication in the doctor patient interaction. Consequently, the doctor-patient relationship in the de-prescription should reverse the type of relationship where the doctor becomes absent, and only the drug -"the doctor as drug dealer" - is important, and return to the classic relationship in which "doctor is himself a drug."

Introduction

Although medicalization has multiple dimensions [discourses, practices and identities], and multiple levels of analysis at which it occurs [macro, meso and micro], and medicalization and demedicalization occur simultaneously [1], in this article we will focus on general medicine level. Overdiagnosis and overtreatment are close to the hearts of GPs [2].

Everyday problems become diseases, inappropriate screenings are made, etc. [3], and finally, patients receive too much health care [4]. Overdiagnosis leads to multimorbidity and polypharmacy, and finally to iatrogenic adverse reactions to drugs, drug interactions, and hospital readmissions [5].

The consumption of medications (for example, psychiatric drugs, etc.) increases even though the pathologies [for example, the mental illnesses, etc.] seem to remain stable or with only a slight increase, despite the mulmorbilidad, which does not justify the increase of the use of drugs [6]. Non evidence-based prescribing (for example, of antipsychotics, etc.) is common, with high doses use, and polypharmacy the norm [7]. All this leads to recommendations to avoid unnecessary interventions to patients [8] or "Do not do" [9], and to de-prescribe.

Deprescribing is an active review process that prompts the physician to consider which drugs have lost their benefit in the risk-benefit trade-off, especially in patients with changing goals of care or limited life expectancy [10,11]. Deprescribing has been studied from the point of view of the tools to be used, or technical guidelines, or from the general population [12-14], but rarely in its dynamic interaction with the doctor-patient relationship in the general medicine practice, place where most drugs are prescribed.

On the other hand, doctor-patient relationship is keystone of care. Doctor-patient relationship is the connection or link established between two entities, doctor and patient (and their family and caregivers) that creates a specific context through the communications established with patients as a result of implementing a series of strategies professional-patient relationship, to make medical services are acceptable, relevant and accessible. So, this "creation of context" can achieve an interaction between doctor and patient that allow integrating the human and technical, the communication and clinical reasoning. The doctor-patient relationship or communication connects the biomedical and psychosocial aspects of clinical care. This is essential to achieve the final objective: it is about achieving "good decisions", which reduce or manage the uncertainty of the impact [15-17].

However, the doctor-patient relationship is a complex, multiple and heterogeneous concept, which is describing by means of several models or ways of understanding, classifying and practicing this doctor-patient relationship: according to a hierarchy of dimensions from less to more complexity of the relationship of continuity physician-patient, according to the ages of the patient, according to the degree of interpersonal relationship, according to the control exercised by the physician or the patient, and according to the psychosocial aspects of diseases, among others. Furthermore, the active ingredients of the models are not known exactly, each of which could be appropriate or not in certain contexts [18-22], and consequently, all of the above implies great difficulties in the measurement instruments of this

Correspondence to: Turabian JL Health Center Santa Maria de Benquerencia Toledo, Spain, E-mail: jturabianf@hotmail.com

Key words: *family physician, family practice, communication, physician-patient relations, physician's role, decision-making, deprescribing, potentially inappropriate medication, nocebo, placebo, specific and non-specific treatment effects, treatment context*

Received: March 24, 2019; **Accepted:** May 22, 2019; **Published:** May 25, 2019

doctor-patient relationship, so we could even ask ourselves if we can really call "models" of doctor-patient relationship to these scenarios when we can not measure their performance [23].

In this situation, how deprescribing? Or expressing it from the beginning of the process: how to review the medication in patients with polypharmacy [24,25] and be aware of the effects of the doctor-patient relationship in de-prescription (in the two directions that are fed back: from the doctor-patient relationship to the de-prescription behaviour, as well as from the de-prescription behaviour to the doctor-patient relationship)?

Discussion

Doctors and patients have different expectations of their relationship with each other [26]. But, there is growing evidence that the phenomenon of polypharmacy and low quality of drug use is substantially due to mis-communication [or non-communication] in the doctor patient interaction [27-32].

General practitioner [GP] has the responsibility of updating and reviewing the prescriptions that it carries out, as well as of any other that each patient takes, especially in old people, polymedicated or multi-pathological, in order to promote the benefits and safety, including the withdrawal of inappropriate prescriptions. This makes he to be the most suitable for deprescribing due to closeness for controlling treatments prescribed in other levels, for his longitudinality in care and accessibility. The GP is the best place to understand and integrate the different orbits of the patient: social, functional and biomedical.

De-prescription is often guided by intuition because while guidelines often explain how and when a medication should be initiated, there is often no information about when and how medications should be reduced or stopped [12], and it can be done spontaneously when the conditions are propitious, that is, it can be an opportunistic intervention, although there are decision instruments that allow to indicate the drugs susceptible to withdrawal: Garfinkel algorithm, Hamdy questionnaire, Medication Appropriateness Index, Beers criteria, STOPP-START criteria, or serial therapeutic trials of prescribing and deprescribing [13].

There are two extreme types of reaction of the patient to the proposal of doctor's prescription: 1. grateful acceptance for doing something that he had already wanted for some time; "he had always thought that he was prescribed too many drugs"; "he is not a supporter of medicines", "he takes them only if there is no other remedy"...; and 2. Front rejection of the reduction or withdrawal of the drug, which is experienced as restricting or removing something of his property and to which you are entitled. He usually attributes it to the fact that the doctor, harassed by the system, wants to save costs ... at his expense. The taking of drugs, whatever their number, is for them a right, and their withdrawal is to restrict that right hard earned. The knowledge of the dangers of interactions and adverse reactions are minimized by the patient: "when I have been prescribed for something would be it." And if other prescribers were doctors, the patient puts them as references of knowledge in front of the current doctor who wants to cut that right: "You will not know more than the specialist, right?"

In a doctor-patient relationship of the "consumerist" type, which may be frequent in younger patients, who tend to be more demanding, they exercise more control than the doctor and give the impression that they "consume" health services when they are in front of the doctor. During the time that the requests of these patients are considered reasonable by the doctors, the relationship works perfectly, although the doctor always has the doubt as to whether the patient really trusts in him or he is only used. But, deterioration and doctor-patient rapport may be due to increased consumerism, a rise in medical technology, and a societal trend towards deprofessionalization [33].

The spectrum of drugs that a person consumes opens up between those of great utility [proven benefit and broad in the designated population and low risk of harm] and those of low utility [questionable indications, high cost, high risk of damage in most of the consumers]. In the drug to be de-prescribed, we must consider the patient's preferences, which redefine the priorities of de-prescribing, the benefits and potential harms [adverse reactions and withdrawal syndromes], and the form of use of the medication: adherence, duration, etc.

But, keep in mind that medicine is a relational object. From the manufacturing laboratory through the doctor's office to the patient's body, the medicine incorporates a world of social representations and symbols [34]. In the use of drugs, the aspect related to pharmacology completely eclipses the importance of the non-pharmacological aspects of medication, which are not considered, and which, however, especially in family medicine, acquire great importance.

Doctors also tend, in some cases, to be uncomfortable discussing de-prescribing with patients [35]. The unresolved tension in the GP about these two problems: 1. The prescription / de-prescription, and 2. The possible changes in the doctor-patient relationship in the prescription / de-prescription [29,30], make he unsure about the de-prescription, and tends to blame others for the existence of this polypharmacy scenario [the system, the multimorbidity, the pharmaceutical industry, society ...], but he does not dare to consider or implement changes in the consultation with your patient. GPs may hesitate to address issues they feel will bother their patients, including discussions about life expectancy and reducing preventive medication. Thus, GPs are concerned that patients can interpret de-prescription as a sign that they have to give up their medical care.

The practice of medicine poses more and more obstacles and problems for the establishment of solid relationships between doctors and their patients [36]. The workload and the need to contain costs affect the doctor-patient interaction favors severe tensions between doctors and patients, and can lead to a "defensive medicine", which describes physicians' behavioral response to medical malpractice litigation, and causes overprescribing diagnostic tests, procedures and drugs [37-39].

Most of the pharmacological prescription is generated by GPs, without clear data on what part of it can be induced or delegated by hospital specialists. For example, in 2012 the Spanish National Health System billed more than 950 million prescriptions. According to these figures, Spain occupies, after the United States, the second place in the consumption of drugs. These bulky figures condition that all health systems put the GP in the spotlight to try to reduce the expense generated by its prescription. Many doctors find it uncomfortable to incorporate economic aspects when prescribing, arguing that this would restrict their freedom of prescription. However, there is a deontological duty to prescribe responsibly [40].

On the other hand, in the patient, the drug becomes the representation of "something" that needs, and therefore must be good and not modifiable, and he can demand the repetition of his medication. For example, in United States older adults are willing to have their prescribed medications: more than 90% would stop taking certain medications but they believe that all their medications are

necessary [38]. In this situation, the GP feels insecure, and can accept polypharmacy and the "status quo", even if it considers it incorrect, to preserve the "peace" of the doctor-patient relationship, or can maintain its assertiveness and face de-prescription, which includes technical and communication aspects. De-prescriptions, like the pharmacological prescriptions, in this way, have a function not only in the face of the patient's illness but also indicate an attitude of the GP on his patient, a certain type of doctor-patient relationship [41,42].

From the point of view of doctor-patient communication and the Theory of the Exchange of Affections, the de-prescription can be understood by the patient as "affection deprivation" and this can be negatively related to most of the outcome measures [43]. On the other hand, the nocebo effect, which is defined as the incitement or worsening of symptoms induced by any negative attitude of the non-pharmacological therapeutic intervention, can occur when a patient anticipates a negative effect associated with an intervention, medication or change or withdrawal of the medication [44].

It is essential to inform and reassure the patient: de-prescription does not abandon the therapeutic objectives; on the contrary, it is designed to eliminate the risks of those non-beneficial medications. One approach is to propose the relaxation of these objectives (blood pressure figures, glycemia), as well as anticipate possible barriers and discuss them with patients and caregivers [45].

Iona Heath argues that doctors and patients need to face up to their fears of uncertainty and death if we are to control overmedicalisation [46]. In its core, the intervention aims at enhancing the doctor-patient-dialogue and identifying the patient's agenda and needs. We assume that the number of pharmaceutical agents taken can be reduced by a communicational intervention and that this will not impair the patients' health-related quality of life. Improving communication is a core issue of future interventions, especially for patients with multimorbidity [27]. It has been recommended, above all, that any de-prescription guidelines emphasize a patient-centred approach, focusing on a patient's preferences and the treatment burden that they may experience [35].

Motivational Interviewing has been established as a reference to help prescribe with more awareness and patient participation [47], and it should be assumed that it could also help to deprescribing. "Motivational Interviewing is a collaborative, goal oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." Motivational Interviewing is widely disseminated in mental and medical care settings. It was found apparently efficacious in primary health care when used in the routine medical care to support the treatment of chronic diseases and preventive care [48]. Shared decision making [when perceived by patients as occurring], tends to result in improved affective-cognitive outcomes. But, evidence is lacking for the association between empirical measures of shared decision-making and patient behavioral and health outcomes [49,50].

In addition, the fact of introducing the patient-centered interview and the recommendation to support the patient's right to participate more actively in medical consultations does not resolve all the uncertainties of the impact of deprescribing. Doctors' attitude is of central concern for establishing the physician-patient relationship. The patients 'behaviors of active participation in medical encounters can contribute to physicians' aversion to patients and lead the physician-patient relationship in an unfavorable direction [51].

Regarding to effects of de-prescribing in the doctor-patient relationship, it has been reported that patients who did not receive prescriptions reported having greater satisfaction with the communicative aspects of their visits to physicians than patients who received prescriptions. Thus, it seems that the pharmacological de-prescription gives rise to a certain type of doctor-patient relationship, focused more on the drug than on other aspects of the medical intervention, and thus can hinder the patient's satisfaction with the doctor-patient interaction by substituting that communication more "significant" between patient and doctor, for another communication or relationship "only with the drug" [29,30,52].

It would try to reverse the dynamics of the type of doctor-patient relationship that may be common in general practice consultations in the era of polypharmacy, where the doctor becomes absent, and only the drug is important: "doctor as drug dealer ". So, is proposed to changing that relationship centered on the drug to the classic relationship in which "doctor is himself a drug.", and he can de-prescribe a drug (as a chemical) [28]. In family practice, the GP is called upon to respond psychotherapeutically to an enormous range of patient problems, and he is in an excellent position to do so: "the doctor as a prescription for his patient" [53].

On the other hand, although very little is known about initiation, style and content of the conversations on de-prescription, it seems that they can be different depending on the drug (for example, a proton pump inhibitor vs. a benzodiazepine). It has been communicated that (which on the other side is logical), patients with a higher educational level have a greater initiative to talk about the topic, as well as that the content of the conversation in case of proton pump inhibitor can focus less on the "dose / instructions", and more in the "action and effectiveness of the medication" and in the need for "follow-up.", while conversations about the interruption of the benzodiazepines are more likely to stagnate in the "if" instead of in the "how." Therefore, it is suggested that the GP should conduct the conversation or prescriber interview according to the situation, including according to the drug [54].

That is, it can be thought that the model of relationship or interview centered on the patient is not the only possible, nor the only appropriate to de-prescribing. It can be thought about situations where other models of prescribing interview are appropriate, for example more directive or assertive de-prescribing interview in situations involving danger, such as severe adverse reaction, severe or high-risk side effects, high risk drug interactions, danger of addiction, etc.; for example, in patients in who overlap prescribing of opioids and benzodiazepines that are at excess risk for overdose and death [55]. Only one form of relationships might not fit all situations, and one model will not be suitable for all patients, physicians, drugs, etc., in the same way [56].

Conclusions

In a scenario where the pharmacological prescription dominates the doctor-patient relationship, both doctors and patients are uncomfortable with the de-prescription. This situation cannot be fully addressed and in all circumstance's (different characteristics of the patients, of the drugs, of the doctor, etc.) with the patient-centered consultation, the motivating interview and the sharing of decisions. Polypharmacy is an indicator of low quality of drug use and of a mis-communication [or non-communication] in the doctor patient interaction, but the introduction of the topic of de-prescription in the interview, without a biopsychosocial approach, can make the doctor-patient relationship even harder, probably by means of reinforcing the tendency to focus on the drug, and forget other more significant

aspects of medical intervention. There is a lack of studies that provide more information relevant to the daily practice in general medicine on how the pharmacological de-prescription and the doctor-patient relationship are mutually affected.

References

1. Halfmann D (2012) Recognizing medicalization and demedicalization: Discourses, practices, and identities. *Health* 16: 186207.
2. McCartney M, Treadwell J (2014) The RCGP's new standing group on overdiagnosis. *BMJ* 349: 4454. [Crossref]
3. Cerecedo Pérez MJ, Tovar Bobo M, Rozadilla Arias A (2013) Medicalization of life at the GP level: Where are we headed to? *Aten Primaria* 45: 536-540. [Crossref]
4. Wammes JJG, Jeurissen PPT, Verhoef LM, Assendelft WJJ, Westert GP, et al. (2014) Is the role as gatekeeper still feasible? A survey among Dutch general practitioners. *Fam Pract* 31: 53844.
5. Wegwarth O, Gigerenzer G (2013) Overdiagnosis and Overtreatment: Evaluation of What Physicians Tell Their Patients About Screening Harms. *JAMA Intern Med* 173: 2086-2088.
6. Pérez Oliva M (2014) Colgados de los ansiolíticos. El consumo de medicamentos psiquiátricos aumenta a pesar de que las patologías mentales permanecen estables. *El País*.
7. Connolly A1, Taylor D2 (2014) Factors associated with non-evidence-based prescribing of antipsychotics. *Ther Adv Psychopharmacol* 4: 247-256. [Crossref]
8. 8.AGS Choosing Wisely Workgroup (2013) American Geriatrics Society identifies five things that healthcare providers and patients should question. *J Am Geriatr Soc* 61: 62231.
9. http://edocumentossemfyc.es/recomendacionesnohacer2aparte/
10. Frank C (2014) Deprescribing: a new word to guide medication review. *CMAJ* 186: 407-408. [Crossref]
11. Cross C (2013) Introducing deprescribing into culture of medication. *CMAJ* 185: E606. [Crossref]
12. Okeowo D, Patterson A, Boyd C, Reeve E, Gnjidic D, et al. (2018) Clinical practice guidelines for older people with multimorbidity and lifelimiting illness: what are the implications for deprescribing? *Ther Adv Drug Saf* 9: 619-630.
13. Ouellet GM, Ouellet JA, Tinetti ME (2018) Principle of rational prescribing and deprescribing in older adults with multiple chronic conditions. *Ther Adv Drug Saf* 9: 639-652.
14. Turner JP, Currie J, Trimble J, Tannenbaum C (2018). Strategies to promote public engagement around deprescribing. *Ther Adv Drug Saf* 9: 653-665.
15. Turabian JL, Perez Franco B (2008) The Effect of Seeing the Sea for the First Time. An Attempt at Defining the Family Medicine Law: The Interview is Clinical Medicine. *Aten Primaria* 40: 5656.
16. https://www.amazon.es/Actividadescomunitariasmedicinaatenci%C3%B3nprimaria/dp/8479784741
17. Turabian JL (2017) What is a Good Consultation in General Medicine? *J Gen Pract* 5: e115.
18. Turabian JL, Pérez Franco B (2015) Observations, insights and anecdotes from the perspective of the physician, for a theory of the natural history of interpersonal continuity. The colors of time. *Rev Clin Med Fam* 8: 12536.
19. Roter DL, Stewart M, Putnam SM, Lipkin M Jr, Stiles W, et al. (1997) Communication patterns of primary care physicians. *JAMA* 277: 350-356. [Crossref]
20. González Menéndez R (1979) Psicología para médicos generales. Ciudad de La Habana, Cuba: Editorial CientíficoTécnica.
21. Jensen PS (1981) The doctorpatient relationship: headed for impasse or improvement? *Ann Intern Med* 95: 76971.
22. Limon D, Stemmer SM (2015) Doctor-patient hierarchy may have a therapeutic role. *BMJ* 351: h6906. [Crossref]
23. Gakhal NK1 (2018) Can We Call a Model of Care a "Model" If We Cannot Measure Its Performance? *J Rheumatol* 45: 1493-1494. [Crossref]
24. FernándezLiz E (2013) How to review the medication in patients with multiple chronic conditions? *Aten Primaria* 45: 2334.
25. https://www.elsevier.es/es-revista-atencion-primaria-27-articulo-evaluacion-adecuacion-del-tratamiento-farmacologico-S0212656712004635
26. Galván-Banqueri M, González-Méndez AI, Alfaro-Lara ER, Nieto-Martín MD, Pérez-Guerrero C, et al. (2013) Evaluation of the appropriateness of pharmacotherapy in patients with high comorbidity. *Aten Primaria* 45: 235-243. [Crossref]
27. Grain H (2008) Changes in doctorpatient relationships for realizing the personal health paradigm. *Stud Health Technol Inform* 137: 3738.
28. Altiner A, Schäfer I, Mellert C, Löffler C, Mortsiefer A, et al. (2012) Activating GENeral practitioners dialogue with patients on their Agenda (MultiCare AGENDA) study protocol for a cluster randomized controlled trial. *BMC Family Practice* 13:118.
29. Turabian JL (2018) The Wrong Transformation of DoctorPatient Relationship in Drug Patient Relationship: From the Doctor Himself as A Drug to Doctor as Drug Dealer. *Chronicle of Medicine and Surgery* 3: 298301.
30. Turabian JL (2018) Doctorpatient relationship in pharmacological treatment: discontinuation and adherence. *COJ Rev & Res* 1.
31. Turabian JL (2018) Drug prescription modifies the doctorpatient relationship in general medicine. *Arch Fam Med Gen Pract* [In Press].
32. Turabian JL (2018) Doctorpatient relationship epidemiology and its implications on public health. *Epidemol Int J* [In Press].
33. Turabian JL (2018) Hypothesis and practices to avoid polypharmacy in general medicine. *Br Biomed Bull* [In Press].
34. Jensen PS (1981) The doctor-patient relationship: headed for impasse or improvement? *Ann Intern Med* 95: 769-771. [Crossref]
35. Conrad P (1985) The meaning of medications: another look at compliance. *Soc Sci Med* 20: 29-37. [Crossref]
36. Schuling J, Gebben H, Veehof LJG, HaaijerRuskamp FM (2012) Deprescribing medication in very elderly patients with multimorbidity: the view of Dutch GPs. A qualitative study. *BMC Family Practice* 13: 56.
37. Dugdale LS, Siegler M, Rubin DT (2008) Medical professionalism and the doctorpatient relationship. *Perspect Biol Med* 51: 54753.
38. He AJ (2014) The doctorpatient relationship, defensive medicine and overprescription in Chinese public hospitals: evidence from a crosssectional survey in Shenzhen city. *Soc Sci Med* 123: 6471.
39. Gallagher TH, Levinson W (2004) A prescription for protecting the doctor-patient relationship. *Am J Manag Care* 10: 61-68. [Crossref]
40. Robertson J, Walkom EJ, Henry DA (2011) Health systems and sustainability: doctors and consumers differ on threats and solutions. *PLoS ONE* 6: e19222. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0019222
41. Carmona de la Morena J (2012) The Ethics of prescriptions. *Rev Clin Med Fam* 5.
42. Reeve E, Wolff JL, Skehan M, Bayliss EA, Hilmer SN, et al. (2018) Assessment of Attitudes Toward Deprescribing in Older Medicare Beneficiaries in the United States. *JAMA Intern Med*.
43. Balint M, Hunt J, Joyce D, Marinker M, Woodcock J (1984) Treatment or diagnosis. A study of repeat prescriptions in general practice. London: Tavistock Publications.
44. Hesse C, Rauscher EA (2018) The Relationships Between Doctor Patient Affectionate Communication and Patient Perceptions and Outcomes. *Health Commun* 111.
45. Kristensen LE, Alten R, Puig L, Philipp S, Kvien TK, et al. (2018) Nonpharmacological Effects in Switching Medication: The Nocebo Effect in Switching from Originator to Biosimilar Agent. *BioDrugs* 32: 397404.
46. Stevenson FA, Cox K, Britten N, Dundar Y (2004) A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance. *Health Expectations* 7: 235-245.
47. Heath I (2014) Role of fear in overdiagnosis and overtreatment--an essay by Iona Heath. *BMJ* 349: g6123. [Crossref]
48. https://decisionaid.ohri.ca/
49. Oberink R, Boom SM, van Dijk N, Visser MRM (2017) Assessment of motivational interviewing: a qualitative study of response process validity, content validity and feasibility of the motivational interviewing target scheme (MITS) in general practice. *BMC Medical Education* 17: 224.

50. Aubree Shay L, Lafata JE (2015) Where Is the Evidence? A Systematic Review of Shared Decision Making and Patient Outcomes. *Med Decis Making* 35: 11431.

51. Rubak S, Sandbaek A, Lauritzen T, Christensen B (2005) Motivational interviewing: a systematic review and meta-analysis. *Br J Gen Pract* 55: 305-312. [Crossref]

52. Kawabata H, Konishi K, Murakami M, Kisa K, Maezawa M (2009) Factors affecting the physicianpatient relationship regarding patient participation in medical encounters in primary care. *Hokkaido Igaku Zasshi* 84: 1715.

53. Wartman SA, Morlock LL, Malitz FE, Palm E (1981) Do prescriptions adversely affect doctorpatient interactions? *Am J Public Health* 71: 1358-1361.

54. Bacal HA (1975) The doctor as a prescription for his patient. *Can Fam Physician* 21: 103-110. [Crossref]

55. Turner JP, Richard C, Lussier MT, Lavoie, ME, Farrell B, et al. (2018) Deprescribing conversations: a closer look at prescriber–patient communication. *Ther Adv Drug Saf*.

56. Carico R, Zhao X, Thorpe CT, Thorpe JM, Sileanu FE, et al. (2018) Patients receiving prescriptions from multiple healthcare entities have higher risk for receiving sedative class overlap. *Ann Intern Med* 169: 593601.

57. Krones T, Richter G (2008) Physicians' responsibility: doctorpatient relationship. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz* 51: 81826.