2.20 CP Statement Concerning Professional Autonomy and Responsibility

(CP 1999/020 Final)

The health care systems undergo many and rapid changes. On the one hand there is the emancipated, increasingly well-informed patient whose expectations are high and whose demands for medical care are great; on the other hand politicians and managers are following policies of cost containment. Such conditions put pressure to bear on the relationship between a doctor and patient. Professional autonomy, properly defined and used, can help to preserve a balance between needs, demands and responsibilities of the parties involved with a priority for patient's needs.

Maintaining this balance, whilst guaranteeing the best possible doctor-patient relationship as well as high-quality care, requires that patients be free to choose their physician and that the professional relationship between doctor and patient is protected by strict confidentiality. Autonomy and responsibility cannot be separated. The professional autonomy is not absolute, but restricted by professional and social responsibility and the autonomy of patients. This means that doctors can only claim professional autonomy if they are also prepared to account for their prefessional conduct first of all to their patients and their peers and to society. Rules of conduct drawn up by the medical profession and instruments to enforce their application have always served to ensure medical care of the highest possible and ethical standards.

Clinical guidelines, Continuous Professional Development and systems of peer review all can contribute to maintaining a high quality of care and to its objective evaluation. Clinical guidelines can help to base clinical decisions on the best evidence of their appropriateness and cost-efectiveness. They also provide for transparency of medical conduct. They can therefore serve the interest of all parties involved: doctors, patients and third part payers.

Professional autonomy dictates that a doctors shall deviate from a guideline whenever he feels that this is in the best medical interest of the patient; professional responsibility requires him to be prepared to provide arguments – other than invoking professional autonomy – for his decission. If clinical guidelines are to have this function they must be relevant to clinical practice and involved practicing physicians in their elaboration.

Any intervention of third parties in the doctor-patient relationship must be judged as to its benefit to the patient as weel as its respect for the doctor's professional autonomy. Any doctor, independent of his or her manner of employment, must be able under any circumstances to provide the care that is medically indicated. This is equally the case for doctors who are in training for a medical speciality or who works as member of a team. The doctor-in-charge must recognise the responsibility and independence of the team member. Patients must be able to depend on this. Such trust is the basis of the patient-doctor relationship; *professional autonomy is a right of patients.*

3. Health care economics

(see also items 2.5 and 2.12)

3.1 Declaration of Copenhagen on health care costs (CP 79/14)

The Standing Committee of Doctors of the E.E.C. is highly conscious of the financial repercussions associated with the increase in the cost of health care. However, it observes that if health expenses are growing more rapidly than the national revenues of each Member State, the basic reasons for this the following:

- Demographic change and a noticeable increase in the number of elderly people.
- Scientific progress and the diffusion of technical progress in every region of all the Member States: the prodigious leap forward in techniques has permitted a considerable improvement in investigative procedures and treatment; this has made curable disease which were formerly inevitably fatal; it has enabled handicapped people to live, it allows the treatment of conditions previously considered fatal. It contributes to change patterns of illness. Morbidity is evolving, but not diminishing.
- Cultural progress: this has provoked an increased demand for care in relation to the standard of education and of information of the population, and it has indusputably lowered the threshold of tolerance of disease.
- Finally, if the development of social institutions has enabled every family budget to meet its health care needs, these were not created by it.

In 1967, the organisations of the Standing Committee drew up and adopted unanimously a Declaration by the Doctors of the European Economic Community on the subject of professional practice within the Community, article 57-3 of the Treaty of Rome.

In this declaration which is attached in annex, the doctors of the E.E.C. underlined the fundamental principles of the duties of the doctor and also of the state in a modern society corresponding to the level of industrialisation and expansion of the European Economic Community. The conclusion of the declaration was the following:

"Technical progress, the basis of our industrial civilisation, and economic expansion which is the fruit of it, have the natural result, due in particular to a policy on health, of aiding the physical and spiritual development of Man and of all men."

The doctors of the European Economic Community do not however, consider that everything is possible in our modern society and the the profession can

remain indifferent to the repercussions of the cost of health care on the economics of the state. They believe it is their duty to collaborate in researching measures which aim at a better use and rationalisation of resources set aside for health care, on the express condition that in all circumstances, the freedom of prescription of the doctor, the natural defender of every patient, should be respected.

Indeed, the doctor cannot, in the context of an individual case, place the interests of society above those of the individual. Medicine is impossible without mutual confidence between the doctor and his patient. This confidence is based on fundamental freedoms: for the patient, the freedom to choose his doctor, and for the latter, the freedom to choose the necessary investigative and therapeutic methods. This confidence, which is indispensable, ceases to exist when confidentiality is not scrupulously respected and guaranteed.

As economic responsibilities are the province of political power, doctors cannot, without imperilling the technical and moral independence vital for the practice of their profession, associate themselves with the economic and political decisions which are taken by the public authorities with regard to the budget allocated to health care.

But expert advice must be taken before those concerned decide, and at this stage the medical profession intends to be consulted. Equally, when decision has been taken, the medical profession intends to make known its assessment of the consequences of these choices.

The medical profession is prepared to assume the responsibility of advising thoses who must ensure the best use of the resources of health insurance and of the budget allocated to health care and in this regard also, it reserves the right to publish its remarks and comments on the choices thus made.

Furthermore, the Standing Committee of Doctors of the European Economic Community alerts governments to the dangerous consequences of decisions taken on purely economic grounds. It recalls that a medical policy cannot be ounded simply on the criterion of prolonging the span of life, but above all it should evaluate the quality of life that medicine can give to the sick, the handicapped, the chronically ill and the aged.

The function of medicine is to participate, now and in the future, in the betterment of the life of Man and Society. The medical profession is ready to appeal to the population of all the Member States so that this fundamental aim should be respected by the political powers of the states.

3.2 Towards a health care economy founded on social and individual responsibility (1983)

For a health economy based upon social and individual responsibility

Health costs are increasing faster than the GDP

1. In all countries with scientific and economic development, the evolution of health expenses covered by health insurance is developing more rapidly than the GNP. The present low rate of this increase, and the economic constraints forcing all industrialised countries to seek back to major balance and a fight against inflation, no longer permit a continuation of this tendency. However, a study of the rates of increase of expense towards health insurance in the EEC compared to the rate of increase of the GNP shows that in the nine member states for which statistics exist, five states still show a *considerable gap between these two rates,* the freezing of health expenditure in member states with a national health scheme being only due to a decision on the part of the responsible authorities (Cf. enclosure 1).

The social security schemes contribute to social balance

2. In spite of the economic constraints, and because of the world crisis, no sensible policy could even consider watering down the social protection schemes and reducing their role. On the contrary, it is important to maintain them at the level they have attained.

2.1. Social protection schemes are, *historically*, the means for *liberal industrial societies, governed by the laws of marketing*, to provide a means of escape for the worker and his family from the hardest consequences of these laws, when the risks of life jeopardize the ability to earn for him and his kin.

2.2. In the course of a crisis reducing or eliminating the growth of the workers' primary income, *social benefits* make it possible for their *average available income* (2) to maintain, and even *slightly increase*, their purchasing power through the increase of the benefits in the average income. In France, for instance, social benefits in 1960 represented 1/5 of the available income as against 1/3 today (3).

2.3. Thus, social security indirectly plays an economic role, contributing to the resistance of a population to the world crisis, *making it accept the hard effort of competing* that it must continue making.

1) Report presented by the standing committee of Doctors in the European Community to the Commission of the EEC and to the Council of Europe in October 1983.

2) Primary income after deduction of compulsory levies and addition of social benefits.

3) 2nd report on income in France (Centre d'Étude des Revenus et des Coûts, 1979).