Is it possible to practice good medicine today? [1]

Summary

This article begins by analyzing the essence of medical practice, who performs it, who is considered a good physician, and what governs medical actions. To show whether it is possible to practice good medicine in the current context, how current context factors determine it are examined (economic, political, administrative) and raise the foundations of an adequate medical practice (scientific-technical, humanitarian, inquisitive, strategic, ethical). It shows how contextual factors shape and often restrict medical practice. Those who determine health, de facto and formally, society in general, and physician in her/ his specific practice must consider these influences to have adequate medical practice.

Keywords: medical practice, context of medical practice, determinants of medical practice, fundamentals of medical practice

¿Es posible ejercer una buena medicina en la actualidad?

Resumen

Este artículo, inicia analizando la esencia del ejercicio médico, quien lo ejecuta, a quién se le considera un buen médico y qué rige su actuar. Con el propósito de mostrar si es posible ejercer una buena medicina en el contexto actual, se examina cómo actualmente los factores del contexto lo determinan (económicos, políticos, administrativos) y plantea los fundamentos de una práctica médica adecuada (científico-técnico, humanitarista, inquisitivo, estratégico, ético). Muestra cómo los factores del contexto están moldeando y, con frecuencia, restringiendo la práctica médica. Los que determinan la salud, de facto y formalmente, la sociedad en

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general, y el médico en su práctica específica, debe considerar estas influencias para tener un ejercicio médico adecuado.

Palabras clave: práctica médica, contexto de la práctica médica, determinantes de la práctica médica, fundamentos de la práctica médica

É possível praticar uma boa medicina atualmente?

Resumo

Este artigo começa analisando a essência da prática médica, quem a exerce, quem é considerado um bom médico e o que rege sua atuação. Com o objetivo de mostrar se é possível praticar uma boa medicina no contexto atual, examina-se como atualmente os fatores do contexto a determinam (econômico, político, administrativo) e levantam os fundamentos de uma prática médica adequada (científico-técnico, humanitário, inquisitivo, estratégico, ético). Mostra como os fatores contextuais estão moldando e muitas vezes restringindo a prática médica. Aqueles que determinam a saúde, de fato e formalmente, a sociedade em geral, e o médico em sua prática específica, devem considerar essas influências para terem uma prática médica adequada.

Palavras-chave: prática médica, contexto da prática médica, determinantes da prática médica, fundamentos da prática médica

A. Essence of medical practice

a. What is the essence of medical practice?

There are two fundamental questions to delve into the essence of medical practice: What is medical practice? Medical practice is the interaction of a human, trained and certified in this art, with another human suffering from a health condition. The other question is, what is a medical exercise for? It could be answered as one of the participants in this interaction tries to help the other one to solve a situation that negatively affects the latter's health. Thus, the practice of medicine is basically and essentially the accompaniment of the other in his or her process of health and illness; this is the central function of the physician.

This accompaniment implies a direct physician-patient encounter, as well as an empathetic attitude towards the patient (MacLeod, 1994), humanitarian (Sokol, 2008) (Stewart, 2005), friendly and respectful (Chochinov, 2007) (Arango-Restrepo, 2013) of a physician.

b. Who is a physician?

A physician is considered someone who seeks to cure a sick person. That human being with social endorsement, whether defined by her/his culture as a physician, priest, shaman, or herbalist, uses different kinds of resources to try to solve the health problem of a sick subject, according to his training and socio-historical development of the healing knowledge in her/his culture. Thus, in its etymological sense, the physician is a "caregiver" and is a person who performs healing practices based on revealing, signifying, and intervening conditions that negatively affect a patient's health.

c. Who is a good physician?

There are different perspectives to define what makes a good physician. One of them is medical deontology, which is the set of ethical rules related to this profession and which have been set down in a series of codes and oaths (Karchmer-K., 2012) from antiquity (including the Hippocratic Oath and the Maimonides Oration) to modern

times (including the Declaration of Geneva and the International Code of Medical Ethics); as well as guides to good medical practice, some of which include the British (Council, 2024) and the Australian (Australian Health Practitioner Regulation Agency, 2020).

In its part, from current medical practice perspective, there are several criteria to consider who is a good physician; among these are the physician's ability to heal and to relate to patient and his or her caregivers, as well as the possession of ethical and moral values (Ibanez et al., 2010), and capacity for teaching, research and continuing education (Steiner-Hofbauer et al., 2018). In addition, to have a high level of applicable knowledge depending on the situation, quick problem-solving skills, trustworthiness, the ability to act professionally even in stressful situations and under pressure, a high degree of self-control, and not to take risks thoughtlessly (Hofhansl, 2015). Likewise, showing humanity, support for the patient, and respect for the patient's autonomy (Schattner et al., 2004).

A study conducted on 1,000 people from the Austrian population (Grundnig et al., 2022) reported that the most critical category in defining a good physician is his or her social skills, considering a physician devoting time to consultation and listening attentively to patients, as well as being receptive to complaints, caring, reliable, dedicated, understanding, helpful, reassuring and motivating. Professional competence was the second most important category in this definition and consisted of appropriate diagnostic and therapeutic skills; correct, accurate, prompt, and efficient diagnoses; and accurate and thorough assessment. Other categories were physician's personality, communication, practical organization regarding availability, accessibility, resolution, and ethical and moral conduct.

B. What does rule physician's actions?

In general, each country has its regulations governing medical practice. Thus, for example, each country in the European Union has different requirements for granting the right to practice medicine (Panteli & Maier, 2021); although, there have been

efforts to standardize training and periodic certification of these personnel to facilitate their mobility among countries in this zone (Peeters et al., 2010).

For its part, In the United States of America, each state has its own State Medical Board that formally adopts a "Medical Practice Act" that defines requirements for medical practice in its jurisdiction. Likewise, medical practice in China is regulated by the law promulgated by Order No. 5 of the President of the People's Republic of China, issued on June 26, 1998. In Colombia, Law 23 of 1981 (Medical Ethics Law) and Decree 3380 of 1981 regulate this law.

On the other hand, medical practice is governed by administrative norms from different territorial levels (national, state or departmental, municipal) and, importantly, by norms of institutions where physicians practice.

C. Purpose of this article

This article provides conceptual elements to understand the substantial factors that affect the current practice of medicine. To this end, the author set out to answer the following questions: What is the current context in which medicine is practiced? What is good medicine? Is it possible to practice good medicine in the current context?

D. Essence of medical practice and current medical practice

This section seeks to answer the question: What is the current context in which medicine is practiced?

Currently, trends in the world affect medical practice due to the determination exerted on it by external factors, such as economic, political, and administrative factors. Thus, what is taught in the classroom frequently differs from what is learned and practiced in daily life; the latter diverges from the ethos[2] of an appropriate medical practice. Some aspects influencing current medical practice are as follows:

[2] "the distinguishing character, sentiment, moral nature, or guiding beliefs of a person, group, or institution" (Merriam-Webster, n.d.). "From the Greek ἦθος êthos 'custom,' 'character.' The set of traits and modes of behavior that make up the character or identity of a person or a community." (Real Academia Española, 2001)

a. Medical practice and its biological and clinical-care substrate

The current medical practice focuses almost exclusively on the biological aspects of patient and clinical-assistance aspects of patient care (Carmona-Moreno et al., 2005) (Longino, 1998) without considering those of the contexts (family, community, school, work, neighborhood, socio-historical) in which the subject develops and which she/he embodies (structurally or circumstantially), and which can also influence patient's state of health and disease itself, in terms of its characteristics and its form of development. As well as, neither is considered access degree to health services and the quality of them nor from family and social support networks, which are crucial influences on these mentioned aspects.

Usually, from the biologist and clinical-assistance perspectives, patient's demographic data are considered as the social aspects; neither the social context nor the relationship between the biological and the social are apprehended with their own analytical categories.

In a correlated way, in current medical practice, "disease" is sought as if it existed by itself, avoiding that these are nosological entities (constructs or analytical categories) (Hucklenbroich, 2014) that we humans have constructed to understand physiological processes considered pathological because they have negative implications for patient's physical and mental health condition. Thus, we come to have an instrumental vision of medical practice since, from this perspective, it consists of treating diseases and not sick subjects.

Related to the above, several situations affect medical practice quality as an accompaniment to others in their health and disease process. One of them is, with some frequency, the omnipotent pretension of being able to ultimately combat any health affection based on current scientific, technical, and technological advances (Longino, 1998), and we have even believed that we could overcome aging and death. In historical terms, it is only recently that medicine has actually effective therapeutic weapons for resolving many pathologies. The above focuses medical practice almost exclusively on these advances, realized in the mere application of

protocols, tending to leave aside other essential aspects of this practice, including patient accompaniment.

The previous pretension vanishes when a physician faces a terminal patient or one who has not responded to any medical treatment, or an older adult dying of old age, when neither wisdom nor technology can offer a solution to demand a cure, leaving, perhaps, the pretension of alleviating. In these cases, it is evident how the medical practice is to accompany the other, giving emotional support (Koplinka-Loehr, 2017).

b. Medical practice and the importance loss of medical evaluation

Although diagnostic aids are fundamental support in medical practice, physicians often prioritize technology and disregard clinics (Ruano-Restrepo et al., 2021), overusing the former and blindly relying on it (Mrazek et al., 2020) without being aware of the limitations of the latter (Viljoen & Twomey, 2007), errors and faults it may have (Litchfield et al., 2015) (N. C. Elder, 2015) (Sciacovelli et al., 2017) (Beasley et al., 2011) (Ismail et al., 2007).

This undervaluation of medical reasoning and physical examination leads physician to lose her/his ability to analyze a patient's situation. It also encourages a "sending tests first" behavior, which weakly supports medical practice (Shum, 2006); it is associated with losing the human sense and quality of medical practice. In addition, the tendency to send diagnostic aids is favored when physicians have many patients waiting, short attention time, and a high workload (Ergün-Şahin et al., 2022).

c. Medical practice: anonymous meeting

For its part, currently, the physician-patient relationship is between anonymous persons dressed in specific titles ("the physician" and "the patient") and is predominantly of an occasional, fleeting, and non-continuous nature. Moreover, expectations of what constitutes trust in the physician-patient relationship often differ in this encounter, with the former basing it on her/his technical expertise, knowledge, competence, and performance, while the latter bases it on her/his trust and reciprocity with physician (Berger et al., 2020).

On the contrary, the physician-patient relationship is actually a process that is built gradually, both during an encounter, although mainly through different encounters, where the physician's scientific, technical, and interpersonal skills interact with the patient's characteristics and conditions to give unique and personalized characteristics to this encounter.

d. Medical practice and technological training

Currently, medical education debates between creating physicians or medical technologists (Berkow, 2002) in the context of significant scientific and technical medical advances in the last century have made more precise diagnoses and more effective treatments possible. This issue has also implied longer and more complex training periods for physicians and a greater dependence on technology.

These changes have favored the negative effect that many physicians are mainly oriented by technology, and even only by it, which leads them to have less capacity to evaluate their patients clinically, communicate with them, and treat them in a humanistic and personalized care manner; as well Ias it has favored physicians to have a blind trust in science and technology without understanding the patient who has the disease. It has led to incorrect and incomplete diagnoses, treatment failures, excessive costs, dangerous procedures, and patient unwillingness.

Likewise, in current circumstances, associated with the development of medical knowledge and technological advances, there is an implicit perception that the problem in the physician-patient relationship is merely technical-instrumental (Emanuel & Emanuel, 1992); it would only consist of using medical knowledge, technique and technology to achieve healing. Thus, the physician-patient encounter is conceived as having only a "technical repair" nature since the solution to health problems would be merely a matter of using the appropriate technology, making the physician only a sophisticated technologist.

On the contrary, the aphorism (in an expanded form of its original version) that "the physician rarely saves, sometimes cures, often relieves, always accompanies" is

quite true. Usually, the organism heals itself; its vital forces have a reparative capacity, that is, the objective which, to a greater or lesser extent, tools used by those trying to heal, seek to enhance. However, accompaniment is the very essence of medical practice.

On the other hand, worldwide, there is a tension in university education between scientific-technical training and humanistic training. Likewise, in medical education, there is a tension between scientific-technical training, in this case, clinical-care training, and humanistic training, the latter being conceived as the development of the medical student's skills to apprehend the patient comprehensively. At present, the process of medical education is centered on scientific and technical training. Thus, the way she/he sees the world and her/his actions are molded from a utilitarian and pragmatic approach.

e. Medical practice and information technology

The introduction of information technologies in health care (telemedicine, telemonitoring, virtual reality, diagnostic systems based on artificial intelligence) has the risk of diminishing humanity in physician-patient contact and reducing the sources of knowledge for diagnosis and therapy (Botrugno, 2021).

This decrease in sources of knowledge about patient that can occur in the virtual world happens in two ways. One is because verbal language becomes the only basis for diagnosis (weak in itself), and because non-verbal language is less perceived, contextual factors are not appreciated, and sources provided by the physical examination disappear. The other way occurs because, in some forms of telemedicine, the patient becomes a myriad of quantitative data, not necessarily all of which can be assimilated within an interpretative and analytical framework, and the patient's framework of analysis is limited to these data.

Thus, this decrease in sources of knowledge can negatively affect the metacognitive process of analysis of a patient's situation that the physician must carry out for an adequate diagnosis and treatment.

f. Medical practice in health systems

Currently, medical practice occurs mainly within a health care system, which is actually a disease care system, with an organization of the care process that is focused and fragmented (World Health Organization, 2016) (Stange, 2009) (Guevara et al., 2005), and highly normalized (standardized). All of which decisively influences how medicine is practiced and shapes the essence of its practice.

This organization of the health care process involves a high work pace since one of its main objectives is the maximum utilization of resources involved (human, technical, financial, supplies) due to the economic and political determinants, and high demand for health care. All of these often have negative impacts, such as work overload and Burn-out syndrome in health personnel (Cărăuș, 2022) and, among these, physicians (Patel et al., 2019) (West et al., 2018).

The current organization of the health care process emphasizes the maximum use of tasks to increase production efficiency and minimize waste through standardization of production cycles and worker specialization. It is a productive administrative method that originated in the "Scientific Administration" stream of the industrial productive process, which began with the Fordist-Taylorist model (Chiavenato, 2019).

g. Medical practice and work overload

Work overload manifests in physicians as stress and job dissatisfaction and impacts individual performance, absenteeism, desire to change jobs, organizational performance, and quality of care they provide (Williams et al., 2007). In this last aspect, stress and job dissatisfaction negatively affect the quality of the physician-patient encounter, since physician relates differently with patient, adopting behaviors that generate distance and, in the long run, can generate more stress to them (Bakker et al., 2000). Even compliance with hand hygiene standards is negatively affected (Garus-Pakowska, 2011).

Other aspects that have been found related to high work overload are loss of autonomy in the decision-making process at work and control over the work environment, absence of organizational support, as well as an imbalance between work-family and work-life spheres (Tanios et al., 2022).

The strong influence of organizational aspects on Burn-out syndrome in physicians is evidenced by the fact that to reduce it, strategies with an organizational approach are more effective than strategies with an individual approach (Panagioti et al., 2017). A meta-analysis reports a similar finding (De Simone et al., 2021), which points out that the former focus on the work environment and organizational culture and are related to changes in scheduling, reduction of workload, changes in activities operation, and in health care organizations as a whole, while strategies with an individual focus refer to cognitive behavioral techniques to increase work competence, improve communication skills and coping strategies.

h. Medical practice and consultation time

In turn, high standardization of health care process organization means that it is actually a process of caring for illnesses rather than sick people. This high standardization leads to time standardization in medical consultation, which, by its essence, depends on varied factors in each consultation (Šter et al., 2008) and is unpredictable in anticipation of it.

Difficulty in standardizing medical consultation is because a patient with a simple pathology may arrive, and it would be possible to evacuate him/her in the allotted time; or, as it often happens, a patient with a complex pathology, or to whom multiple attentions must be given, or a patient with multiple pathologies may arrive (Reis Tadeu et al., 2020); all of which are difficult to evacuate in the allotted time. Thus, the allotted time for a medical consultation becomes a crucial factor in the quality of care and satisfaction of both patient and physician (Dugdale et al., 1999) (Wilson & Childs, 2002) (Lawson, 2019).

Worldwide, there is significant variability in the time allocated to medical consultation in primary care. A study (Irving et al., 2017) that evaluated it in 67 countries reported it to be between 48 seconds in Bangladesh and 22,5 minutes in Sweden. It found that in 18 countries, representing approximately 50% of the world's population, it was 5 minutes or less. It also found a significant association between consultation time and per capita health care expenditure and hospital admissions for reasons such as diabetes, as well as the density of primary care physicians and physician efficiency and satisfaction.

que lo evaluó en 67 países lo reportó entre 48 segundos, en Bangladesh, y 22,5 minutos en Suecia y; halló que, en 18 países, que representaban aproximadamente el 50% de la población mundial, era de 5 minutos o menos. It also found a significant association between consultation time and per capita health care expenditure and hospital admissions for reasons such as diabetes, as well as a significant association with primary care physician density and physician efficiency and satisfaction.

In addition, this care process has an aggravating factor in that consultation time includes time dedicated to computing process issues (Sinsky et al., 2016), so patient is not given enough attention (Sobral et al., 2015); not to mention that, many times, these systems are time-consuming, because they are slow and meticulous, and present interruptions; therefore, they often become an essential factor of work overload for physicians and increase their risk of presenting burn-out syndrome (Melnick et al., 2020). Thus, in today's medical practice, it is widespread for physician to be engrossed in the computer, struggling with demands and deficiencies of computer systems.

Likewise, this time includes execution of multiple administrative tasks and, many times, resolution of administrative difficulties that may arise, which leads to physician dissatisfaction and a greater risk of burn-out in this staff (Shanafelt et al., 2016) (Patel et al., 2018), and that physician does not provide adequate care to patient, since it increases likelihood she/he will attend to patient quickly with superficial care, without empathizing or knowing anything about her/him, which means that she/he cannot actually solve the patient's health situation.

Likewise, a decrease in time dedicated to patients favors an increase in antibiotics and analgesics prescription and referral of new patients to specialists, as well as a lower tendency to change existing treatment course to patients who already have a pre-existing medications prescription (Neprash, 2016). At the same time, it reduces the possibility that sources to make an adequate diagnosis are sufficient (Shurtz et al., 2022).

All the above favors physician to be late in her/his assigned schedule and, frequently, due to time pressure, to attend patient in a superficially way, cut back her/his study or make a poor-quality note in clinical history, all of which is due to flow inflexibility of sick people care, which depends on the way this process is organized. Also, in an even worse way, all the above favors physician superficially judges trying to know what patient suffers, more as a divination exertion than of reasoning, accompaniment, and support.

Thus, this allotted time is an expression of a specific form of the disease care process organization that, at the time of its configuration, responded (and, in its moments of development, responds) to the political, economic, and administrative guidelines from predominant social actors that configured (and configure) present structure of the health system and provision of health services (Shurtz et al., 2022).

i. Habitus in medical practice

The previous section shows how time allotted to medical consultation (Pisharody Vijayan, 2015) (Cayirli & Veral, 2003) shapes the physician's approach to patient (Konrad et al., 2010) (Kolla et al., 2022) (Yarnall et al., 2003), creating the habit of how to do it and shaping her/his vision and manner of medical practice.

On the other hand, there is another factor shaping medical practice and contributing to create its present specific habitus. Currently, there are new ways worker perceives her/his role at work due to variations in working conditions brought about by changes in type of contracting, level of salary income and mobility in tasks to be performed, which have occurred because labor market deregulation (Ibarra-Cisneros &

González-Torres, 2010); misnamed, labor flexibilization, that has affected workers in general and, specifically, health care workers and, among these, physicians.

Thus, flexibilization of labor relationship has created worker' new identities or subjectivities in her/his role by transforming the subject-society relationship, which occurs mainly through work, and has encouraged worker to perceive her/himself more as an entrepreneur, a free voter, author of her/his own trajectory within a contingent social order (Sisto & Fardella, 2008), that is uncertain, eventual and circumstantial.

Likewise, these new worker identities have been favored by her/his labor precariousness, expressed in greater labor instability, less control over the production process, less social protection coverage, lower income and benefits, decreased job status and social support at work, increased exposure to physical risks, decreased opportunities for training and job advancement (Tompa et al., 2007); as well as a greater sense of marginalization and loss of opportunities for development, career advancement and identification with the company (Guest, 2004).

Other important factors producing this molding in medical practice (medical habitus) are the evaluation of physician's management and the audit of medical processes; due to their effect on control and instruction of how to carry it out. Similarly, the examples that physician receives during her/his learning and practice.

Thus, a habitus is created (Bourdieu, 2007), which are internalized social structures throughout life history in the form of perception schemes, thought, and action (Martín-Criado, 2009), and that physician in her/his practice expresses, too.

Currently, all these factors shape physicians' behavior more than deontological principles. Thus, one of the main effects that current training and the existing economic, political, and administrative determinants have had on medical practice is that now to physician is more common perceives her/himself as a standardized employee who applies therapeutic techniques and performs administrative

procedures, rather than as a professional who exerts the art of caring and healing. Thus, physician now tends to conceive her/himself more as a salaried employee than as a caregiver who cares for another human being health.

j. Medical practice and physician recruitment

In recent decades, there have been changes in the predominant forms of hiring workers in many countries worldwide, with an increase in flexible forms of contracting (Broughton et al., 2016) (Katz & Krueger, 2016). This phenomenon has also affected health personnel, including medical personnel, with an increase in job instability due to the flexibilization of the labor market for human resources in health care (Brito-Quintana, 2000) (Núria Homedes & Ugalde, 2005) (Brito et al., 2001) (Molina-Marín et al., 2010);.

These changes respond to the dynamics of increasing resource use (human, inputs, financial, technical) to increase profitability in the healthcare market niche (Salisbury, 2008), which is one of the globalization and neoliberalism objectives. These latter have driven the current pattern of capital accumulation and have determined in most countries states reform processes and their social policies (Laurell, 2000), among which are those of the health sector (Armada et al., 2001) (Laurell, 2000) (Nuria Homedes & Ugalde, 2005).

Likewise, for most workers, including health care personnel, these flexible forms of contracting are associated with precarious employment (Pereira-Fernandes, 2023), more significant work overload (Minaya-Boada & Morales-Pulido, n.d.), lack of social security (Spasova et al., 2017) (Pietras, 2020), work stress (Bhattacharya & Ray, 2021), job dissatisfaction (Wilczyńska et al., 2016), less availability of free time and time for social life (Campos-Ugaz, 2022), Prolonging the working life of older adults (Wrocławska, 2020), and even deterioration of physical and mental health conditions (Benach et al., 2014) (Bender. & Theodossiou, 2017) (Ferrie et al., 2008) (Pirani, 2017) (Baquero & Pérez, 2021).

k. Medical practice and its determinants

As previously stated, current medical practice expresses its economic, political, and administrative determinants.

In the current context of countries where health is provided through the market mechanism (Schwenk, 2020), economic determinants express the search to maximize economic profitability and intensive use of involved resources (human, supplies, technological, financial). Meanwhile, political determinants refer to the configuration of the health system, which is essentially the consolidation of a particular form of interaction between the actors involved in the decision-making processes of this system. For its part, administrative management manages the aforementioned economic priorities, and it is an expression of the context given by the neoliberal model predominant at present. All the above shows the subsumption of politics to economics.

Those mentioned above favor the fact that current medical practice is highly specialized and fragmented in its care (Watson, 2019), and it occurs under the commercialization of health care, all of which increases the risk of dehumanization (Beaulieu, 2013).

E. What is Good Medicine? Fundamentals of Medical Thought and Action

In this section, the author seeks to answer the question: What is good medicine?

Given the current state of medical practice, as described in the previous section, it is essential to establish the pillars for an integral practice by the physician in each appointment, which, according to the author's opinion, are as follows (Sarasti-Vanegas, 2012):

a. Scientific-technical training

The first pillar is the scientific-technical training, which is learned at university. This learning is essential because it gives elements to know why and what to do when faced with different situations that affect health.

Scientific training is not only learning this type of concepts but mainly learning medical reasoning (Kassirer, 2010) (Walters, 2012) (Harasym et al., 2008), which is taught using different methods (Xu et al., 2021). However, the practice of medicine is more than just the application of science and technology.

b. The physician's humanitarian work

First of all, humanitarianism is different from humanism. At the same time, the former refers to the sense of "humanity, compassion for the misfortunes of other people" (Real Academia Española, 2001), and the second refers, in general terms, to the cognizance of what human beings have produced in the fields of knowledge and the arts.

Humanitarianism is founded on empathy (Larson & Yao, 2005) (Kim et al., 2004) (Mercer & Reynolds, 2002), and it could be synthesized as "putting oneself in the other's shoes"; it is one of the fundamentals in physician's work. Humanitarianism is basically and essentially an accompaniment to the "other" in the interactive process between physician and patient of unveiling the patient's health situations. In addition, this allows the physician to get to know the patient's context from the patient's logic and analyze which aspects of this context could influence the patient's state of health. Thus, in medical consultation, the physician should address not only the biological aspects that occur in consultation but also the psychological and social aspects of the patient (Levinson et al., 2000).

In essence, medical practice, understood as an interaction between two human beings to relieve one, is an act of accompanying that other sick person and putting oneself in her/his position, co-performing, as Laín Entralgo would say (Laín-Entralgo, 1964); This issue was much more evident in the past when current resources were not available. For a physician to accompany a patient is to place her/himself at the same level as the other, welcoming her/him to communicate and to understand her/his world, meanings, context, illness, and the factors that favor it.

Thus, a physician's primary sense is listening and hearing to situate her/himself in the other person through active, open dialogue and, from there, to see her/his world, dynamics, perceptions, etc. Medical questioning (anamnesis) is the central moment of listening to the patient and is a means for a patient to speak and establish two-way communication.

We must remember what Ernst Von Leyden said (Laín-Entralgo, 1964):" The first act of treatment is the act of shaking hands with the patient."Likewise, it is essential to admit patient active participation and to stimulate it, as well as rapprochement between physician and patient. Also, physician must know how to adjust to the diversity that each patient comes with and not be rigid in her/his actions.

This pillar of medical practice provides elements for the physician in relating to the patient, assuming her/him as a person and not reducing her/him to a disease, which "runs loose and is embodied in someone", a predominant implicit belief in current medical practice. Each physician must develop her/his own humanitarian attitude according to her/his own characteristics and particular conditions.

The physician's humanitarian attitude allows her/him to understand that, since disease implies suffering involving the entire human being (Gaibor-Vinueza, 2007), we cannot equate a sick subject to a healthy subject plus an illness since the same subject in a state of illness feels and behaves differently than if he were healthy (Toombs, 1992) (Flensner & Rudolfsson, 2016). Similarly, this attitude allows physician to understand that there are no diseases but sick people and that two patients are not alike, given the uniqueness of each subject. In addition, this attitude allows physician: "to grasp the situation of the moment and to understand the man with whom one is face to face at that moment and to respond accordingly" (Gadamer, 1996).

Equally, the problem of saving, curing, or, more frequently, relieving others is not so simple; it goes beyond mere technical-instrumental problems and must be based on a humanitarian conception. This conception considers solidarity, understanding, and proximity to those needing help to be fundamental (Gaibor-Vinueza, 2007).

Reducing it to the technical-instrumental aspect, the implicit premise in the current conception, is failing to use the humanistic aspect as a fundamental element to save, cure, or alleviate.

This humanistic attitude allows physician to understand that health is not an end by itself because "the end is patient reincorporation to her/his original place in daily life. This is the complete recovery and often goes much further than physician's competence" (Gadamer, 1996).

Although a physician's humanitarian attitude should permeate the entire medical practice, there are two critical moments in the physician-patient relationship in which it is essential to make person-to-person contact with the patient based on this attitude. These situations can be considered moments of truth (Ramírez, 2010). One is the first moment of contact, in which the physician must show receptiveness and willingness to care for the patient. The second is the final moment of interaction, in which the physician must explain her/his diagnosis and management plan to the patient, constructed in a participatory manner with the patient (DiMatteo, 1998) and not in an authoritarian manner. Thus, in essence, the key to a physician's humanitarian attitude in the consultation room is that the patient can see that she/he is actually being cared for.

c. The physician's inquisitive thinking

The physician must have a permanent attitude to inquire, with a critical thought (Harasym et al., 2008); and develop a great capacity for observation and analysis during interrogation and physical examination.

Thus, another foundation of medical work is the physician's inquisitive attitude, who is like a detective (Bain, 2011) (Grais, 2014) (A. Elder et al., 2013) that, during the conversation, using interrogation, with a "sharp eye", scrutinizes and "draws" patient, based on what the latter tells, from her/his logic, about her/his health situation and her/his world. Thus, the physician must be attentive to every indication and every suspicion to establish probable correlations.

Patient during interrogation, through inquiries and feedback given by the physician, talks about her/himself and builds her/himself step by step to her/himself and the physician by narrating her/his symptoms, causes she/he attributes to them, her/his current and previous circumstances, her/his psychological characteristics, as well as elements of her/his affective, family, work, social, cultural, economic, etc. contexts that she/he relates to her/his health situation. This way, the physician gradually builds up the patient's image interactively during the interview.

A physician's inquisitive attitude is very important because it is the driving force to apply the patient's analysis process in consultation, which is critical to approach a patient's situation and implies a metacognitive process that goes beyond knowing different possible manifestations of a disease, as well as knowing patient and her or his contexts in a disjointed way.

In a medical appointment, the process of analyzing a patient to make a diagnosis(s) can be done in two ways, usually sequentially: one, quick and intuitive (but more fallible), to get a first impression of what the patient has, called heuristic (or, System 1), based on pattern recognition, "most likely" (rule of thumb) and/or mental shortcuts (by physician's accumulated experience) and; another, more analytical, which is used to confirm or discard the initial impression, especially in situations where diagnosis is difficult, in tough decisions or with contradictory evidence (called System 2) (Royce et al., 2019).

This last form of the patient analysis process in medical appointments is based on elaborated knowledge (Bordage, 1994), structured, discriminative of essential and specific traits of the different pathologies, which is developed through study and medical practice. Based on it, the physician, during interrogation, focuses on detecting or discarding these traces' existence; therefore, she/he builds some diagnostic hypotheses that she/he submits to scrutiny through cross-examination and physical examination to see if they are sustained or not; until consolidating one (or ones) that are consistent with what patient shows (Charlin et al., 2007). Thus, this form of the patient analysis process in medical appointments uses strategies of hypothetico-deductive thinking, inductive schema, and pattern recognition (Harasym

et al., 2008).

Clinical reasoning should generally be based on data analysis provided by clinical history, medical questioning, physical examination, and diagnostic aids. In interrogation, in addition to anamnesis, elements of the patient's context (family, community, school, work, neighborhood, socio-historical) that are related to her/his pathology(ies) should be sought.

Clinical reasoning involves a physician's appreciation of these data from various sources based on her/his clinical knowledge and the relationship between the biological (patient's pathology(ies)) and the social (contextual factors that influence it). It is also helpful to draw on other types of knowledge (evidence-based medicine, clinical epidemiology, Bayesian reasoning), which should be framed within the metacognitive process of reflecting on how she/he is reasoning (Royce et al., 2019).

Moreover, in essence, the act of diagnosing a patient is a process of "engendering," "painting," or "constructing" him or her through questioning and physical examination, like the Socratic method (Platón, 2019), to form an actual patient image and situations affecting her/his health.

This patient construction implies not only uncovering and, simultaneously, constructing the patient's pathology through detecting its signs and symptoms but also, as mentioned, awareness of the patient's characteristics and contexts. It allows the construction of an articulated whole: the patient her/himself. Therefore, as stated by Laín Entralgo (Laín-Entralgo, 1964): "medical diagnosis is never knowledge of a passive object by an active and cognizant mind, but the result of a conjunction between physician's mind and patient reality" and how this relationship is established determines, in part, what is diagnosed.

Once this construction is done, which ideally should go beyond the morbid entity definition afflicting the patient, the physician can now understand the patient, her/his context, pathologies, and determining and conditioning factors; in addition to that, it is possible to define treatment and make suggestions and recommendations.

In current conditions of medical practice, medical reasoning in medical appointment runs the risk of not being exercised or at a minimal level for the analysis that would be required due to time pressure and economic determinants, which favor the predominance of quick and simple reasoning methods, as well as a higher productivity of patients attended with a lower quality of care (Elstein, 2009).

d. Physician's strategic thinking

Another pillar is the physician's strategic thinking, which allows her/him to act comprehensively according to circumstances. Thus, the physician evaluates patient conditions ("the terrain"), disease, and its stage ("the opponent"), and recognizes therapeutic resources available to her/him ("evaluates her/his resources"). In this way, a physician, like a strategist, continuously observes and looks at the terrain, the opponent, and the available resources. It allows her/him to define an action plan (i.e., management), which becomes a prescription or medical order in the emergency room or in the hospital, including recommendations that are given. Thus, the management plan is a product of the physician's analysis of the patient's situation.

The definition of intervention strategies and subsequent evaluation of their results are based on the physician's assessment of the patient's circumstances and pathologies.

The physician must have strategic thinking during her/his actions, which is to define as precisely as possible the entity or entities she/he is facing, the illness's stage(s) in its natural history, determine resources availability, determine patient conditions (vital forces) to face them and define how to deal with them and guidelines to evaluate treatment evolution (Sarasti-Vanegas, 2012).

In addition, within the strategic thinking, the physician, in her/his different working scenarios (outpatient, priority appointment, emergency room, hospitalization), defines an action plan, executes it, evaluates its impact, and, according to this, readjusts her/his actions, which is applies the PDCA (Plan, Do, Check and Act) Continuous Improvement Cycle in management.

a. Physician ethical behavior

Another pillar is the physician's ethical behavior, which includes three fundamental principles that she/he should consider in every appointment. The first one is not to harm ("primum non nocere"); the second one is to seek to make good (principle of beneficence); and the third one is that the physician's only interest is the patient's health and not to put their employer's economic interests defense before the latter, bearing in mind the Hippocratic oath which states: "The health and life of the patient will be the first of my concerns".

In current medical practice, the physician is measured, controlled, and pressured by expenditure, as if it only depends on him and not on the patient, turning her/him into a cost controller and jeopardizing her/his role as a physician. Thus, it does not matter how good or bad she/he is at diagnosing or treating.

F. Is it possible to practice good medicine in the current context?

This answer cannot be exhaustive or generalizable, but must consider the specific context in which this analysis is intended to be carried out in terms of its conditionings upon medical practice, which are of the following types:

1) Regulatory affairs: a) specific form of organization of patients' care productive process, and of the medical practice auditing and evaluation processes; b) predominant approach to medical practice (usually biologist and focused on clinical care, without considering influential social factors); c) regulations governing it.

2) The habitus: that includes the habitual way in which the physician perceives her/himself; how consultation is customarily conducted; and relative importance given to questioning, physical examination and technologies within consultation.

3) Physician's working conditions such as overload, consultation time and type of contract).

All these factors influence the possibility or not of an adequate medical practice. The latter implies a solid scientific-technical training, a decisive humanistic commitment, a clear practice of physician's inquisitive and strategic thoughts, as well as an ethical behavior.

Thus, some contexts are too restrictive, which stifle the possibility of an adequate medical practice; others enable a restricted medical practice; and other contexts that make possible an adequate practice. Which context is it? This analysis must be based on restriction specific terms in which the relationship between structure and subject occurs. The previous sections of this article analyzed the framework of possibilities for action given by context (the structure) for medical practice (the physician's capacity for agency). The current state of medical practice evidences how structure influences it.

This article shows how economic, political, and administrative determinants currently shape medical practice and how they tend to restrict its proper practice due to its present configuration.

For its part, influence transformation of these determinants does not imply its disappearance, but, ideally, it should enable an adequate medical practice. In any case, it must be kept in mind that this task of transformation begins with location of this influence effects as an aspect of public interest and that some social actors promote this task. It would occur in a field of interactions between social actors and decision-making processes that has a specific configuration according to each society. It would also occur between social actors, with different interests, who have a differential capacity to influence decision-making processes.

In this interaction between actors, an element of capital importance is what position is chosen to consider health as a right or as a commodity, which in health care is reflected, respectively, in having economic rationality as a factor to be considered or having economic profitability as a priority. Likewise, involved actors, and social forces interested in influencing these processes, as well as in the very configuration

of this field, should structure one which enables adequate health care; one of its pillars is medical practice.

For her/his part, the physician, at individual level and within this current context, should maintain profession axiological principles as her/his actions north, moving for this purpose within the framework of possibilities offered by the structure and seeking to place her/himself in a work environment that will enable her/him to practice medicine adequately.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the author used Google Translator, DeepL translator, and Grammarly in order to improve language and readability. During and after using these tools/services, the author reviewed and edited the content as needed and takes full responsibility for the content of the publication.

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