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Articoli/*Articles*

THE FUTURE OF THE DOCTOR-PATIENT RELATIONSHIP IN A WORLD OF MANAGED CARE*

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SUMMARY

Today, the doctor-patient relationship is strictly linked with the larger context of the medical profession and the managed care revolution. This articles focuses on three important questions: 1. In the U.S, how did we arrive at the current situation where the DPR is under sustained assault and is now being used increasingly as a mechanism of cost control? 2. What approaches will be used in the managed care setting to limit and control the decision-making freedom of patients and doctors within the doctor-patient relationship? 3. Will the doctor-patient relationship, as we know it, survive the managed care revolution?

Introduction

In considering what effect the development of managed care in the United States is likely to have on the doctor-patient relationship, it is necessary to place the doctor-patient relationship within the larger context of the medical profession. My definition of the medical profession is a trained segment of society dedicated to improving the health of the population by two principal approaches: *public health and hygiene* (housing, nutrition, safe water, clean air),

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and second, *direct medical services*, often provided or supervised by individual practitioners within a doctor-patient relationship.

The opening paragraph of the Hippocratic Oath includes an important reference to these two fundamental approaches to health: the paragraph reads (in the English translation by Ludwig Edelstein, 1943):

> *I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant.*[1]

There are four gods referred to in the opening paragraph of the oath - Apollo is the god of light and truth. Asclepius, the father of medicine and a semi-divinity, was the child of Apollo, and had two daughters, two goddesses. One was Hygieia, the goddess of health, or in modern terms, the goddess of health maintenance and disease prevention. The other was Panaceia - which means *all heal*, the goddess of curing illness or of treatment. My paper focuses on the doctor-patient relationship and is therefore concerned primarily with the role of Panaceia - who is responsible for treatment and healing. I also will restrict my observations to the doctor-patient relationship in Western Medicine, primarily in the U.S., because that is where I have practiced and observed medicine for more than thirty years.

1. The thesis of the paper

In my view, the managed care revolution is more than a medical or economic revolutions; it is a true political revolution designed to achieve a major intergenerational shift of support from the elderly to the middle-aged and in the process to contain health care costs. In the United States, where it is political suicide to talk of withdrawing support from the elderly or to talk explicitly of rationing, the method that is being used to achieve these goals is implicit rationing that involves controlling the doctor-patient relationship. Specifically, to achieve implicit rationing, it is necessary to control the autonomy of physicians and patients to make discretionary decisions that provide the patient with a *marginal benefit* as viewed from the patient's perspective.

Managed care, especially competitive, for-profit managed care, has rapidly emerged in the U.S. as the organizational structure through which dyadic doctor-patient decisions will be subjected to external oversight and control in order to restrain health care costs. In 1995, in the U.S., more than 50 million people were enrolled in a formal managed care organization and probably at least 50 million more received health benefits through some type of managed care arrangement. Recent reports suggest that the managed care approach is working economically as the increase in health costs, initially projected at 12% per year, has declined to below 8%. Managed care combines incentives and penalties to encourage physicians to balance their patient's welfare against other institutional and societal goals especially the goal of cost containment and perhaps social justice. Since the primacy of the doctor's commitment to the patient's welfare is attenuated, the doctor-patient relationship is changed from its Hippocratic tradition focusing primarily on the individual patient to a new model that takes account of institutional and societal needs.

The central questions that I will examine today are the following:

1. How did we reach a situation in the U.S. where the doctor-patient relationship is under sustained assault and is now being used by managed care organizations as a mechanism for cost control?
2. What approaches will be used to limit and control the decision-making freedom of patients and doctors within the doctor-patient relationship?
3. Will the doctor-patient relationship, as we know it, survive the managed care revolution?

Question 1. In the U.S, how did we arrive at the current situation where the DPR is under sustained assault and is now being used increasingly as a mechanism of cost control?

A. Health care costs.

In the U.S., concerns about the cost of health care have escalated into a crisis for at least the following 4 reasons:
1. U.S. costs are, absolutely and on a *per capita* basis, and as a percent of GNP, greater than in any other country in the

world. In fact, the U.S. health care budget of almost $1 trillion is comparable to the GNP of some of the largest industrial countries in the world.

2. Until the past year, the annual rise in health care costs of about 12% was more than 4 times the rate of economic growth and there was no suggestion that health costs were coming under control.

3.The burden of supporting health care costs was falling increasingly on a smaller number of younger and middle-aged workers.

4. Despite massive expenditures on health care, the U.S. continued to have the worst access to health care in any developed nation with regard to the poor, the unemployed, the employed/poor, and infants and children. There is a general agreement that to improve access to care for the 40 million uninsured or underinsured in the U.S., it would be necessary to bring health care costs under better control.

It is easier to describe what happened in the U.S. than it is to explain why it happened. I think the American political tradition encourages the rhetoric of fairness and equality and also the rhetoric of libertarian self-determination. Americans want to offer unlimited and equal access to the best care available and to permit everyone to make their own personal choices about health care. The struggle to accomplish both these goals, with no principle to limit one or the other, has resulted in rationing by access rather than rationing by restricting either the excellence of care or the freedom of choice for those who have insurance that gives them access to the health system. As I mentioned a moment ago, current thinking has it that in the U.S. it is essential to control costs in order to broaden access. And, as I said earlier, the free market, competitive managed care approach, is the one that is currently regarded as offering the best hope to achieve this goal. The decline in the rate of increase in health care costs during the past year - the first such decline in almost 30 years - signals that the managed care approach to controlling costs may be working.

But the final answers are not in. Although managed care has enrolled more than 50 million individuals, most of them have

been relatively healthy, young or middle-aged, and generally employed. The real tests of the managed care approach are coming. Managed care has not yet proved it is capable of providing cost efficient care for the chronically ill, the disabled, the elderly, the poor, and other vulnerable patient populations. Nor, for that matter, has managed care been supportive of or committed resources to support many other important features of the health system (features that also contribute to costs) including improving access to care, improving the quality of care, supporting medical education, or supporting medical research.

B. The Three Ages of Medicine

The history of the physician-patient relationship in Western medicine can be divided into three periods: the age of paternalism (the age of the doctor), the age of autonomy (the age of the patient), and the age of bureaucracy (the age of the payer).

The age of paternalism lasted thousands of years from about 500 B.C. to 1965 and represented the basic authoritarian and sacerdotal strain in medicine. This model of medicine - the physician-in-charge model - was premised on trust in the physician's technical skills and moral stature, on the ethics of beneficence, and was characterized by patient dependency and physician control.

Medical achievements during this lengthy period were rather modest and not very expensive. Medicine provided symptomatic care rather than cure; it emphasized the power of information (the prognosis), which was a mystery known only to trained physicians; it was better able to deal with psychological than with physical aspects of disease; and it taught principles of hygiene and preventive health care. In light of our modern ideas about scientific medicine, we are often struck by how long this older and much less effective medical system was respected by men and women. We are thus forced to realize that for all its limitations, this traditional and relatively ineffective system of healing must have addressed and satisfied many basic human needs for most of the patients it served.

The age of autonomy (the age of the patient), by contrast, lasted at most 50 years (1945 to the present), and still may not have

emerged completely in some countries. I refer here largely to my experience in the U.S. Technically, this was an age of extraordinary advances in the understanding of disease, and in the development of remarkable medical and surgical therapies. It was an epoch that emphasized treatment rather than prevention, cure rather than care, and in contrast to the earlier age, prove to be very expensive.

Especially in the U.S., the theoretical balance of power also shifted subtly from physicians to patients. Many ethicists, legal scholars, and patients began to assert that the foundation of the doctor-patient relationship should be based on patient rights and informed consent. Informed consent was a key concept. The rhetoric of this age was libertarian and consumerist and the medical air was filled with cries of *autonomy... self-determination... patient sovereignty ... freedom from paternalism...* and the like. My own view is that remnants of this informed consent model will carry over into the 21st century, but in most developed countries the second age never existed with the force that it did in the U.S., or if it did, it is gradually being supplanted by the third age.

The third age, *the age of bureaucracy* (the age of the payer) has arrived. This new era demands cost containment, cost efficiency, and is based on societal risk-benefit analyses. Quality of care, always so hard to define, is no longer an end in itself, but is now balanced against cost of care, which is much easier to quantify. Physicians in the age of bureaucracy will be divided in their allegiances because they will be serving the conflicting demands of society for social justice and of their patients for personal care.

In the previous two eras, the patient's *good* was the dominant concern for physicians. In the age of paternalism, it was the patient's *best medical interests.* In the age of autonomy, it was the patient's *freedom and right of self-determination.* In the new era, however, the patient's good will be balanced against other goods such as the needs of society. Decision-making no longer will be vested exclusively in the hands of physicians or patients.

Physician paternalism and patient autonomy, particularly with respect to medical decisions, will be replaced by institutional and societal efficiency and expediency, based largely on

cost concerns and societal needs. These measures of efficiency have emerged rapidly as the major elements in decision-making in the third age of medicine. In contrast to the two earlier ages, the wishes of both patients and physicians will be subservient to the wishes of administrators and bureaucrats. All of this implies that dramic changes are occurring in the traditional doctor-patient relationship as it has evolved in this century and in the process of decision-making.

C. The Multiple Roles of the Physician

Alistair McIntyre suggested some years ago that the modern physician played three simultaneous and intersecting roles in the doctor-patient relationship: 1) the physician as magical healer; 2) the physician as applied scientist; and 3) the physician as bureaucratic administrator[2]. McIntyre's view struck me not only as an accurate rendering of the modern physician, but also, to some degree, an adequate description of the evolution of the doctor-patient relationship in the 3 Ages of Medicine. In earlier times, before the scientific revolution, the primary physician role was a magical healer; in the scientific era, the role increasingly became that of applied scientist; and in our modern era, the physician plays an increasingly complex role as bureaucratic administrator. In describing the physician as bureaucratic administrator, McIntyre anticipated one of the major problems in the third era of medicine - the age of the payer - and that is, who has the right to determine the patient's goals - the patient or the bureaucracy?

D. A Decision-Making Approach

In our book, Clinical Ethics[3] Al Jonsen, Bill Winslade, and I proposed that clinical and ethical decisions in medicine were based on the 4 following considerations: 1) medical indications; 2) patient preferences; 3) quality of life considerations; and 4) external factors. At a later time, we sometimes represented these considerations in a 4-quadrant box where medical indications and patient preferences represented the 2 upper tiers of the box and quality of life and external considerations, the 2 lower tiers. The paradigmatic case was one in which a physician reached a

diagnosis and proposed a plan to the patient. Because the goals of the patient and physician are usually quite similar, in the vast majority of instances, under the doctrine of informed consent, the patient accepted the physician's proposal or negotiated a modification of the recommendations. The key point here is that in the U.S. from 1960 to 1990, the vast majority of clinical-ethical decisions were based primarily on medical indications and patient preferences, an approach consistent with Hippocratic ethics. Physicians hesitated to make decisions for patients based on third-party assessments of the patient's quality of life or on external considerations such as cost or scarce resources.

During the past 5 years, however, in the third age of medicine, the decision-making approach has begun to change. There is a sense in the third age of medicine that in the interest of cost containment patients and physicians cannot be permitted to make any decision they want without external review and oversight. The reason for this is the concept of *marginal benefits*. In the Hippocratic tradition, the patient and doctor will always try to maximize the marginal benefits for the patient. Even if there is a 1% chance of benefit, the attempt will be made regardless of cost, especially if the cost is borne by third-party payers. To limit this freedom of choice in the interest of cost containment, there had to be a societally-tolerated mechanism for gaining control of the decision-making process (to restrain pursuit of marginal benefits) even though in doing so limits would be imposed on both patient and physician autonomy. This is what the managed care revolution is all about and the next section of my talk will explore some of the mechanisms now being used to control the decision-making process and the doctor-patient relationship.

Question 2. What approaches will be used in the managed care setting to limit and control the decision-making freedom of patients and doctors within the doctor-patient relationship?
Five ways in which patient and physician autonomy and self-determination will be limited.
1. End-of-life decisions. Patient autonomy, particularly for end-of-life decisions, may become a one-way street. Patients will always be allowed to express their autonomy by saying,

Enough is enough - stop my treatment; however, they will rarely be listened to when they request that expensive end-of-life care be continued and their physicians disagree. Everybody will be encouraged to say no, but making positive claims will be difficult. In fact, how can physicians respond to patient wishes when physicians' discretion, in turn, will be limited by third-party payers, government regulators, and institutional policies and procedures.
2. Futility standard. Decision-making discretion will be limited by the futility standard, an issue that Professor Jonsen will address in the next talk. Futility is another way to obtain control over patient and physician choices. If a third party decides that a 3%, 5%, or 15% chance of success qualifies as *futile*, that party can quickly cite a statement such as that by the American Thoracic Society: *A life-sustaining treatment intervention can be limited* without the consent of patient or surrogate *when the intervention is judged to be futile.*[4]
The point about futility is that it changes everyone's clinical, ethical, and legal responsibilities to continue treatment. It alters the need for discussion and negotiation with patients and families. In fact, it changes physicians' opportunity to provide care because physicians and hospitals will be restrained by payers and managed care organizations from providing *futile* care. I see the emerging futility standard as a key in the shift from a personal standard of care to an externally imposed standard. Practicing physicians know that patients are often less interested in the *probability* of success than in the *possibility* of success. What are *my* chances? Can I benefit? Might I get a *marginal benefit*? Those types of personal choices will likely be limited by an externally imposed futility standard.
3. Quality of life standards. Discretion will be limited by a quality-of-life standard. This standard is an extension of futility. An external party may say, *Although you can achieve the specific goal that you are pursuing [that is the goal is not 'futile'], in our opinion, your quality of life is so bad, it is not worth pursuing that goal.* The patient's health status is regarded as an undesirable quality of life; thus, even if an infection can be treated successfully and the patient's life sustained, an external party may decide that the

poor quality of life makes it not worth doing. A quality-of-life standard might be applied initially to persons in a permanent vegetative state. In the future, however, limiting the types of people to whom such a standard could be applied may prove to be difficult. For example, a quality of life standard could be applied to persons with Alzheimer's disease, to profoundly handicapped persons, or to congenitally mentally retarded persons. In addition, it could be used for many diseases that are regarded as incurable including perhaps drug abuse, alcoholism, or even AIDS.

4. Social Darwinism. Patient and physician discretion will be limited by social utility or social Darwinism, sometimes couched in the language of rationing and allocation of resources. The current catch phrase is *the high cost of dying*, which describes the expenditures on patients during their last days of life. The implication is that physicians should know when a person is dying and therefore should not waste valuable resources. In my experience, physicians frequently invest resources to care for patients in situations of uncertainty. They are unsure whether the patient is dying or whether the patient's life can be saved. Another closely related approach to rationing is proposed by Daniel Callahan, director of The Hastings Center, who suggests that age be used as a specific criterion to allocate resources and to limit health care expenditures.[5] *High cost of dying* language and Dan Callahan's approach represent examples of a social utility strategy that can also be invoked to limit the rights of patients and of doctors to make decisions.

5. Practice guidelines and clinical paths. Practice guidelines will limit patient and physician autonomy. Guidelines were originally conceived to assist medical decision-making, but now they may be used to make the decision. I believe that guidelines will decrease the individualization of the doctor-patient encounter. No two patients are precisely the same; no two patients have identical backgrounds, values, or even physiologic status. Guidelines reduce the need for communication between doctors and patients. The application of guidelines relies primarily on physiologic parameters that do not necessarily include wishes, desires, values, or preferences of patients or physicians.

During the past 20 years, American medicine has emphasized the centrality of knowing and respecting individual patient preferences. The right of individuals to make choices has been defended. Guidelines provide an approach that is efficient and cost-effective for a group of patients. What may be right for a group may not be acceptable to individuals within the group. Guidelines obviously limit the freedom and discretion of both patients and doctors and thus change the DPR in substantial ways.

In summary, the managed care approach to change the freedom of patients and doctors to make individual decisions will employ at least the 5 strategies I have just discussed: autonomy as a uni-directional concept; futility; quality of life standards; rationing by disease or age; and practice guidelines.

Question 3. Will the doctor-patient relationship, as we know it, survive the managed care revolution?

As we contemplate the future of the doctor-patient relationship, our only guides are the past and the present. Despite scientific developments during the past century, the role of the medical profession in human societies has changed surprising little since the time of Hippocrates. Further, since Hippocratic times, the doctor-patient relationship has also changed very little. The encounter of healer and patient (*sufferer*), has remained the principal means by which medicine achieves its goals. There are three reasons the explain the extraordinary *continuity over time* of the doctor-patient relationship:

1. Medicine serves a universal and unchanging human need;
2. Medicine therefore has an unchanging central goal - to help patients; and
3. Most medical help is delivered in the direct encounter of patient and physician, in the doctor-patient relationship.

1. Medicine serves a universal and unchanging human need.

Medicine deals with the most fundamental aspects of the human condition. Birth, life, health, psychological integrity, physical functioning, vulnerability, loss, and death. These are the eternal problems for which patients seek help from doctors in all

countries at all times. Regardless of advances in science or changes in politics, these fundamental aspects of the human condition will always be with us.

When people are ill or have a sense of *dis-ease*, they lose the normal harmony and equilibrium that enables them to enjoy life. At these times, people turn for help to the doctor or healer in their society. That clinical encounter between the patient and the healer is the *unchanging event in medicine*, the constant. In this sense, medicine is the most universal and unchanging of professional disciplines. Regardless of the social, economic, scientific, and political changes that have affected how medicine is organized over the last 3,000 years, the clinical encounter of the doctor-patient relationship, remains virtually unchanged. I don't think that high technology such as intensive care monitoring or cancer chemotherapy will eliminate the need for a personal and caring physician.

2. Medicine has an unchanging goal - to help those who ask us for help and to improve patients' quality of life.

The second paragraph of the Hippocratic Oath makes this crucial point: *I will use treatment to help the sick according to my ability and judgment; I will keep them from harm and injustice.* Almost 2,500 years after the Hippocratic Oath, Dr. Edmund Pellegrino stated the central goal of the medical encounter to be: ... *a right and good healing action for a particular patient in a particular set of clinical and life circumstances.* The poet Valery made the same point: ... *You doctors are the champions in the struggle of the individual life against the law of life.* Medicine achieves this unchanging goal of helping patients in a variety of ways - by talking to people and hearing their fears and concerns; by caring for people and treating them with dignity and respect; by relieving their distress; by attending to their physical pain and psychological suffering; by restoring their ability to function; and sometimes by curing disease. Most of these functions of medicine are delivered in the context of a doctor-patient relationship.

Today, we physicians know far more than our predecessors knew about the science of medicine. The biological revolution since World War II has been one of the great intellectual flour-

ishings in human history - comparable to Greece of the 5th century B.C., or Spain in the Golden Age, or 15th century Florence under the Medicis. Yet, despite the advances in the science of medicine, the central goal of medicine, to help a patient and to improve the patient's quality of life, has not changed.

3. Most medical help is delivered in the direct encounter of patient and physician, the doctor-patient relationship.

There are many ways to help people through the practice of medicine. Since I completed medical school, researchers have developed many new pharmaceuticals (including antibiotics, antihypertensives, cancer chemotherapy); new surgical approach (for example, for cardiac disease and organ transplantation); astounding diagnostic tools to image previously hidden parts of the body; not to mention newer developments in reproductive technology, genetics, and molecular biology. All of these scientific and technical achievements benefit our patients.

But at some point, these new research developments have to be applied in a face-to-face encounter between the person asking for help and the doctor who is prepared to respond. This is the practice of clinical medicine, this is the heart of the doctor-patient relationship, and for 30 years this has been my greatest joy in practicing medicine. It also has been the best and most parsimonious method discovered to provide care.

In discussing the DPR, let me add that the concept of *managed care* is not an entirely new idea. It started as a clinical concept rather than as an economic or administrative approach. The first reference I can find to managing patients appeared in a paper published in 1970 in the *New England Journal of Medicine* and authored by the great physician at Johns Hopkins, Dr. Phillip Tumulty. The title of Dr. Tumulty's paper was: *What is a clinician and what does he do?* Dr. Tumulty answers his own question as follows:

> *A clinician is one whose primary function is to* manage *a sick person with the purpose of alleviating most effectively the total impact of the illness upon that person.* ... Managing *a sick person is entirely different from diagnosing an illness and prescribing therapy for it.* ... Management *means that the physician comprehends and is sensitive to the*

total effects of an illness on the total person, the spiritual effects as well as the physical, the social as well as the economic.

I think the paper by Dr. Tumulty might be a useful guide to the managed care community in that it emphasizes the importance of clinical management and the value of the doctor-patient relationship while encouraging primary care, cognitive services, and the judicious use of testing.

The doctor-patient relationship will be in trouble in the early years of the 21st century. Most developed countries are now struggling with ways to control the high cost of modern scientific health care. It is very expensive to empower patients through informed consent and to give them full range of choices about which health care they want to receive. Some limitations on free choice are essential but no system has yet developed a fool-proof method for establishing such limits. Whatever system is finally established in developed nations, it should rely heavily on preserving the essential elements of the traditional doctor-patient relationship.

Almost 2,500 years ago, in a remarkable passage in Book IV of *The Laws*, Plato recognized that good doctor-patient relationships were required to achieve the goals of medicine. Plato described inadequate doctor-patient relationships, what he called *slave medicine*, as follows:

The physician never gives the slave any account of his complaints, nor asks for any; he gives some empiric treatment with an air of knowledge in the brusque fashion of a dictator, and then is off in haste to the next ailing slave...

Plato contrasted this inadequate doctor-patient relationship with what he called the physician-patient relationship for free men, in which

... the physician treats their disease by going into things thoroughly from the beginning in a scientific way and takes the patient and his family into confidence. Thus he learns something from the patient. He never gives prescriptions until he has won the patient's support, and when he has done so, he aims to produce complete restoration to health by persuading the patient to comply[7] .

The best clinical medicine, Plato tells us, is practiced when physician and patient have concluded a relationship in which the scientific aspects of care are placed in the context of a personal relationship. In this regard, the doctor-patient relationship which establishes a healing bond of trust between two individuals is destined to last. Only in this human relationship, can the benefits of modern scientific medicine be provided to meet patient needs, which have remained essentially unchanged since the times of Hippocrates and Plato. In an era of managed care, informed consent and social efficiency will be in tension. But the healing doctor-patient relationship will never be abandoned because it serves universal needs of both patients and physicians.

Conclusion

While the fundamental aspects of the healing encounter have remained constant over time, some important changes have also occurred in the doctor-patient relationship. Even though medicine serves unchanging human needs and has an unchanging goal, medicine never has been a fully autonomous profession. Instead, from Hippocratic times to the present, the relationship between the patient and the doctor has always been shaped and limited by the prevailing social, cultural, economic, scientific, and especially, political forces. As my colleague at the University of Chicago, Professor Leon Kass, has written:

Physicians have always been obliged to live under the law of their communities. This subordination of medicine is entirely proper: there is more to life than health. Sometimes the pursuit of health competes with the pursuit of other goods, and it has always been the task of the political community to order the different and competing ends.[8]

I agree with Professor Kass. The battle over managed care in the United States is really a political struggle. It is a fight for the allegiance and support of the American middle-class - workers, parents, the middle-aged, and the grown children of elderly parents. Ultimately these people will determine if the managed care revolution succeeds or if it proves to be a false approach that will leave us with a residue of useful reforms that we decide to organize in a different way - perhaps in a single payer

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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