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Who is Mariana Carvalho? Why did you decide on Medicine, what inspired you? Why did you follow this path?

Mariana has always grown up with this purpose of caring for others. I'm an only child, I didn't have any siblings, but this meant that my family context involved me a lot in adult conversations. I spent a lot of time with my grandparents and that was it, and I think that this family context ended up making me mature quickly and differently from other children, because obviously at school I lived with my peers, but there were always people who said that I was different in some way. And I think that ended up shaping me in terms of my personality. Besides, I can't deny that it didn't influence my decision, both my paternal grandparents and my parents are doctors and I also have other relatives who are doctors in the family.

So I grew up in this bubble of always talking about other people with that purpose, that I always had someone to take care of, not just my own, but other people's, and so medicine was always in my sights, as a professional goal and in fact this ended up defining my career choices, already within medicine, because I really dealt with everything and I made my choices as I knew what I liked, what I didn't like, what I was most interested in and what was very funny was that when I chose my specialty, which is general and family medicine, that specialty belongs to everyone. I've seen my patients born, I've seen my patients grow up, I've seen my patients get sick, unfortunately they've died too, I've followed all the stages of people's lives and then, when I changed my career path a little, I went to work in a long-term care unit where my mindset had to change. Why did that happen? Because I dealt with death up close, with ageing. But the ageing that we... I think we deny that there is this ageing aspect of people who end up alone in the world, who don't have a family, don't have children, who have serious illnesses e. And that made me question a lot of things: why does this happen? Why do these people become entirely dependent on what society has to offer them, which is sometimes very little. So I started studying palliative care, the limits of medical practice, how far should we go? What is important to respect so that the person has a dignified death? So all these questions began to affect me in some way, because I really had to start thinking about what my role was with these people? Didn't I? Because palliative care is about more than just the end of life, it's about caring for someone who has an incurable disease. So we can't offer that person a cure, but there's a lot we can offer them. And I learned that. In other words, I was at my limit as a doctor, but that didn't stop me from continuing to help that person. And the truth is that today I proudly say that I helped people to die with dignity and comfort, with or without their families around, because that's what really matters at the end of the day. What does it matter? Is it dying painlessly? Is it dying next to the people we love? And

that made me question a lot of things, because it's something you don't learn at university, it's something I didn't learn in my specialty, because I also didn't have much interest in serious illnesses, palliative care and all that scared me, because it all happened after I dealt with the death of my grandparents and people close to me, and my mentality, my mindset, changed a lot when dealing with this on a daily basis.

So where am I now? I left that job for personal and even health reasons, but I feel that my mission there was accomplished and that what I take back from that place where I worked, not only on a professional level, but on a personal level it made me question a lot of things that I was even afraid to question or even afraid of... it was taboo to talk about death, wasn't it? So what have I learned from this? That, in fact, this year there have been a series of events in my life that have made me change my mentality, not just about myself, but about the way I deal with the people I work with, my patients, the people who come to me for help. Because, in fact, we live in a society in which we are almost victims of the lifestyle we are almost forced to lead. Right? Working to pay the bills, I have to study to work, to be able to have a house, a place to live or to have the minimum conditions to be able to live with dignity. And over the course of this year I've learned that that's not all, and in fact, traveling has also allowed me to open my horizons a little in that sense and get to know other cultures too, so Mariana is a bit of a result of her story and her progression as a person and in her career. I think I'm a person who can't do the same thing for very long. I'm always trying to find answers for the people who ask me for help.

And now that you've mentioned travel, I know you've taken a trip to one of the destinations where IKIGAI originates, and it's one of the blue zones of the planet in terms of ageing, which is Japan. You've heard of the IKIGA philosophy, you know the main IKIGAI principles. How do you think these principles can be applied to medicine?

Well, to begin with, IKIGAI is the purpose, the meaning of life, a purpose or reason for getting up every morning. And what's curious is that this year I also had an awakening of interest in the question of blue zones and active ageing and why these people live longer, and what is the reason and what are we doing wrong and what can we learn from them? Being in Japan and observing that, for me it was a really transformative experience in terms of mentality, because obviously it's not a perfect society either, because there are no perfect societies, but it was older people who surprised me in the sense that “why not?” Why don't we work later? Why don't we always have something to motivate us to live and get out of bed every day? And I think this is a cultural problem of ours, of the Mediterranean countries, of Europe too, because I was... I'm going to tell you an experience.

When I read the word IKIGAI, it was that experience that struck me the most and that fits perfectly with the concept of IKIGAI. I was in Kyoto visiting their Buddhist temples and we got hungry, I went with my husband, and we got hungry and decided to find somewhere to eat. So, near where we were, there was a small house. A small restaurant, it was open, no one was inside. It was around 3pm, which in Japan is a real find to find a place to eat outside of meal times, like finding a pin in a haystack. But that little house was open, we went in, and there was a gentleman, I can't tell you how old he was, because looking at the faces of Japanese people and saying how old they are is difficult, but I'd say around 70, 80, certainly. They didn't speak English. Japanese people don't speak English well. Communication is always a bit of a barrier, but what was funny was that he was super cordial, as they are, and told us to choose a place and sit down, and choose what we wanted to eat. Then he goes up the stairs and calls his wife. And the woman, also elderly, comes down, greets us in her own way and goes to help the Lord prepare the meal for us, and we sit there watching it all, and that's it. And I was absolutely fascinated by it. I mean, those gentlemen had a business, their little restaurant, they lived in the house above the restaurant and that's it, and they served us. It was a wonderful meal and we were very satisfied. We were very grateful and then, when we left, we were like, “This really was an otherworldly experience. Only in Japan”, because here we see an old man with a cane crossing the street, we go and help. Not there, they almost take it the wrong way. Because they are there to serve, they have their IKIGAI. Their IKIGAI was to serve us that meal, that day, at that time, completely after hours. And I think that's how it is. That experience in Japan that makes me think most about the concept of IKIGAI and that my husband and I were absolutely positively impressed by, because for us it's unthinkable that a person of that age would still be working there, but that's what keeps them going. And that's fabulous.

And how do you think these principles, when applied to medicine, can promote healthy and active ageing? Obviously, from the story you've just told us, it's clear that the main principle of IKIGAI is to have a purpose in life. And often what happens to our elderly people is that they lose that purpose because their working life ends and a whole dynamic is lost and they feel a bit lost, empty and stagnant. Often they even let themselves die. How do you think these principles, if applied to medicine, can promote active and healthy ageing?

I work with a lot of elderly people, both in consultations and in the context of residences for the elderly. I live with the two worlds of elderly people in Portugal, which are those people, I have a lot of widowed ladies who come to my consultations on their own, in their 80s, on their own, living on their own, but they always come very well groomed. So there you have it, they've found their IKIGAI in a way. And then there's the other world, which is the elderly who have completely lost their autonomy, who don't have people in their family to look

after them, or who do, but don't have the time because they also have their own lives, their own jobs and so on. These are two opposites, which I deal with on a daily basis and which make me think “what would I like for myself or for my parents, that one day their old age will come and I too will have to contribute to it, so that they have that dignified, autonomous and active old age”. In fact, I think it's the fact that they not only have a purpose, but that they are in a community context, that they have friends, that they have family who pick them up for lunch.

So I think that when people start to isolate themselves socially, that's when there's a big decline in their cognition, their autonomy, their ability to move. And then they start to reduce their activity, not only mentally, but also physically. And that ends up being the beginning of the end, as they say, the end that has no quality and no dignity. So how can medicine help? I think there still needs to be a major transformation in the mentality of my colleagues and this has to start in medical schools. It's not just when we come into contact with real patients, why? I traced this path and ended up finding answers to my questions and today I feel prepared to help completely different people with different needs. And in fact it always makes me wonder what's best? Is it this or is it this? Why is it that there are people who have a greater decline in their state of health and there are people who really seem to age, but at the same time don't? What makes the difference between a person who is institutionalized or a person who is active, who lives alone, despite their age, moves around, goes shopping and does everything and cooks and cleans the house. And I think it's the lifestyle, the mentality and IKIGAI can find no other answer to this question, because in fact the illnesses we live with today, which we have more and more of, are a consequence of the lifestyle we lead. And right now I focus a lot on this aspect in my consultations with my patients, because lifestyle is what shapes our health and it can't just be about work, and stress, and making money, because if we don't take time out for ourselves, and I learned this the hard way, I also needed to do it for myself, for my mental and physical health.

More and more I see problems directly related to the lifestyle people lead, because we work long hours, but we're not profitable either, but we need to work because we need to earn money, because we have bills to pay and this is a vicious cycle. People can't get off this wheel, and it's very difficult to make them realize that they are the ones who have to change and that they have to make an effort to look after themselves. Which is also a concept that I've come to realize: ok, I have a purpose, my purpose is to take care of other people, but I can't stop taking care of myself, because if I don't, I'm not capable. And I think that's the way it is. Teaching in medical schools that the treatment or cure of illnesses doesn't involve medication, surgery or medical interventions. There's a lot that needs to be done at a preventative level, so as not to let people reach a point of illness that is no longer reversible. So we are living in curative rather than preventive medicine. Of course, in terms of costs to society, there's no comparison between healthy lifestyles that lead a person to have less need to go to health institutions, as opposed to those people who work, work, work and do

nothing for their health because they don't have time, or think they don't have time, but then they won't have that time in the future, or with quality, because they don't have the health to live their old age, and with more costs for the person, for the family and for society. And so I think that preventive medicine, my medicine, which is preventive, is not so curative. That's where the change in mentality that I think my colleagues need to have comes in.

What are some of the strategies you use in your consultations to basically help steer patients down the path of active and healthy ageing?

Well, first I try to understand what their routines are like, it's also very important to understand whether the person comes with someone, whether they come alone, who they live with, what their family background is, what their social background is? Because that ends up affecting my suggestions or the way I try to adapt my suggestions to that person. But at the moment, in this population, preventive medicine focuses a lot on lifestyle too. If it's a person who has close family relationships, I always end up meeting the daughter, or the niece or the grandchildren, the grandchildren also take the grandparents to the appointments, it's quite funny that relationship, and I really try to explain that that person, despite the difficulties or limitations they have, has to be active mentally and physically. Of course it's not easy, but there are always solutions at parish level, at municipal level, we have a lot of elderly people who really enjoy going to aqua aerobics classes or who have a lot of habits that force them to leave the house and I just say: what you like is what forces you to leave the house. That's enough. It doesn't even have to be to do a physical activity, it's enough to go and buy a bag of food just for that day, because the elderly don't lose their ability to carry heavy loads either. Therefore, anything that forces the person to leave the house, to keep minimally active, to move around, to go for a walk, if there are stairs, even better, because it forces the person to climb stairs, but with all the precautions that we have to suggest, for example, changes to the house to prevent falls, because if you live alone and there's a risk of a fall at home, the situation can get worse because of a fall or the possibility of a fracture of the femoral neck, which is quite common and has quite high mortality ratios in the following year. That's why you need to understand that person's context and adapt the health and preventive consultation advice to that person, to that context. But that takes time. Consultation time, attention time and everything else that I try to give, that I make an effort to give and I think it's very important.

I'm going to ask you a series of questions more related to digital health, because it's also one of the topics of this project and it was something that got a boost during the pandemic. Do you usually do teleconsultations, if so, and do you still do them?

No. During the pandemic, we all had to adapt to the digital world in all areas, and medicine was no exception. I did a lot of teleconsultation, it was one of the

few ways we could reach everyone. Indeed. I think the power of digital is that we can reach more people. And that was a topic of conversation at the Congress I attended last week. In fact, the digital world is here to stay. We have to accept that we now have artificial intelligence and that we have increasingly advanced devices and we're going to have to learn to live with them and we're going to have to adapt to them and take advantage of them. And the older population shouldn't be left out, on the contrary, I think there should be an adaptation of the type of applications or type of devices to that age. It's funny that I see older people increasing the size of the letters in their messages, isn't it? And so we can adapt everything to that age group in order to take greater advantage of digital platforms and devices, especially cell phones. So I think we really need to change this resistance, sometimes, to moving everything to digital, because it's not the future, it's the present, isn't it? That's why we have to know how to get the most out of it, so that we can also reach more people. Obviously there are things I can't do without, I really like seeing the person, being with the person, looking at the person. There have been situations where it would be absolutely impossible to diagnose or repair over the phone, haven't there? The person goes for one reason, but then there's the other, which is more worrying, because I saw the person in person and it was a prompt situation, which was immediately referred. But this means that I can't exclude digital or teleconsultation from my medical practice. I think I have to learn how to do it and, interestingly, I know that there are already general practitioners doing teleconsultations at times of the week, depending on their schedules and availability. And I'm even considering it, because no, it makes sense, because we can reach more people. We may not be 100% as effective as a face-to-face consultation, of course not, there will always be flaws, there will always be gaps. There are things that are going to get past us, but we do have that reach and I think we have to know how to take advantage of it.

Maybe more as a complement, using digital health more as a complement, in other words, the person has that consultation, Mariana can see that there's a problem there and then makes an appointment for a face-to-face consultation.

Or even the other way around, making a face-to-face appointment and then teleconsulting and then following up digitally.

Mariana has already managed to answer the question two in one, almost two in three, because when she spoke about digital health in the way she did, she was already answering the question "what do you think of digital health?" We'd also like to know how the process of making appointments, attending teleconsultations and sending teleconsultation results normally works?

I don't do teleconsultation at the moment.

May I ask when was the last time?

When was the last time? It was in 2020, certainly. 2021 at the latest. I was monitoring COVID patients, because at the time it was the only way to be there, to reach everyone. Everyone who was infected couldn't go to the health center or the hospitals. So we did this teleconsultation. Then we also tried to adapt at the health center, but then we quickly went back to face-to-face, because we were also somewhat resistant. Patients didn't feel accompanied by us, they felt it wasn't a consultation, it was a phone call just to see if everything was OK, and so there was this resistance, not just from the doctors, but also from the patients. So we quickly went back to face-to-face. But how did we do that? There was contact with the patient via email, the patients had the health center's email, or directly the doctor's professional email, through which they sent us test results or analyses. There you have it, I think that with will everything can be done. And everything can be achieved. However, I think that doctors who have more contact with patients who don't have physical complaints may have greater potential to be able to carry out this follow-up and assessment, as is the case with mental illnesses, or simply states of: “I now think I have an appointment for chronic tiredness, asthenia”. I think everyone is tired of something. Those are relatively easy, aren't they? You don't have any physical complaints. I don't have to do an extensive objective examination from head to toe. Now, when it's something very specific, it's difficult to assess. And a lot of things when it's a backache, knee pain, something physical, it's difficult to assess in a teleconsultation. Of course, we can always assess, guide and diagnose with complementary exams. But I think it just takes willpower.

You were telling me earlier that patients thought they were making a phone call to find out if everything was going well. You've never used a video call consultation, for example?

No, we haven't reached that point. I haven't experienced it myself. But I do believe, and I work in the clinic with a psychiatrist who for a long time, even after COVID, after the pandemic has calmed down and everyone has moved on from face-to-face work, face-to-face consultations, the psychiatrist has continued to consult via video call. That's why I was saying that the doctors, more on the mental health side, who are able to continue to do this monitoring with video calls, with teleconsultations. But I confess that I feel a little more open to accepting that teleconsultation has many possibilities and I think that's what I want to emphasize. It's the reach, reaching more people, helping more people. Of course, there are limitations. Maybe I even need to see the person in person, why not? Then make an appointment. What's resolved, fine, it's resolved by teleconsultation. What isn't solved because I really need to observe

the person, auscultate, do a physical examination, or a maneuver to try to diagnose something, then I refer them for a face-to-face consultation. So I believe it has potential and I already feel a little more open to making this digital transition for my patients.

From the last answer you gave us, I could tell that you quickly moved on to the face-to-face part. Don't you usually refer to teleconsultation for older patients?

No, no. In fact, I feel that they like going to the hospital, they like to feel the doctor's touch, they like to feel the doctor's presence. And I can tell you that I have many ladies who go there just to ask for medication, because everything is fine, but they feel the need to come and talk to me, and for me to listen to them. Maybe from the 80s upwards, I think people really feel the need for human contact, for the doctor, and we don't see much of that anymore, unfortunately we always have computer screen barriers and other barriers, of course. But I think this generation, the boomers, the 60+, I think they're already way ahead and much more adapted and more open to this possibility, because it suits them better. Because they don't waste time commuting, because their doctor is just a phone call or message away. I think that in this generation, in the future, it will undoubtedly make sense to apply digital medicine here.

You've already spoken to us about this topic, what do you think are the main benefits and challenges of teleconsultations compared to face-to-face consultations? You've already told us that one of them is the reach, the fact that you can reach more people. What do you consider to be the other benefits and challenges that you think doctors and patients will face, and how do you compare these benefits and challenges to face-to-face consultations?

Well, I think I'm going to talk a bit about my transition in the way I've been communicating with patients, which is through WhatsApp. I think WhatsApp, I used to abhor WhatsApp for professional situations, but then I started to think it was a very useful tool so that people could reach me very quickly, and I could promptly solve a problem for them, within seconds, minutes. As soon as I could reply, I could read the message, reply and give advice. And I think we can consider it a kind of teleconsultation, isn't it? It's not that formal “hello, what are you doing here?” consultation. No, I think this transition, WhatsApp is also changing the way we practice medicine. And I began to realize the potential of WhatsApp as a working tool that I had previously abhorred. Those groups, the health center group, the hospital group, the palliative care group, the long-term care group and, well, I didn't really like that, that dynamic, but the doctor's contact with the patient via WhatsApp I think has enormous potential here and I

think I've learned to deal with it in a way, that is, I've started to accept it as a working tool and, in fact, I'm starting to see the benefits. Because we doctors think that the patient can't have our personal or professional number, whatever it may be, because then they'll always be asking for it or calling. No. Those are the people who annoy me the least, if you'll pardon the expression. They're the people who are the most careful even in the way they talk to me, they're not there interrupting “doctor Later, when you can answer my message, I have a question here” and I think that helps us to triage the situation in the sense that “this is something serious I have to deal with now” or this is something “that I can deal with tomorrow or next week”. And I think I'm learning to deal with this way of working and communicating with my patients, not the formal teleconsultation. That consultation where we're on the computer looking at each other with a camera on, making a video call, in the form of a consultation. So there you have it, it's that follow-up, I do the face-to-face consultation and then I do the follow-up via WhatsApp, which ends up being a digital tool.

And I think it might also be a way of breaking down that barrier a little, we were saying that these people are the ones who are most careful, perhaps because they feel a little safer, because they know that if anything happens they can get in touch immediately, and that gives them greater security, greater peace of mind.

Yes, definitely.

What do you consider to be the most important thing in consultations with the elderly?

An excellent question. I like to look at the elderly person as a whole and I'm always very curious about how they live, what they do? How is their day, what do they do, what do they do in the morning, what do they do in the afternoon, where do they go? I'm always very curious, because I like them to feel comfortable talking about things other than illnesses. I'm already familiar with diseases and I know what the problems are. I think that's very important. Here too, when I went through palliative and long-term care, I had to do some training in the context of palliative care and geriatrics. Why was that? Because our elderly are overmedicated. We consider poly-medication, now I'm not sure how many different drugs are considered poly-medication, but we certainly have a lot of elderly people taking more than 10 different drugs. And this is frightening because they know what that little yellow pill is for, or the blue one, or the green one, or whatever... But many of them get to a point where they start either not taking it properly, or repeating doses or overdosing on a particular medicine that they shouldn't. They buy the generic and they buy the brand name. They buy the generic and they buy the brand name, they're doing

both at the same time. So what really worries me in terms of health? Not just the day-to-day part, the context, but when I ask them “what do you take?”, they can't tell me the names. Okay, so I'm going to ask you, please, to bring me all the boxes of medication you have at home, because as much as they tell me they take blood pressure medication, cholesterol medication, thyroid medication and uric acid medication, I don't know if the person knows what they're taking, and if they're taking it properly, because they know from the boxes. So the boxes, if they come to the consultation, are the best way to find out if they're taking them correctly, if the dosage is right or not, because I think there should be a growing concern about polymedication.

I think it's a public health problem, because many of these elderly people end up in the emergency room because of side effects from their medication. So the cleaner, the simpler, the more essential the medication people take, the better. And the truth is that, unfortunately, we live in a super-specialized medicine, where each doctor has their own medicine. To offer that patient. So the patient runs around all the squares, goes to the cardiologist, goes to the endocrinologist, goes to the nephrologist, goes to the family doctor, goes to the orthopedist because he has a knee pain, a back pain, and the next thing you know, the patient comes to the family doctor and asks for prescriptions for all that for six months. And we're like, “Okay, but why take this?” “Oh, was that a cardiologist?” “Look, but this is a lot of medication and maybe your blood pressure is already too low and we're going to have to...” “Oh, you can't take that off because the cardiologist did it.” So this is very difficult to manage in a consultation, it's hard to explain to an elderly person that they're taking too much medication, that it could be harmful to them and it's hard to deconstruct what the cardiologist, nephrologist or endocrinologist has prescribed, maybe it's not working at the moment and we'll have to take it away.

So there really has to be a relationship of trust, a therapeutic relationship. And in fact, there are very few patients who don't accept my therapeutic attitude of trying to remove what isn't working or what isn't beneficial, because what isn't beneficial isn't working either, is it? So I have this attitude a lot because it's something I've acquired over time, because what do I observe in practice? I have nursing home patients, many of whom are entering that “they're no longer getting better or worse” phase. So I'll look at their medication and see what doesn't make sense to continue. What do I check? I start withdrawing medication from neurology and diabetes. Not diabetes, because it's something you have to be careful about, but let's say. Sleep medication, medication that could be sedative, that could make the elderly person more confused. And what happens? That person is transformed, that person comes back to life. I've already seen this in patients who were bedridden and fed through a tube and who started to get out of bed and eat at the table. This is the ultimate example of the fact that our elderly are over-medicated and that there is nothing good about this. And I believe there are many, many medications, of course, we doctors are trained to follow guidelines. We follow guidelines. The patient has this diagnosis, has this analytical value, is already indicated for... OK, what are

the risks of this medication? What are the benefits? Are the risks greater? No, so it has more benefits? OK, go and take this medication. But I think we've already missed stages in this process, we've missed stages and this is what happens. And the cardiologist's pill, the orthopedist's pill. And then who has to manage it? It's the family doctor, it's the home doctor, isn't it? And this example I've given isn't just one, it's several. It's drug interaction and side effects. And I think we have to evolve towards de-prescribing. And those who can de-prescribe must also be those who prescribe. But that's a mindset that also has to be worked on with my colleagues, but it's very difficult to remove the role of the prescribing doctor, isn't it, the doctor is a prescriber. If I go to an appointment and don't bring a prescribed pill, the doctor isn't that good. I'm proud to say the opposite. I'm proud to say that there are patients of mine without medication.

That's what I was going to ask. If medication can't be, let's say, replaced by a healthier lifestyle. Let's imagine that, in the first phase, instead of going straight to medication, for example, a healthier diet, a lifestyle of sport, of physical activity, might not be able to solve these health problems more quickly than, for example, a medication that will last a lifetime, and which later adds to the medication, almost every month we have another pill to take, and why isn't it prescribed in medicine? I know it's already done in some countries. Why isn't it prescribed more often? The healthy lifestyle, and is medication prescribed more?

The answer is very simple, because it's very difficult. It's much more difficult to tell a person that they have to do 20 or 30 minutes of physical exercise - it's not physical activity, it's physical exercise - three times a week. It's harder to have someone who can't eat cheese or who can't eat that fried food, who can't eat that stew, or who can't add too much olive oil to their food. It's more difficult. It's easy to say, but I know that that type of patient, I can tell from the type of person, that the lifestyle, despite being more effective in the long term, is not going to be effective in the time I need to lower that cholesterol. Cholesterol is very ungrateful, because we have a lot of people with familial hypercholesterolemia, that is, that hereditary cholesterol that my mother also had, my father also had, my grandmother also had. And only those people who actually try to “doctor, please let me try to change my lifestyle” and I do, of course, but that person can't reach the target value in a month, two months, four months, and time keeps ticking and the cardiovascular risk is still there. So it was an example of something that is very unpleasant for us to treat, which is dyslipidemia, or high blood cholesterol, because of the long-term consequences. Obviously, when we start, and the guidelines say that lifestyle changes are the first thing to do, but we don't have time. Now I do, now I can be happy, because I have time to talk to my patients and I have more availability than I did when I was working at the health center. It's easier to prescribe, it's harder to prescribe a healthy lifestyle, it's easier to prescribe a pill to take once a day for the rest of your life.

You told us that doctors follow the guidelines a lot. But does that also mean that a healthy lifestyle isn't, perhaps, just now entering the doctor's guidelines?

When it comes to cardiovascular disease in general, diabetes and obesity, the guidelines always include lifestyle changes as the first step. What ends up happening? Even if we take this first therapeutic step, the patient ends up not achieving the goal we want for them. We want it according to the guidelines, but I'm not going to go into other economic interests here, because those who make the guidelines are obviously the scientific communities, the major European and American cardiology and endocrinology societies. The problem is that those who finance the guidelines are also the pharmaceutical industry, which has every interest in patients continuing to need medication. Increasingly expensive, but also increasingly effective. More and more adapted to patients who are more sensitive or who are more... how do you say... There's also a certain concern that the medicine doesn't have any undesirable effects or that it doesn't have any worsening effects on, for example, kidney function, or any other disease that the person has. There is growing concern that medicines are effective and that they don't cause harm to other organs or other systems. There is this concern. But even so, of course, those who make the guidelines are driven by a whole system, a machine, of the pharmaceutical industry. So there you have it, following guidelines, I think we have to personalize medicine more and more, look at the person in front of us. Maybe they have an indication to start taking a medicine, but maybe we need to understand what the person's objective is, what does that person want? Because I'm not going to force anyone to take medication they don't want to take, it's not part of the way I work.

I always like to work cooperatively with the patient. There's also the issue of taking responsibility - it's talked about a lot now, isn't it - giving the patient the power to make decisions, informed decisions. In other words, I explain what the health problem is, what medication is indicated, what the side effects are, what the advantages and risks are, and whether the person actually wants to start therapy or not. And if they don't, I have to accept that they don't, and continue to be available to help them and accept that they don't want to take the medication. I don't think it's an easy attitude to have at first, but then, with experience, you start to realize that the patient isn't obliged to follow your instructions. I'm only there to suggest, to improve, to help. That question of the doctor's paternalistic attitude, I think it's something that more and more of our younger generation of doctors are doing away with, because it doesn't make sense and it's not effective for people.

Is there anything else I'd like to add to what has been said?

So in summary, I can say that this year has been a very, I guess I could say that the word of the year has been mindset. For me and for a lot of people. I don't know, I think it's fashionable to say mindset, because it was effectively a change of mindset due to the trip I made to Japan, the culture shock, realizing how I could learn and apply what I learned or what I saw or what I experienced in my practice, with people, with my friends, with my family, with my patients. And improve those relationships, because I think the disadvantages of digital are that it can end up isolating people a bit, but on the contrary, we have to try to counteract it and take advantage of digital to bring people together. And I think that's the goal, to bring people together and give them the power, the empowerment, ok another very fashionable word, of having someone at their fingertips who is available and who really helps. And I think that's my role, my IKIGAI. I think it's my way of being, my way of working. It's the availability I have for people, which I think is what others lack. I'm not just talking about medicine of course, I think that in every profession we have our purpose and I found my purpose in medicine, the willingness to help, and if I can't help, I'll try to guide that person to the best possible person to help solve a particular problem. And that was also something I learned in Japan, because from the moment you get help from a person on the street who doesn't speak English but understands what you're asking for, that person won't rest until they help you get there, solve or fulfill your request. That was something that fascinated me in Japan too, because at any time we were in a place where we didn't understand the signs, we didn't speak the language, but we went to someone who never refused to help us, was always available to help us and didn't rest until they helped us solve our problem. And I think that's also a lesson that Japan has taught me this year, which is in fact my way of being: I don't rest until that person is satisfied with the request they've made of me.