system coordinated by the government. The useful residual legacies of managed care will include: consolidation within the system; a decline in fee-for-service; an increase in capitated care; more primary care and less specialty care; and the increased industrialization of medicine with more formal priority setting both within the system and between medicine and other social support systems.

The struggle I am referring to is not primarily a legal battle. It is instead, as Leon Kass suggested, a political battle in the original sense of political, meaning the will of the polls, the people. I think eventually good sense will prevail and the doctor-patient relationship will be supported as the most effective, efficient, parsimonious, and elegant way to provide high-quality health care to the citizens of every country including the U.S.

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Articoli/*Articles*

THE IDEA OF PHYSICIAN AS A BIOETHICAL TOPIC

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SUMMARY

The model of the physician as a caregiver and as a researcher has been given extensive attention in the bioethical debate. There has been a transition in the last decades from the traditional idea of a physician inserted in the hippocratic ethos *to a more technical and contractarian model; we contend that the latter fails to capture the essential features of the clinical encounter, in that its presuppositions are abstract and lead to unintended results. Other models have been proposed (beneficence, covenant, care) which seem to better fit the reality of the clinical encounter. In the experimental setting there is a particularly illuminating example of the type of relationship which we find more convincing.*

1. Models of Medicine. Contract, Covenant, Care.

In these last decades, bioethics has been dealing not only with specific substantive or procedural issues related to the medical practice, but also with the general idea of medicine, that is with the model of health care that should be proposed or defended in the future. What are the essential features of such a model? What are the reasons why they have to be implemented? The very fact that we are raising such questions shows that there is a sort of a crisis of the idea of medicine itself.

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Key words: Physician-Patient relationship-Ethics-Beneficence-Autonomy- Covenant

1.1. The traditional model of medicine: the reasons of a crisis

Many are the causes of the crisis of the traditional concept of the physician-patient relationship.

On one side, there are causes internal to the profession. In many countries, medicine is nowadays a public service supplied by a technician; the health care professional is ever more a stranger, from whom the patient expects technical solutions and requests no future personal contact. The patients, as consumers of the health care services, are ready to change their physician much more than they used to in the past, for what they are primarily looking for is a technically excellent service. Correspondingly, it is deemed less important that the physician be a well-known and trustworthy person, bound to the patient by familiar and customary relationships.

Besides, medicine is ever more a specialistic discipline, focusing on organs or bodily parts. This means that the good that is protected (the good of the organ) is quite different from the well-being of the patient, or better, it is just a very small part of it. The physician focuses on the broken mechanism and can hardly be concerned with the ill person's story.

Finally, medicine is nowadays practised as a teamwork and the physician is ever more the captain of a ship, rather than an isolated professional, meeting his/her patient face to face.

This makes the therapeutical relationship even more impersonal and cold; besides, it generates conflicts between different specialists who speak different languages and between the medical and the non-medical (nurses, technicians, volunteers) personnel of the staff.

A second group of reasons are of a *sociocultural kind*. Citizens nowadays ask for a better quality of life, are well informed on health care, are conscious of their rights. They are eager to get more information and to be involved in the clinical decision about themselves. They sometimes even set up groups of self-help in which no physician has a leadership. These are democratic groups who call for the physician when in need, but who are ready to do without him/her. Many of these groups claim the priority of prevention over cure, of environment over drugs, of the political over the medical power.

Besides, pluralism must be considered: in our societies there are many visions of the world, many ethical theories, and therefore many interpretations of the concept of health. The medical model of health is not unitary anymore, and physicians are urged to satisfy the many requests for health expressed by citizens. Just think of assisted procreation and aesthetic surgery.

The increased power of medicine in relation to the beginning and the transformation of life also contributes to this process. The physician, as if he/she was an *apprenti sorcier*, not only makes men/women healthy, but even seems to be able to produce new human beings. Medicine is thus not only therapy but aims to the improvement of the human kind: the ideal of a healthy person is not the physician's business, but it depends on the preferences of the public.

Finally, another element limiting the professional's independence is the cost and sometimes the dangerousness of treatments (e.g., the liberation of a pathogenic virus from a laboratory or the transmission of genetic modifications to the future generations). It is up to, the society to decide how many resources to allocate for medicine, how much freedom to allow to the researchers, and by what criteria biomedical activity can be judged just or fair or good.

1.2. The technical and contractarian models

As a consequence of the fall of *medical paternalism* and in the attempt to respond to these historical and cultural thrusts, many have proposed a technical model of medicine. In this view, medical practice is regarded as a job, characterized by the technical services it offers. The physician must only have the theoretical knowledge and the practical expertise sufficient to accomplish the patient's requests; it is not the physician's job to assess the consequences of these requests on the patient's overall good or to judge their moral quality. At the most, the physician can refuse to comply with these requests on the basis of his/her own moral principles. The physician's independence from the economic or political powers does not make any sense: the physician just does what he/she is asked by someone who has money to pay him/her or the power to give orders to him/her. As a technician, he/she promises only to correctly carry out his/her job.

The technical model of medicine can take different forms. The first version is the mere commercial one, the market model, in which health is considered as a good whose price depends on business transactions. The professional is a well-paid technician who supplies a product. The higher his wages, the more the requirements he/she is committed to comply with, and the risks he/she is willing to run. Each citizen chooses the ends and asks the physician to supply the means.

A second version suggests that society should supervise this contract and should reserve the right to intervene in difficult situations or for reasons of public interest.

Still another version interprets the physician's duties not as referred to the patients but to the medical lobby. The medical corporation makes an agreement with the patients' associations and then chooses the physicians who are willing to lend themselves for certain types of cure. This form of the model is perhaps similar to Ivan Illich's proposal: the control on the physicians and the fight against the medicalization of life must be implemented by *the union of drug addicts into consumers' associations* and by *public controls on the professional mafia*.

All these versions are characterized by the centrality of the *contract*: what a partner asks, the other must supply, provided that it is written in the contract and that the wages are fair. There is no limit to what the contract may provide for, except for the case in which the health professional should find disgusting a particular clause. However, the physician has no right to ask himself/herself whether professional ethics is offended, for this ethic is nothing but a technically correct performance of a service.

This technical model may also be called the model of autonomy, for the principle of autonomy (that is, the priority of the patient's wishes) gains decisive weight: you have to respect and implement the competent and free demands of your patient.

1.3. The therapeutical encounter: the limits of autonomy

The technical model is not at all a value-free model. It is not even a simple, or the only possible procedure in a pluralistic society. On the contrary, it is a model resulting from particular and not unquestionable moral and anthropological assumptions. To prove this, it suffices to consider a misunderstanding to which that model leads. It is not true, indeed, that the therapeutical encounter is the meeting of two symmetrical and detached partners who agree on the clauses of a contract, who try to make their business each on his own, and who require full information on possible future events before they commit themselves to such a relationship.

The physician-patient relationship cannot be reduced to a contract of this kind. It is right, for example, to obtain informed consent from a patient, but it is not possible to have a written consent form concerning every moment of the cure. Not only is this impossible (for it would demand that one should give an enormous amount of information and there could always be unforeseeable situations), but it is also dangerous, because it would paralyze the healing relationship, giving it an impersonal character.

The model of autonomy rests on some prejudices:

a. the *intellectualistic* prejudice: the event of illness is reduced to the breakdown of a part, whose mending may be performed (by the patient, with the physician's help) with detached, rational objectivity, by a subject who in the end is not really affected by it. On the contrary, illness is a personal event, inscribing itself in a man's or a woman's story, and affecting such a story. It cannot be objectified because introduces disorientation in life, a sense of uncertainty and instability: that's why the experience of illness is always expressed metaphorically. We talk of illness as something affecting the very heart of man, as the threat of *fainting*, of *not being able anymore*, of *falling*. We represent it as an *enemy*, a *stranger*, a *stain*, a *corrosion*. Whatever be its representation, it makes uncertain the very horizon of my will and freedom.

b. the *individualistic* prejudice: the individuals' identity is understood as completely defined before any meeting and mutual recognition of theirs. Thus, from this atomistic point of view, the social roles and functions, exterior and changeable in their nature, have nothing to do with the personal identity of the partners of that meeting, and in the end such an identity is not at stake in these transactions. Starting from an individualistic and atomistic conception of man, one is led to interpret the interpersonal relationship as a contract drawn by isolated and perfectly *autonomous* entities (i.e., able to give norms to themselves). Men are exclusively guided by the search for their material interest (in the contractarian hypotesis two persons sign a contract only because each one foresees an advantage for himself). The subjects have a self-centred equilibrium long before entertaining relationships with others.

I build up myself by myself: this is the individualistic maxim. I do not need any recognition by the other, because in the end I am not involved in the relation with him/her. I do not owe him/her anything as he/she does not owe me anything, before both become engaged by stipulating a contract.

c. Finally, a *legalistic shift* is possible: in the contractual model, the physician must only perform a series of actions, nothing more and nothing less. He is not requested to participate in the understanding of the patient's story. His/her aim is just to avoid legal accusations. We may call this engagement *minimalistic*, or *defensivistic*.

1.4. The beneficence, covenant and care model

The patient, who fears the threat of illness, asks for help not only in a technical sense (the mending of the broken mechanism), but also in a moral sense. That is, he/she asks for reassurance and for reasons to hope behind the disgrace that hits him/her. The physician, as every health professional, is not a shepherd of souls, nor a preacher, nor a confessor: thus, he/she has no competence to offer for the search of salvation. However, he/she is involved in the fight for the freedom from illness and evil too. The physician testifies to be on the patient's side if he/she takes to heart what happens to the patient and promises to accompany him/her and to take care of him/her. The caring person thus promises to remove the threat, as far as this is possible, to kill the pain, not to withdraw from giving comfort even in the imminence of death.

In illness, one who is in necessity *(Not)* asks for help *(Hilfe)*, and receives care *(Sorge)*. The triangle *Not, Hilfe, Sorge* (in German authors) is not only medical, but typically human. Just think of *Sorge* as trascendental characteristic of Existence (*Dasein*) in Heidegger. Thus, in the therapeutical encounter a radical bond among persons is more evidently manifested: we could say that medicine is but a more technically sophisticated expression of *solidarity*, of the *original* proximity that binds persons.

The technical model of medicine fails to see the proximity that binds the healer to the patient, because it does not see the proximity that binds the human kind: it is a demanding proximity. It requests that the patient be true and trusting, showing what he/she formerly hid out of shame. That requests that the physician be competent and willing to help the suffering even at the cost of some personal risk, to understand patient's story and to hold preferences and demands by the patient in due consideration. If I do not understand the patient's fears and hopes and I do not respect his/her freedom, I will not be able to act for his/her good.

This willingness to help constitutes for every physician a calling that cannot be given up, and it cannot be the object of a contract, nor of external pressures nor can be twisted by economic interests. What is historically negotiable are the concrete forms in which the physician's action can be performed.

Many are the ways in which the philosophy of medicine and the ethics of the therapeutical relationship have tried to describe this second model of medicine. I will just mention a few of them:

a. *Health care as beneficence in trust*, in Pellegrino and Thomasma's words. The physician commits himself/herself to acting in the patient's interest and the patient answers with a credit of confidence. What is the patient's interest the physician is committed to promote? Which patient's good does the physician take care of? The physician commits himself/herself to give a specific service relating to the promotion of the psycho-physical conditions (the basic, or penultimate conditions) that allow the full exercise of freedom (freedom seeks the ultimate, or supreme patient's good: happiness or salvation). These psycho-physical conditions are: the defence of life, the promotion of health, the killing of pain.

b. *The covenant model*, in W.F. May's words. The physician offers himself/herself for a covenant. The contents of this covenant (*I* *will never break my promise to heal you*) is not as specific as the clauses of a contract: without a covenant, a contract could never be well grounded and guaranteed, for too large is the gap of knowledge between the partners.

c. *The ethics of care*, in W.T. Reich's words. Medicine is a scientifically grounded way of putting up a stranger who is alienated from his/her world because of illness. Medical beneficence is rooted in the solicitude, in the experience of being creatures who care and are cared for. To care means being attentive to the needs of the other.

P.L. Entralgo also wrote:

> *A person who offers help to the necessities of an other: this is the general foundations of the medical relationship.*

This relationship of help (that may assume the traits of friendship) calls for empathy and a sincere will to cure, readiness for every need, almost a second nature. An *enlarged* concept of care, a care that is not only the taking of illness, but also the indefinite promotion of health is proposed by L. Lombardi Vallauri. Medicine, in the end, will deny itself in morality and politics. An *enlarged* care is also proposed by the marxist tradition (see, for example, G. Berlinguer): medicine must heal, but also denounce the socio-economic causes of illness: this is the true prevention.

d. Medicine as *Wissenschaft und Humanität* (science and humanity), in K. Jaspers' words. The physician is a person who is expert in science, or better in many sciences, for he/she uses a lot of knowledges (biology, physics, psychology) and he/she must know the limits of them, and where one gives way to the other. It is not the physician's job to find the meaning of illness and to lead the patient to the salvation of his soul (Jaspers was very critic towards A. Jores and V. von Weizsäcker). Medicine, however, is action-in-the-world; it is an example of *Weltorientierung*, in which two persons meet at various levels. The technical and physical level is only one of them. At the highest, existential level, the physician does not have any peculiar competence: the physician is a person faced with another person, a reason in front of a reason.

Jaspers' teaching is still topical. I think of F. Hartmann works, dealing with *Medizin als Praxis*, and not only *als Wissenschaft*: he denounces today's hypertrophy of diagnosis compared to the therapeutical praxis.

Both in the *beneficence*, in the *covenant*, and in the *care* model the physician's *virtues* have great importance. We could say that to the patients' rights (to be cured, respected, and understood) there correspond specific duties for the physician (to cure, inform, listen, keep secrecy). However, these duties (the objective side) would not be fulfilled if the physician did not possess the proper human and professional qualities. Virtues are exercised dispositions of the will that are so natural for an agent that they become almost a second nature of his/her: diligence, sensibility, discretion, generosity, truthfulness.

Many virtues constitute a character, that is a personality, the human and professional type that each physician is, in virtue of his individual *ethos*. However, this character must be periodically verified, in order to avoid arbitrariness. This can be accomplished by comparing the type of physician that one is, with the ideal to which the medical profession is committed. It is bioethics' job to critically analyze the model of medicine that an historical age has set as an example to imitate. Bioethics must rationally verify the coherence of the moral values that such a model regards as fundamental. Bioethics can justify those situations in which a single physician can decide, on moral grounds, to follow his/her conscience instead of the conduct proposed by the association of health care professionals.

2. *The physician as caregiver and researcher*

2.1. *Two different relationships*

In the clinical setting the physician is faced with problems which result mainly from his responsibilities as a clinician. Yet the scientific structure of contemporary medicine implies that an ever increasing effort be devoted to the development of sound experimentation for the validation of new treatments. Thus, when the physician meets the patient, the former may happen to have two aims in mind, which interact with each other: to *cure* and to *know*.

One might say that the purpose of medical knowledge is always of a *practical* kind, because the aim of biomedical research is first of all to improve our means of curing people; and, therefore, one might argue that there should be no conflict in the activitiy of the clinician-researcher, because the scientific aim is always connected with the practical aim of curing. The facts are not so simple, anyway: to take care of a *particular* patient *here and now* might be quite different from trying to verify the efficacy of a new treatment in this patient *for a number of patients who will suffer from the same condition in the future*.

The source of possible conflicts, we would suggest, lies in the different natures of the relationships that are established between, on one side, the caregiver and the patient and, on the other side, the researcher and the subject (patient or volunteer) involved in a protocol. The healing relationship is one where the patient comes to a doctor seeking help against the threat of an illness; the patient feels impotent and incompetent against this threat, and the answer of the physician is to put his knowledge and abilities at work in order to provide the best treatment available. Thus, the healing relationship is *in primis* dyadic, and the medical profession one in which the physician promises to act in response to a need of the patient.

In the experimental situation, the dynamics of the relationship are somehow reversed: it is the resarcher who, in a sense, *needs* the cooperation of the patient in order to be able to do the experiment. It is of course true that, in a therapeutic experimentation, the expected benefits concern first of all the patient herself or himself, but, *at the same time*, there is always, in the background, a *third* person - the *future* patient - for whom the clinician-researcher is trying to validate a cure. Without the willingness to cooperate by a number of patients, the experiment simply could not take place. Thus, the first step in this relationship is the proposal by the researcher to the patient to participate in a research project, solicitating him or her to be willing to share in its goals. This kind of *partnership* is therefore open to the pursuit of benefits also for others (whom the patient himself might never meet). It is a *triadic* relationship, in which both the researcher and the patient must be aware of the social relevance of their mutual cooperation.

From a global point of view the healing relationship always has a social dimension. The physician has a mandate by the society to operate in the interest of ill persons in general; the status of the profession itself requires the physician not to be too devoted to a single patient but to be able to treat as many diseased people as he reasonably can. And, on the other side, especially in the complex health care systems of our advanced societies, the patient himself is sometimes forced to recognize that there can be priorities in providing assistance and care. Yet, caregiving implies, to use the words of Paul Ramsey, a *canon of loyalty* or, to use another recurring image, a *covenant* which is defined more by the reciprocal duties than by the possible responsibilities towards others.

Thus, for example, the physician-as-caregiver would probably deal with experimental treatments only when they were strictly therapeutic, and only in case of extreme need (e.g. lack of any effective therapy), while the physician-as-researcher might reasonably propose a patient to participate in an experiment which has far less outstanding perspectives, implying only minor advancements in therapy, or even, provided that certain conditions are met, in a non-therapeutic protocol.

2.2. *Possible conflicts*

As Edmund D. Pellegrino has pointed out, the leading value of science is the pursuit of *truth*, and therefore such values as knowledge, freedom of research, universalizability of results, rigour of the experimental design play a very important role in the scientific activity. On the other hand, *beneficence* is the value which gives shape to the enterprise of medicine in general and it is a background for the more restricted values of the benefit of the patient, respect for autonomy, compassion, trust and truthfulness. The physician as caregiver-and-researcher is therefore exposed to situations in which these two sets of values, to which he or she is at the same time committed, might come into conflict.

For example, obtaining a truly free and informed consent for an experimental treatment from a patient who is seriously ill and who puts his trust first of all in the physician-as-caregiver might be seen as, in a sense, hardly possible. Such a patient might not be able to understand all the discomforts and risks of the experiment, and he or she might accept too easily any kind of proposal coming from the physician. The honest physician finds himself or herself in an awkward situation when he or she knows that the patient would not oppose any experiment which might give a chance for hope; clearly, the patient's autonomy in such cases is not full, and yet the physician is willing to offer a treatment which needs to be tested. In such a situation the responsibility of the physician is increased, we contend, in terms of *beneficence* rather than in terms of pursuit of scientific truth: the decision of presenting the patient with the possibility of participating in a research must be taken for the patient's interest, i.e. when the physician has reasons to believe that participation in the experiment can really benefit the patient, whatever arm of the protocol he or she will be assigned to.

Another conflict may take place when the physician is wondering whether to stop or not an experimental treatment for one or more patients: interrupting the experiment might have as a consequence invalidating the research and not being able to give any meaningful result; or, less dramatically, it may mean to obtain less data because of the withdrawal of some patients. On the other side, the physician may perceive that the patient is not benefitting from the treatment, although the patient herself might be not willing to withdraw. The case can be even more complicated when the study is a randomized, double-blind one: should the physician break the code of randomization when he or she thinks that the patient is in a less beneficial arm of the study? Or should he or she simply suggest the patient to withdraw? It is a general rule in similar cases to let the benefit of this individual patient take precedence over the benefit of research, but at which point the balance between the two is lost cannot be decided in advance. The physician is obliged to make a *discernment* in each case, applying the general rule with an act of *prudence* of his or her trained moral conscience: the risks and the damages (also in terms of loss of a more appropriate therapy) must always be proportionate to the foreseeable benefits for the patient. Furthermore, as we will argue in the following, the decision-making process, especially concerning such dilemmas, should always involve the patient himself or herself: for this reason the informed consent is meant to be an ongoing process and a particular moment of the general continuous communication process between the physician and the patient.

The use of placebos poses other difficult problems, especially in those areas where effective standard therapies are relatively rare. A new treatment is best verified if compared with placebo, but such a procedure, though recommendable from a scientific point of view, is clearly unethical when standard therapies are available. To use or not to use a placebo has different relevance for the researcher than for the caregiver, although this conflict poses itself in an earlier phase than the clinical setting, i.e. in the design of the protocol. Placebos should always be justified on a solid evidence of no effective therapy available for the same condition, and should always imply a full disclosure to the patient concerning the procedure; and finally, the review by an ethics committee should be sought by the researcher on every such occasion.

A last, but sometimes relevant example of conflict takes place when the clinician-researcher is proposed to work out a protocol the meaning of which is mainly *bureaucratic* or commercial, or even futile in terms of scientific interest. Such cases happen not too rarely in relation to already well known drugs which are still waiting for registration in a particular country, or in connection with slight changes in the preparations or in the dose regimens, or just as the result of the competition in the free market. In some cases, the problem might raise because the physician-researcher somehow depends (also) from the sponsor for his or her incomes as a professional. In such situations it has been suggested that the researcher and the caregiver be two different persons, working in close cooperation with each other but with a clearly defined role and aim for each of them. Apart from cases in which a competent and responsible ethics committee would refuse approval for a particular protocol, the patient should be made aware of the relative importance of the experiment and be fully free to express his or her willingness to participate in or withdraw from the experiment.

2.3. Autonomy-in-trust *and joint decision-making*

The responsibilities inscribed in the two roles of the physician as caregiver and researcher can be tied together in the formula *autonomy-in-trust*, suggested by Edmund D. Pellegrino. This suggestion results as an analogy of the more famous formula *beneficence-in-trust*, already quoted: in the healing relationship the physician is asked by the patient to do the best for his or her benefit. This *benefit* is largely variable in different patients, depending not only on their physical conditions, but also on their perceptions, their convictions, and the place they give health in their overall conception of the good (the *final* good, the good of the *person*, the *subjective* good of this patient); and yet, the determination of some aspects of the good of the patient in the clinical setting (i.e. the strictly *medical* good) can be done only by the physician, who is therefore afforded a special trust in deciding, for example, which examinations or interventions are most important.

It is generally recognized that scientific research should have a certain autonomy from the pressures of everyday clinical activity, otherwise it would be impossible to pursue serious and reliable results. But when research and clinical activities interact in the same person (and *with* the same person, the patient) the autonomy of scientific research must be strictly connected with the moral basis of the healing relationship, i.e. with the *trust* which the patient poses in the physician. For this reason, the special autonomy of the clinician-researcher is said to be an *autonomy-in-trust*. This means that the physician who is at the same time caregiver and researcher is recognized to have a particular power in the decision-making process, but that the limits of that power are just those set by trust: to break the basic bond of trust with the patient would be unfortunate not only for this patient but for the general trust in the medical profession as well. To aim first of all at promoting the good of this patient and at preserving the trust in the physician as a person and as a professional are responsibilities which make the role of the researcher a very prudent one.

This perspective stresses the duties of the physician, defining the nature of his or her freedom (*autonomy* is not just *free will*) and its limits. Yet, the patient also has a role to play in such situations: as we have suggested, the decision to participate in an experimental protocol implies the willingness to share in sociality to the point of running some risks for the sake of others. Such a decision is a noble and praiseworthy one, but in order to be also an authentic one it must result as a part of a more complex relationship between doctor and patient, in which a fundamental role is played by *communication*. The present emphasis on informed consent in contemporary medical practice is only a legalistic constraint if it is not considered in the context of an ongoing communication. The point is that the patient should be ever more involved in the process of decision making concerning how his or her illness is going to be treated: being health a very personal value, the general life style and convictions of the patient heavily influence the weight and the meaning given to many kinds of medical interventions. While we argue elsewhere that the patient cannot be considered just as a partner on a level of parity with the physician, we contend that the involvement in the decision making process is essential to make the patient understand the situation and have an active role in facing illness. Thus, the process of decision making in the clinical setting assumes the feature of a joint enterprise to give the proper meaning to the time spent with illness. For this reason, we think that the physician should give up his or her sometimes paternalistic attitude and make as frequently as possible the patient aware of the possibilities which lie ahead of him or her. That the caregiver is also a researcher, who is trying by profession to improve the ability of medicine to cure people, might be seen as an invitation or an occasion for the patient to correspond to these efforts of the scientific community with an act of willingness.

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Articoli/*Articles*

CANADIAN PHYSICIANS: THE STRUGGLE WITH HEALTH REFORM

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SUMMARY

The Canadian health system is now in an era of significant change. Decentralization, the changing role of government, consumer movement and new views on health greatly affect physicians' relationships with patients, consumers and other health professionals, and will determine the governance and mandate of medical associations. While the Canada Health Act requires coverage of all medically necessary health services provided by hospitals and medical practitioners, the understanding of the term medically necessary *appears to be changing to include issues related to financial sustainability and scientific appropriateness. As governments become interventionist in the health care system as a reaction to fiscal imperatives, their traditional role as funder and planner is changing as they begin in a more explicit manner, to manage the health care system and to engage in directly influencing patient management decision-making. These new directions will have a major influence on the practice of medicine in the 21st century.*

In Canada, there is strong public and political support for the basic principles that underlie the health care system. Indeed, for most Canadians, the national public health insurance system is a significant social, cultural and economic achievement[1]. How-

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