services and not just for people with diabetes.

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The relevance of mobile applications helping in doctor–patient relationships

Smartphone applications are becoming a major part of 21st-century doctor–patient relationships.[1] Medical follow-ups that constantly monitor their health are extremely important for people with chronic conditions. These patients are more likely to develop additional symptoms, physical or mental, which will result in more visits to their GPs and unnecessary medical examinations. Or other patients with chronic illness might miss or neglect early symptoms of relapse as they rely too much on the routine of taking the same medications and going for only scheduled check-ups. For checking physiological data, 'logging applications' might prove useful because one's calorie intake, lifestyle, and activity can be monitored. However, these apps give relatively little and limited feedback to the users. Also, patients can only notify their physician in person if a problem occurs according to these applications.

To solve this problem, some new software is currently being tested and developed in Hungary that will help GPs and patients communicate more efficiently, and eventually it will be available for the whole population (NetDoktor, https://www.netdoktor.hu). The patients can call their doctor through the application, send their examination results right after receiving them, easily make an appointment, or pay medical bills. Moreover, the GP will see all the patient's prescriptions and the exact time the medicine was purchased, and can send reminders of an upcoming appointment. A fixed appointment will also appear on both parties' calendars. The patient's profile can be connected to an online database, where GPs can upload prescriptions using their digital signature. These are accessible to pharmacies, so patients can purchase their medicine easily. This process is meant to simplify health care by minimising face-to-face consultation between patients and GPs. The application is not only tested by healthcare professionals but by carefully chosen patients too, who are expected to give valuable feedback and ideas to improve this new system during the experimental period. To sum up, this innovation should be received positively as it's not only making health care more convenient and easier to use but will also improve compliance and adherence, and optimise persistence.

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Amending WONCA's P4 definition: the cure has been worse than the disease

We appreciate Martins *et al*'s effort to present an amendment to WONCA's P4 (quaternary prevention) definition. However, there are some problems with their approach. First, we found it problematic to state that *'demedicalisation is often not a science-based concept'*. Dating back to the 1960s and 1970s (for example, Ivan Illich's *Medical Nemesis* — 1974) there is an enormous amount of academic and scientific evidence on the political and social implication of medicalising human experience. Second, it is a mistake to assert that P4's new definition is *'more than demedicalisation'* since it diminishes the scope of P4 by getting rid of the scientific concept of medicalisation. Apart from individual clinical harms, there are social and cultural iatrogenies, which are characterised by humans' impoverishment in dealing with life's inherent crises. This generates excessive dependence on, and demands for, medical interventions for almost all human hindrances. Third, evidence-based medicine (EBM) is presented as the only valid paradigm. Unfortunately, EBM is not a neutral phenomenon, but a socially constructed approach to authority over medical knowledge.

There are vested interests in biomedical research, and its agenda is value laden. EBM deals, in general, with monodisease scenarios, excluding complex and multimorbid patients from clinical trials. In complex cases, the realm of P3 and P4 (as in medically unexplained symptoms), polypharmacy tends to be the norm. They need careful assessment by GPs. Fourth, the 'new definition' drops Jamoulle's insight on the origin of P4. P4 was born by highlighting a particular group of patients: those who feel unwell, but have no disease, which includes mental health problems. The latter needs a new understanding that surpasses the EBM paradigm, but includes the philosophical, sociological, and anthropological perspectives. Finally, GPs have to expand what counts as medical interventions. Thus, Martins *et al*'s proposal seems to portray that the 'cure has been worse than the disease'! Not all GPs' activities can be evaluated by 'EBM paradigm'; in fact, most of them cannot. Therefore, WONCA's P4 definition requires clinicians to reflect upon what sort of lens (the clinical gaze) they are using in order to constrain biomedical jurisdiction and to protect patients from being medicalised.

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