Ethics and professional autonomy

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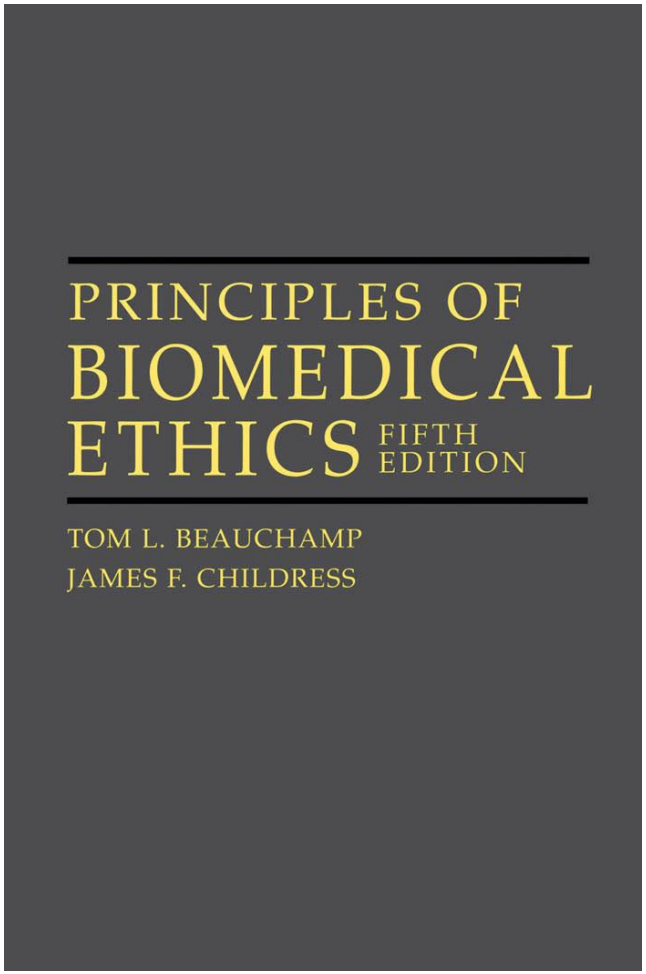
Disclosure

- Vice-President of the International Pharmaceutical Federation (FIP)
- Member of the World Health Organization's Expert Panel on Drug Policies and Management
- Member of the South African National Essential Medicines List Committee (NEMLC)
- Member from 2015-2018 of the South African Medicines Control Council (MCC)
- Currently a member of three expert advisory committees of the MCC's successor, the South African Health Products Regulatory Authority (SAHPRA)

Familiar and well-used



- Respect for autonomy (of persons)
- Non-maleficence
- Beneficence
- Justice

Uniquely applicable to medical (or health professional) practice – but the concept of professional autonomy is far more widely applied and appealed for, not always successfully

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RESCINDED: WMA DECLARATION OF MADRID ON PROFESSIONAL AUTONOMY AND SELF-REGULATION

Adopted by the 39th World Medical Assembly, Madrid, Spain, October 1987, editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and rescinded and archived by the WMA General Assembly, New Delhi, India, October 2009
**** This document has been replaced by the "Declaration of Seoul on Professional Autonomy and Clinical Independence" (2008) and a completely rewritten "Declaration of Madrid on Professionally-led Regulation" (2009)***

The World Medical Association, having explored the importance of professional autonomy and self-regulation of the medical profession around the world, and recognizing the problems and the current challenges to professional autonomy and self-regulation, hereby adopts the following principles:

1. The central element of professional autonomy is the assurance that individual physicians have the freedom to exercise their professional judgement in the care and treatment of their patients.
2. The World Medical Association reaffirms the importance of professional autonomy as an essential component of high quality medical care and therefore a benefit to the patient that

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WMA DECLARATION OF SEOUL ON PROFESSIONAL AUTONOMY AND CLINICAL INDEPENDENCE

PDF

Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008

23rd August 2017

The World Medical Association, having explored the importance of professional autonomy and physician clinical independence, hereby adopts the following principles:

1. The central element of professional autonomy and clinical independence is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals.
2. Medicine is a highly complex art and science. Through lengthy training and experience, physicians become medical experts and healers. Whereas patients have the right to decide to a large extent which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.
3. Although physicians recognize that they must take into account the structure of the health system and available resources, unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients, not least because they can damage the trust which is an essential component of the patient-physician

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WMA Resolution to Stop Attacks Against Healthcare Workers

1. The central element of professional autonomy and clinical independence is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients **without undue influence by outside parties or individuals.**

Short and sweet – but narrow?

The World Medical Association, having explored the importance of professional autonomy and physician clinical independence, hereby adopts the following principles:

1.The central element of professional autonomy and clinical independence is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals.

2.Medicine is a highly complex art and science. Through lengthy training and experience, physicians become medical experts and healers. Whereas patients have the right to decide to a large extent which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.

3.Although physicians recognize that they must take into account the structure of the health system and available resources, unreasonable restraints on clinical independence imposed by **governments and administrators** are not in the best interests of patients, not least because they can damage the trust which is an essential component of the patient-physician relationship.

4.**Hospital administrators and third-party payers** may consider physician professional autonomy to be incompatible with prudent management of health care costs. However, the restraints that administrators and third-party payers attempt to place on clinical independence may not be in the best interests of patients. Furthermore, restraints on the ability of physicians to refuse demands by patients or their families for inappropriate medical services are not in the best interests of either patients or society.

5.The World Medical Association reaffirms the importance of professional autonomy and clinical independence not only as an essential component of high quality medical care and therefore a benefit to the patient that must be preserved, but also as an essential principle of medical professionalism. The World Medical Association therefore re-dedicates itself to maintaining and assuring the continuation of professional autonomy and clinical independence in the care of patients.

Professionalism, Governance, and Self-regulation of Medicine

Howard Bauchner, MD; Phil B. Fontanarosa, MD, MBA; Amy E. Thompson, MD

JAMA May 12, 2015 Volume 313, Number 18

"As increased transparency reveals many aspects of medicine that have formerly been hidden from patients (such as conflicts of interest and costs of care), **as more physicians are employed**, as the economic stakes for patients and their families are greater, and as the belief that medicine should be more personalized becomes integrated into practice, it is incumbent on the leaders of medicine to re-examine the organizational, governance, and self-regulatory structure of the profession."

Linked to self-regulation

- Competencies – control of entry into the profession
- Accreditation of educational providers and qualifications, continued competence
- Disciplinary powers – judgment by one's peers and no-one else

CMAJ, October 2, 2012, 184(14): "granting doctors complete control over their own ship is becoming a tougher sell"

The concern in pharmacy

- Pharmacy ownership by non-pharmacists; corporate interference in professional activities
- European Court of Justice, 19 May 2009, in Joined Cases C-171/07 and C-172/07:
  - “a Member State may take the view that there is a risk that legislative rules designed to ensure the professional independence of pharmacists would not be observed in practice, given that the interest of a non-pharmacist in making a profit would not be tempered in a manner equivalent to that of self-employed pharmacists and that the fact that pharmacists, when employees, work under an operator could make it difficult for them to oppose instructions given by him.”

A broader view

- As the working environment has changed for many health professionals, with fewer being self-employed solo practitioners, so professional autonomy has also been seen as under threat, or at least subject to change.

And a broader set of “threats”

Calnan and Williams. International Journal of Health Services. 1995

“…so-called threats to professional autonomy in the United States might also be manifesting themselves in the United Kingdom through the introduction of **market principles** and the new “**managerialism**” into the National Health Service by the government and through the emergence of **complementary medicine** and the role of the **“articulate” consumer**.”

. . . we are being put on from above and below.
Interviewed general practitioner

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Australia news

Doctors 'muzzled' and bullied into leaving public hospitals, says AMA

Melissa Davey

@MelissaLDavey

Wed 9 May 2018 07.19 BST

Australian Medical Association's president Michael Gannon blames '**rise of managerialism and bureaucracy**' for pressure on clinicians

Physician Autonomy and Health Care Reform

Ezekiel J. Emanuel, MD, PhD
Steven D. Pearson, MD, MSc

MANY PHYSICIANS ARE DISTRESSED AS THEY LOOK TOward the future. A recent survey of physicians reported that 65% thought the quality of health care will deteriorate in the future.[1] Part of this malaise is driven by concerns that reforms contained in the Affordable Care Act (ACA) will further erode physicians' autonomy.

On the contrary, the ACA has provisions that will mitigate the long-standing concern that payers determine what physicians can and cannot do and will instead enhance the role and authority of the medical profession. However, this possibility can only occur if physicians leverage the opportunities to shape and ensure effective implementation of new payment models proposed in the ACA.

What Is Physician Autonomy?

While physician autonomy is frequently invoked as an important value, there have been few attempts to specify its meaning. To many, physician autonomy means that physicians should have complete freedom to provide treatments for patients according to their best judgment.

However, this characterization is inadequate.[2,3] First, it is too limited in scope. Part of physician autonomy extends beyond specific treatment decisions to include broader control of the terms, conditions, and content of work, in particular how to organize the way care will be provided. More importantly, this characterization conflates autonomy with liberty.[4,5] Liberty from controlling interference is necessary but not sufficient for autonomy. For example, in addition to liberty, the conditions necessary for patient autonomy include mental competence, adequate information, and understanding of that information.[6] Similarly, physician autonomy requires conditions beyond liberty.

Perhaps the defining element of physician autonomy is that it arises in the context of the patient-physician relationship. Illness renders patients vulnerable and physicians have specialized knowledge and skills that give them the power to take advantage of that vulnerability. Consequently the ethical justification for physician autonomy requires that they exercise liberty to promote their patient's best interests not their own interests. Therefore, physician autonomy is the freedom to determine both the conditions of practice and the care delivered with the principal goal that care decisions are aimed at promoting the patient's well-being. Requirements include that the physician is technically competent to assess the patient's illness and concerns and to recommend or perform appropriate care; care decisions are guided by the best available medical evidence and professional standards; and—when the patient is mentally competent—are made through a process of shared decision making.

Physician Autonomy and the ACA

Will health care reform restrict or enhance physician autonomy? The ACA contains many provisions that will both expand coverage for patients and reduce their financial barriers to adherence with physicians' clinical recommendations, such as removing co-payments from preventive services and subsidizing individual purchase of health insurance.[7] More relevant to physicians' autonomy, the ACA initiates payment reforms that will give physicians greater financial flexibility to redesign care delivery, and to provide services that may not have been reimbursed before. For example, traditional fee-for-service payment mechanisms do not reimburse for efforts to enhance medication compliance or to oversee the results of wireless physiological monitoring in patients' homes.

In contrast, an ACA pilot program featured bundled or lumpsum payments to physicians for the care of individual patients over time, allowing physicians to develop and deliver new approaches to care without being concerned about whether Medicare will pay for a specific service. For example, if congestive heart failure is selected for bundled payment, physicians will have the financial power to redesign the structure of posthospital care to improve patient adherence with medications and other tertiary prevention measure. Physicians could decide whether to introduce new wireless technologies for monitoring weight and blood pressure, or whether to make a house call instead of directing the patient to seek emergency department care.

Another provision of the ACA that offers physicians more liberty to pursue patients' best interests is the move toward accountable care organizations (ACOs), which are combinations of physician groups, hospitals, and other providers that will coordinate care for patients.[6] The proposed ACO regulations require physician leadership and empower physicians to determine the information systems and infrastructure necessary for coordinating care. The freedom to redesign care occurs along a spectrum depending on how the ACO is paid. Global or partial capitation that provides physicians with a pool of resources to manage a population of patients provides the maximal flexibility and liberty, although it also has the greatest financial risk.

See also p 369.

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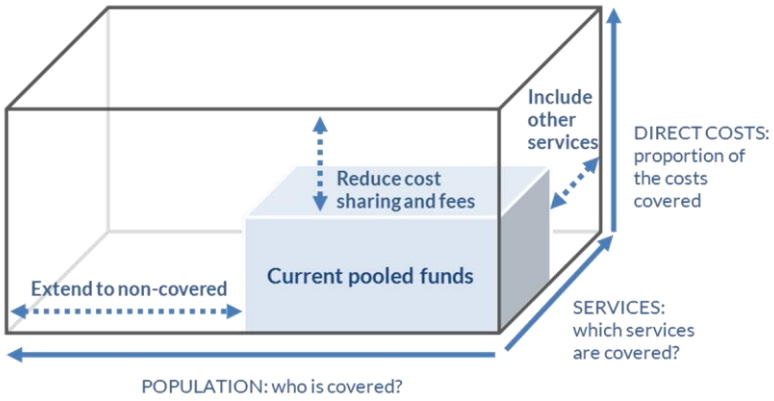
Corresponding Author: Ezekiel J. Emanuel, MD, PhD, University of Pennsylvania, 122 College Hall, Philadelphia, PA 19104 (zemanuel@upenn.edu).

"Many physicians are distressed as they look toward the future. A recent survey of physicians reported that 65% thought the quality of health care will deteriorate in the future. Part of this malaise is driven by concerns that reforms contained in the Affordable Care Act (ACA) will further erode physicians' autonomy."



Three dimensions to consider when moving toward universal coverage.

Hathout *Philosophy, Ethics, and Humanities in Medicine* 2012, **7**:11
http://www.peh-med.com/content/7/1/11

PEHM PHILOSOPHY, ETHICS, AND HUMANITIES IN MEDICINE

COMMENTARY Open Access

The right to practice medicine without repercussions: ethical issues in times of political strife

Leith Hathout

Abstract

This commentary examines the incursion on the neutrality of medical personnel now taking place as part of the human rights crises in Bahrain and Syria, and the ethical dilemmas which these incursions place not only in front of physicians practicing in those nations, but in front of the international community as a whole.

In Bahrain, physicians have recently received harsh prison terms, apparently for treating demonstrators who clashed with government forces. In Syria, physicians are under the same political pressure to avoid treating political demonstrators or to act as informants against their own patients, turning them in to government authorities. This pressure has been severe, to the point that some physicians have become complicit in the abuse of patients who were also political demonstrators.

This paper posits that physicians in certain countries in the Middle East during the "Arab Spring," specifically Syria and Bahrain, are being used as both political pawns and political weapons in clear violation of Geneva Convention and World Medical Association guidelines, and that this puts them into the most extreme sort of "dual loyalty" dilemma. They are being forced to choose between their own safety and well-being and that of their patients – a negative sum scenario wherein there is no optimal choice. As such, an international call for a United Nations inquiry must be made in order to protect the neutrality of medical care and personnel during times of armed conflict.

Keywords: Medical neutrality, Bahrain, Syria

Dual loyalties: Everyday ethical problems of registered nurses and physicians in combat zones

Nursing Ethics
1–16

10.1177/0969733017718394
journals.sagepub.com/home/nej
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Kristina Lundberg
Jönköping University, Sweden; University of Borås, Sweden

Sofia Kjellström
Jönköping University, Sweden

Lars Sandman
University of Borås, Sweden; Linköping University, Sweden

My duty on this operation was to be a nurse and to care for injured patients, and I did not want to be the one to hurt others. (Interview 9)

LMPs are not supposed to be used as liaison officers in order to rig information . . . it would be like a sort of espionage under false colours – no . . . (Interview 10)

Health and human rights

Military tribunals at Guantanamo Bay: dual loyalty conflicts

Jerome A Singh
Howard College School of Law, University of Natal, Durban 4041, South Africa

THE LANCET • Vol 362 • August 16, 2003

Apartheid South Africa highlighted how unilateral, self-serving security policies and acquiescent institutional associations can aggravate dual loyalty tensions. Physicians and institutional bodies must not subordinate their loyalty to patients to the interests of the state—even if the state is a superpower engaged in a so-called war on terror.

American Medical Association Journal of Ethics

October 2015, Volume 17, Number 10: 966-972

HISTORY OF MEDICINE

Dual Loyalties, Human Rights Violations, and Physician Complicity in Apartheid South Africa

Keymanthri Moodley, MBChB, MFam Med, DPhil, and Sharon Kling, MBChB, MMed, MPhil

Conclusion

Apartheid seriously corrupted the moral fiber of South African society in a manner that permeated and broke the core ethical covenants of the medical profession. Separation between the profession and the state became opaque and ambiguous. Through this dense veil of confusion, a minority of health professionals were able to see their way clear and rebel against injustices in health care in the prisons and security forces. However, the stance of many was one of indifference or, worse still, complicity.

HEALTH POLICY AND ETHICS

Resolving Ethical Conflicts in Practice and Research

Dual Loyalty in Prison Health Care

Jörg Pont, MD, Heino Stöver, PhD, and Hans Wolff, MD, MPH

American Journal of Public Health | March 2012, Vol 102, No. 3

"Professionals caring for prisoners should strictly and exclusively adhere to their role as caregivers to their inmate patients, acting in complete and undivided loyalty to them, and should firmly refuse to take over any professional obligation that is outside the interest of their prisoner patients."

Bioethical Inquiry (2014) 11:75–83
DOI 10.1007/s11673-013-9493-0

ORIGINAL RESEARCH

Human Rights, Dual Loyalties, and Clinical Independence

Challenges Facing Mental Health Professionals Working in Australia's Immigration Detention Network

Ryan Essex

"Staying silent in the face of human rights abuses only serves to exacerbate dual loyalty issues and may even result in collusion."

CENTENNIAL DECLARATION
Improving Global Health by Closing Gaps in the Development, Distribution, and Responsible Use of Medicines

The **responsible use of medicines** means:

- That a medicine is only used when necessary and that the choice of medicine is appropriate based on what is proven by **scientific and/or clinical evidence** to be most effective and least likely to cause harm. This choice also considers patient preferences and makes the **best use of limited healthcare resources**.
- There is timely access to and availability of quality medicine that is properly administered and monitored for effectiveness and safety.
- A **multidisciplinary collaborative approach** is used that **includes patients** and carers in addition to health professionals assisting patients in their care.

WHPA STATEMENT ON INTERPROFESSIONAL COLLABORATIVE PRACTICE

May 2013

Collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care across settings.

Professional regulatory systems and processes including professional competencies, practice standards, and scopes of practice should permit and facilitate effective collaborative practice.

Reliance on the “internal morality” of medicine

- “Do good and avoid evil is the *primum principium* of all ethics. All ethical systems, medical ethics included, must begin with this dictum, which means that the good must be the focal point and the end of any theory or professional action claiming to be morally justifiable.”
- “The good of the person served is linked ontologically to the end of the professional activity. It is not subject to change at will. With the good as the end of professional activity, **autonomy becomes mandatory since to violate autonomy is to violate the dignity and humanity of the person**.”

Journal of Medicine and Philosophy
2001, Vol. 26, No. 6, pp. 559–579

0360-5310/01/2606-559$16.00

The Internal Morality of Clinical Medicine:
A Paradigm for the Ethics of the Helping and Healing Professions

Edmund D. Pellegrino
Georgetown University, Washington, DC, USA

Conclusions

- As the working environment has changed for many health professionals, so professional autonomy has also been seen as under threat, or at least subject to change.
- On the positive side, collaborative practice has blurred the boundaries between professions and between professionals.
- However, health professionals also need to guard against the negative consequences of dual and divided loyalties.

Thank you!