6. Patients who become incompetent should retrain the same rights in respect of health care as those who remain competent.
7. It should be possible for a statement of wish/intention to be overridden where the clinical circumstances are not precisely covered by their provisions. Such circumstances are a matter of clinical judgement and would merit further discussion.
8. If there are discussions about developing policy on the use of statements of wish/intention, representatives of medical and other health professions should be involved while the complexity and sensitivity of the various factors which must be taken into account should be drawn to the attention of the public and appropriate authorities.

2.13 Ethical and economic consequences of the limitation of resources for health care

(CP 94/49)

Recognising that the problems raised by an increase in health expenditure at a rate which exceeds that of the GNP are a challenge not only for governments and the citizen, but also for the medical profession.

Recognising that it is difficult to reconcile the need to guarantee the citizen the enjoyment of the best health care available with the most recent developments in the world of medicine and the desire by the various governments to control increases in expenditure.

The Standing Committee hereby expresses the following opinion:

I. *The Problem*

Although it appears to be a legitimate desire on the part of governments to contain expenditure, it must nevertheless be emphasised that:

1. that part of the nation's wealth which is devoted to health care is a function of choices made by society.
2. public health also constitutes an investment, and the potential benefits for the health of the citizen of an increase in the share of GNP allocated to health care have not been given suffcient consideration.
3. the health care sector constitutes a source of employment for a not inconsiderable proportion of the active population at a time when the problems of unemployment and employment are among the principal concerns of the majority of Governments and trade unions;
4. an important proportion of the expenditure in this area returns to the state in the form of taxation;
5. the health care sector also has productive aspects to it if account is taken of the pharmaceutical industry, biomedical equipment, computer technology, construction, etc.

It is therefore clear that the health care sector is not only a source of expenditure but also a source of benefit for public health and the state.

It is therefore appropriate to consider it in terms of its positive economic aspects, and not only in terms of expenditure.

II. *The causes*

The increase in expenditure results from a number of medical and social and economic factors which need to be identified in order to establish which proportion of it is unchangeable and, of that which is changeable, which it is acceptable to change and which it is not.

Certain causes have their origin in natural developments and are difficult to avoid.

1. medical progress which make available to patients increasingly effective diagnostic and therapeutic techniques;
2. more effective but also more expensive medicinal products;
3. the increased use of organ transplants as a routine procedure;
4. an increase in the number of physically and mentally handicapped people, due to an increase in their life expectancy;
5. an increase in the longevity of the chronically sick;
6. an increase in the average age of the population, while the incidence of chronic afflictions and of cancer is higher for aged persons.
7. the emergence of new illnesses such as AIDS;
8. the need experienced by medical teams to have at their disposal for the benefit of patients increased numbers of better qualified staff, who are by that very fact more costly;
9. an increase in the insurance premiums for professional negligence, caused by medical techniques which are more effective but which at the same time carry greater risks.
   This increase in medical liability also affects the attitude adopted by medical practitioners, who feel obliged cover themselves by means of increased levels of professional guarantees, particularly by multiplying their procedures;
10. increasing public pressure for progress in preventive medicine which, even though it gives rise to certain savings, is nevertheless very costly.

Certain causes have their origin in society itself, and could become the subject-matter of preventative action on the part of the governments:

1. increasing levels of severity in road traffic accidents;
2. an increase in illnesses caused by pollution and the working environment;
3. an increase in the number of alcoholics and drug users who all require increased levels of health care.
   Certain factors are worthy of increased consideration: additional demands made by citizens on

health care, but with an absence of any sense of responsibility in relation to the expenditure because of health care being free, or practically free, of charge.

Factors which require radical action and which are often the responsibility of the governments:

1. the politicisation of health care, which results in the best medical services being used even more for electoral or propaganda purposes rather than serving the needs of the patient;
2. management systems which act in their own interest and which consequently divert financial resources intended for health care;
3. inflationary trends in running administrative charges;
4. payment for complementary therapies without any scientific basis.

Finally, factors in which the medical practitioners or health care institutions have their own responsibilities:

1. advertising which encourages the general public to use medical services even if they have no real need to do so;
2. medical practices which have been diverted from their original objective and which seek essentially to earn profits on the basis of inappropriate acts.

Conclusions

I. *The responsibilities incumbent on medical practitioners*

1. The first task of the medical practitioner is to act in the best interests of the patient.
2. It is incumbent upon the medical practitioners to oppose vigorously any measure which, by seeking to control costs, would infringe medical ethics.
3. Medical practitioners cannot remain indifferent to the problem of increasing expenditure and, although they must recognise the fact of health care rationalisation affecting them, they must nevertheless refuse the imposition of rationing which would lead to the non-treatment of disabilities or illnesses and to premature deaths for economic reasons on the one hand and to social discrimination, on the other hand, since the victims would be those who do not have the means of enjoying private and expensive health care, or which would lead to choices between those who are entitled to care and those who are not.
4. Where resources are inadequate for the purpose of covering the legitimate health care, it is also the duty of the medical practitioner to attract the attention of the public to the reasons for increasing levels of expenditure.
5. High standards of rigour must be applied when using the available resources. Medical practitioners must refrain from conducting superfluous examinations or engaging in superfluous ineffective or needlessly difficult treatment.
   Any abuse of the medical practitioner's therapeutical freedom must be severely penalised by the profession itself.
6. Medical practitioners must above all seek to achieve quality in the care dispensed by them.
   They must also feel concerned by economic issues. They must therefore be conscious of the economic implications of the examination procedures and courses of treatment which they prescribe.
   Therefore they are under the obligation to submit themselves to continuous medical training during the entire course of their careers in order to keep up to date and even to improve their knowledge.
   They are also obliged to assess, or to take part in assessments, of the quality of the health care which they provide.

II. *The responsibilities of governments*

1. It is for governments and those who finance health insurance to engage in a permanent dialogue with medical practitioners in relation to the best possible use of the means at the disposal of health care. Only by granting doctors this right can governments obtain from them their full ethical and social responsibility as regards health care expenditure.
2. Cost control does not give the government any right to take measures which infringe the principles of medical ethics, in particular the right of the patient to choose his doctor, the professional freedom enjoyed by the medical practitioner and professional confidentiality.
3. Elderly persons, physically or mentally handicapped persons, patients afflicted with psychiatric illness have a right of access to health care equal to that of all other patients. The treatment given must only be adjusted in the light of the clinical judgement made and the likely response by the patient to the treatment and rehabilitation.
4. Like the medical practitioners, the governments must promote a sense of responsibility among members of the public in the field of health and prevention, particularly by means of educational programmes.
5. The governments must ensure that the resources which are intended for health care are not diverted from their original objective. Governments must meet their responsibilities in providing the necessary resources for the profession in order to improve the quality and efficacy of care.
6. Hitherto rationing measures have already been applied by the majority of governments.
   1* Waiting lists
   2* Limited access to health care
   3* Monitoring of admissions to hospitals
   4* Indicative budgets
   5* Excessive bureaucracy and complex procedures which act as disincentives.

   Governments must recognise that these mechanisms have proved to be of limited effectiveness and

are contrary to medical ethics and the interest of patients.

7. Where resources which are available for health care purposes and which can no longer meet all the various needs, they must be used in such a way as to provide each person with access health care, in particular low-income groups.

2.14 First statement on storage of medical data in computer banks

Adopted at Dublin, 1982
(CP 82/153, Item 9.2)

Le Comité Permanent des Médecins de la C.E.E., après avoir pris connaissance des différents documents, en particulier: de l'U.E.M.S., de la motion de l'U.E.M.O., de l'Association médicale Mondiale, du Comité Hospitalier de la C.E.E. et de la communication de la Commission des Communautés Europeennes, constate que uassi bien le recueil des informations médicales dans les banques de données médicales que l'accès des personnes à ces banques de données médicales mettent en cause le respect de certains principes d'éthique médicale.

Pour cette raison, il estime que *seuls les médecins* doivent avoir la responsabilité de ces banques de données médicales.

Les données stockées dans les banques doivent être recueillies, conservees puis diffusées en respectant les règles déontologiques professionnelles de nos différents pays et tout particulièrement le prééminence des droits et liberté des malades: le respect de la personne humaine et de son droit au secret mèdical.

Les données codées, ne permettant pas l'identification des malades et respectant la confidentialité, sont enregistrées sous la responsabilité du médecin qui détient la clef de codage.

Aucune donnée personnelle ne peut être enregistrée dans une banque sans que le malade en soit averti et mis à meme d'obtenier d'éventuelles modifications par l'intermédiaire d'un médecin désigné par lui.

Tout doit être mis en oeuvre pour que les reseignements médicaux transmis soient couverts par le secret professionnel.

Dans ce but les données statistiques oú figurent certains éléments susceptibles de permettre l'identification des malades doivent être absolument séparées des données à caractère médical (comprenant par exemple des diagnostics ou des traitements), qui doivent rester anonymes.

Less banques de données médicales ne devant être utilisées qu'à des fins médicales doivent rester autonomes et ne peuvent pas être reliées à d'autres banques n'ayant pas le même objet.

Seule les médecins peuvent avoir accès à des banques de données médicales non codées dans l'unique intérêt du diagnostic ou des soins à donner à leurs patients.

2.15 Mdical secrecy in community law

(CP 84/90 Mod.)

Le secret médical en droit communautairve[1])

Le Secret médical est une des modalités permettant de faire respecter un droit fondamental de l'homme, une disposition éthique, voire légale, protégeant la sphère personnelle du patient et lui permettant de tout dire au médecin qui a sa confiance et dont la profession comporte la mission de lui donner des soins en toute indépendance. La protection de la mission du médecin a pour contrepartie la discipline professionnelle, imposée et contrôlée dans l'intérêt général par des institutions habilitées à cette fin.

La base commune de cette protection de la confidentialité dans les dix pays membres est d'ordre éthique. Elle est devenue une règle civile reposant le plus souvent sur le contrat de soins, ainsi qu'une règle professionnelle dont le respect est contrôlé par la juridiction disciplinaire. Dans huit pays sur dix (font exception le Royaume-Uni et l'Irlande), cette règle est en outre inscrite dans la loi pénale, acquérant ainsi un caractère d'ordre public.

1. Précisons qu'il n'y a pas et qu'il ne peut y avoir de secret entre le médecin et son patient: l'obligation pour le médecin d'informer le patient qui l'a choisi est d'ailliurs à la base de l'exigence du consentement éclairé avant toute intervention. Lors de sa révélation, le médecin doit cependant garder une certaine prudence: il ne faut pas, en effet, que l'information du patient nuise à sa santé. Les limites et les modalités de cette information varient selon la déontologie, les usages et les traditions de chaque Pays-membre.
2. Le médecin peut-il être délié du secret par le patient en vue de révéler à des tiers des faits secrets? Le consentement du patient à cette révélation est une condition nécessaire, mais non suffisante. De manière générale, le médecin peut "retenir" certaines informations, se elles peuvent porter préjudice matériel ou moral au patient. Le consentement ouvre une possibilité, mais ne crée pas un devoir dans tous les Pays-membres. Une des modalités de cette communication à des tiers est la remise par le médecin au patient lui-même d'un certificat sur son état, le patient ayant été préalablement dûment éclairé sur les conséquences éventuellement dommageables pour lui de cette communication.
3. Le secret peut d'autre part être partagé entre le médecin-traitant et:
   - les autres médecins participant au traitement du patient, soit actuellement, soit ultérieurement;
   - les membres des diveres professions de santé dont le concours est utile au traitement, dans la mesure oú cette révélation est utile à leur exercice;

1) Document élaboré à la suite d'une enquête du Comité Permanent auprès des délégations nationales et adopté par la réunion des Commissions "Ethique Médicale" et "Juristes" des 20 et 21 septembre 1984.