# FROM DISEASE TO PERSON OR FROM PERSON TO DISEASE

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Once the dilemma is posed, it can be answered from a teaching perspective in two scenarios:

Scenario 1: A 78-year-old college-educated professional with a history of chronic heart failure, type 2 diabetes mellitus with diabetic retinopathy, high blood pressure, and chronic obstructive pulmonary disease (COPD). Barthel, 60 points. He lives in a residential neighborhood, on the third floor of a building with an elevator. His wife, assisted by their daughter, is the caregiver.

Scenario 2: A 78-year-old with primary education and a history of chronic heart failure, type 2 diabetes mellitus with diabetic retinopathy, high blood pressure, and COPD. Barthel score: 60. She lives alone in a gentrifying neighborhood, on the third floor of a building without an elevator.

We persist in healthcare based on linear models: disease-centered or patient-centered care. In the first case, Evidence-Based Medicine (EBM), with the development of protocols, clinical pathways, clinical practice guides... In the second, the patient, Picker's eight Principles. The Pan-Hispanic Dictionary of Medical Terms (DPTM) defines patient as "a person who receives or is going to receive medical care, either for a disease or for preventive purposes" and goes on to say that "it is often used loosely as if it were synonymous with sickness."

We know that with advancing age,[1] there is a loss of multisystem and functional reserve, rooted in biological determinants and associated with a greater susceptibility to chronic diseases. This becomes clinically evident as the presence of multiple chronic diseases in the same person. When a certain threshold of deterioration is reached, it leads to poor quality of life, disability, drug interactions, drug-disease interactions, hospitalization, and mortality. Thus, we know[2] that people over 80 years of age may have eight or more chronic diseases.

In Lee's study,[3] 11,113 individuals aged ≥65 years (representing 37.1 million Americans) were interviewed; 75% were aged ≥76 years, and 58% were female. Five highly prevalent conditions were present: three diseases (ischemic heart disease, heart failure, and diabetes mellitus) and two geriatric syndromes (urinary incontinence and injurious falls). 56% had at least one condition, ≥2 additional conditions (20%–55%), and 23% had ≥2 conditions. The profile with the most conditions was advanced age, female, living alone, or residing in a nursing home. Therefore, a comprehensive and coordinated approach to concomitant diseases and geriatric syndromes is essential.

In this situation, a dilemma arises: comorbidity or multimorbidity. Comorbidity[4,5] is defined as any clinical entity that has existed or could occur during the clinical course of a patient with an index disease under study. Multimorbidity, defined by the World Health Organization (WHO) as the presence of two or more chronic conditions. The problem with multimorbidity is that different authors and institutions[6,7] define it differently, so the studies are not comparable. Even so, it is more assertive to speak of multimorbidity, pluripathology or multiple diseases or chronic conditions than of comorbidity. This leads to a more

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holistic, integrative and generalist vision. Comorbidity is a specialist vision, which entails problems when a person is treated by several specialists in a multidisciplinary manner (each acting independently), and its consequences are an increase in the number of diagnostic and therapeutic errors and polypharmacy.[3] We must strive for interdisciplinary care (assisted by several professionals in a coordinated manner and with a common goal). Another added problem is the use of EBM, which uses different guidelines for different diseases, which can lead to contradictions, especially regarding treatments, since they are linked to the disease.

In both scenarios, both individuals present the same diseases, but some relevant factors, among others, differentiate them, such as the following: a) Educational level,[8,9,10] which directly influences life expectancy and health. The higher this level, the longer the life expectancy and better the health. b) Loneliness,[11,12] has significant implications for several physical and mental illnesses such as depression, alcoholism, cardiovascular problems, sleep difficulties, immune system disorders, Alzheimer's disease, general health status, and early mortality. c) Socioeconomic status,[13,14,15] is a largely unrecognized risk factor in the primary prevention of cardiovascular diseases (CVD). Risk scores that exclude socioeconomic deprivation as a covariate underestimate and overestimate risk in the most and least disadvantaged individuals, respectively. This study highlights the importance of incorporating socioeconomic deprivation into risk assessment systems to ultimately reduce inequalities in health service provision for CVD. Socioeconomic status (SES) has a measurable and significant impact on cardiovascular health. Biological, behavioral, and psychosocial risk factors prevalent among disadvantaged individuals accentuate the link between SES and CVD. Four measures have been consistently associated with CVD in high-income countries: income level, educational attainment, employment status, and neighborhood socioeconomic factors.

Thus, if attention is focused on diseases or on the patients themselves, the living conditions that make them different will be overlooked. The first approach will expand a transversal view[16] in which everyone is equal, and the second (social determinants of health) will showcase an individual perspective, which is what makes us human.

"*It is more important to know what sort of person has a disease than to know what sort of disease a person has* " (quote attributed to Hippocrates, 460-377 BC).

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