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Medical Professionalism

The Royal Dutch Medical Association (KNMG)
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Contents **p.**

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Summary

The Dutch healthcare system and parts of the social security system are currently in transition, moving from a framework of price regulation to one of regulated market forces. The aim of these changes is to improve quality, accessibility, the degree of labour participation and affordability. This process places greater pressure on health insurers, income insurers and care providers to meet requirements such as giving concrete performance data and operating efficiently.

Society at large must be able to see how (collective) resources invested in healthcare have been used. The quality of care is made transparent and comparisons can be made thanks to performance indicators. The accountability of medical professionals and care providers speaks for itself in this regard, and making care transparent is indeed central to the quality policy. Doctors must not, however, be overloaded with administrative duties

Rarely do doctors still work alone. Their work is increasingly being carried out within a team context, through participation in healthcare chains and, in part, on a part-time basis. The shift towards teamwork (also outside institutions) and rearrangement of duties impacts upon responsibilities. These are shared and (re)distributed. Other responsibilities affect the doctor's professional autonomy.

The foundation of professional medical conduct is formed by research and consensus within the professional group, preferably laid down in standards, guidelines and protocols. These are based on the principle that each individual patient should receive optimal care – cheaply if possible, expensively if necessary. This principle can generate tension on the part of patients, insured parties, insurers, supervisors and government authorities, all of whom have their own views as to what constitutes good and qualitatively sound care. The fear of doctors is that non-medical professionals will to an increasing degree determine the actual care provided. The opinion of the professional group itself as to what the best care for a given patient would be does not become the leading opinion as a matter of course. Doctors experience this as a curtailment of their professional autonomy.

In view of the developments outlined in the foregoing, the Royal Dutch Medical Association (KNMG) is of the opinion that the import of these developments in terms of the exercise of the medical profession by doctors and professional autonomy must be made clear to doctors and to society at large.

The patient must be able to rely on the doctor to direct his knowledge, clinical and specific skills – also in terms of practical acts – as well as capacity for sound judgement towards the protection and restoration of his patient's health.

The professional demonstrates that he is worthy of trust through daily acts. Medical professionalism is:

'The values, forms of conduct and relationships with society as a whole that support and justify people's trust in doctors.'

Medical professionalism assumes mutual respect, individual responsibility and accountability. Medical professionalism is the cornerstone of the covenant between the medical profession and society. For the patient, the doctor's professionalism is the bedrock of his trust in the doctor; a trust that must be earned anew every day. The daily acts of doctors are based on roles and skills arising from competencies accepted by all specialised professional groups. These roles are elaborated in terms of operational behaviour, with respect to which the doctor is a role model. Medical professionalism is the encompassing role within which roles that doctors fulfil in practice can be distinguished: medical acts, knowledge & science, cooperating, communicating, acting socially and organising.

The assumption of responsibility by every medical professional is the basic principle. At the same time, he bears a joint responsibility with the parties referred to above. This requires ensuring that the shared and distributed responsibilities are linked effectively. Clear and balanced agreements must be made, established in concrete terms and complied with in respect of duties, responsibilities and management. In the interests of the patient there must be clarity about who is responsible for what and when. In doing so, doctors manifest medical leadership.

The adequate accountability within the professional group concerning medical practice forms part of a doctor's professional habit. An important method for doing so is testing by peers based on consensus about professional medical practice and applicable standards, preferably established in guidelines or sets of standards. Inter-peer testing is primarily a responsibility of the medical professionals. The systematic monitoring and improvement of quality are part and parcel of the work, and doctors give this process concrete form.

When rendering account, it is necessary to distinguish between two aims in advance: 1) learning from experiences and 2) monitoring. When rendering account, the following must therefore be clear: the aim of such rendering, the type of information being gathered, the frequency with which and the way in which this is done, the party registering the data, the party for whom the data is intended, and the way the data is to be used. Last but not least, the usefulness of the data to the medical professional himself must be determined. In other words, how does accountability contribute to the quality of care? In this connection, the parties involved must ensure that accountability does not become an end in itself and lead to unnecessary bureaucracy. In order to do this properly, doctors and their professional associations require the cooperation of patients, the management of the institution in question, health insurers and government authorities.

Medical professionalism forms the foundation of trust placed in doctors by patients and society. Due to the importance of public interest of health, members of society wish to have a healthcare system which they can use without anxiety or the fear that interests or considerations other than their individual health needs will play a determining role. That public interest of health must be maintained, even if circumstances change. Patients must be able to trust that the doctor will make their individual health needs the main priority, and that the doctor aims to provide the best quality of care possible for individual patients. After all, the government stands surety for accessible and qualitatively sound healthcare and cannot fulfil this function without the patient's trust in the doctor. This makes medical professional autonomy a matter of wider societal interest:

'The doctor's freedom to form an opinion without the interference of third parties, to make a diagnosis within the context of the individual doctor-patient relationship, and to provide advice about treatment and/or carry out diagnostic and therapeutic acts, all of which includes research and counselling activity with the aim of protecting and/or improving the health of the patient.'

The freedom of a doctor to make his own decisions is important, because it serves the patient's individual health needs, but is not unqualified. This freedom is, rather, determined by professional standards applicable to him which encompass rules of conduct, standards, guidelines and protocols. The application of standards, guidelines and protocols is not free of obligation. If a doctor deviates from the standard, he must be able to justify such a course of action on the basis of care-related expertise and lines of reasoning. In this sense, medical professional autonomy is also a form of 'freedom within given constraints' and forms part of professional responsibility.

Chapter 1 Introduction

Rationale
The Dutch healthcare system and parts of the social security system are currently in transition, moving from a framework of price regulation to one of regulated market forces. Moreover, legislation such as the Health Care Insurance Act (*Zorgverzekeringswet*), the Eligibility for Permanent Invalidity Benefit (Restrictions) Act (*Wet verbetering poortwachter*, Wvp) and the Income (Ability to Work) Act (*Wet werk en inkomen naar arbeidsvermogen*, WIA) was implemented in short order. The aim of these changes is to improve quality, accessibility, the degree of labour participation and affordability. This process places greater pressure on health insurers, income insurers and care providers to meet requirements such as giving concrete performance data and operating efficiently.

Due to the change in the system, individual doctors are themselves parties in negotiations with insurers to a greater extent than was previously the case. In this connection, doctors have business interests that they must weigh against collective interests. Because health insurers have commercial interests in the provision of care, doctors can also acquire commercial interests with respect to certain treatments or through prescribing medicines. The broadly held assumption is that doctors are capable of properly weighing the interests involved. If market forces exert too great a pressure on quality and production, however, then it must be asked whether this assumption remains justified.

Society at large must be able to see how (collective) resources invested in healthcare have been used. The accountability of medical professionals and care providers speaks for itself in this regard, and making care transparent is indeed central to the quality policy. Doctors must not, however, be overloaded with administrative duties (Council for Public Health and Healthcare [*Raad voor de Volksgezondheid en Zorg*, RVZ] 2001, RVZ 2006). A one-sided emphasis on arrangement, payment and inspection does not foster the necessary trust in medical professionals and adversely affects their intrinsic motivation (Brink 2005; Dijstelbloem 2004; Horton 2005; Jeurissen 2006; Kingma 2006; Meurs 2006; Maassen 2006; Tonkens 2003; WRR 2004).

The quality of care is made transparent and comparisons can be made thanks to performance indicators. An increasing number of surveys on who provides the best care and who is the most patient-friendly care provider, or on both subjects, are being conducted, and the media makes much of the results. Indeed, the call for performance measurement in the public sector has never been so loud (Westert 2006). As a result, there is a risk that scoring points with the public may become more important for the medical professional or care provider than providing the best possible treatment for the individual patient (Trappenburg 2005). As long as the indicators are measuring whether doctors are putting in enough effort, there is generally nothing amiss. The indicators, however, often measure results, and, although doctors aim to achieve agreed-upon results, they cannot always guarantee their achievement.

Rarely do doctors still work alone. Their work is increasingly being carried out within a team context, through participation in healthcare chains and, in part, on a part-time basis. The shift towards teamwork (also outside institutions) and rearrangement of duties impacts upon responsibilities. These are shared and (re)distributed. Such changing responsibilities affect the doctor's professional autonomy.

The foundation of professional medical conduct is formed by research and consensus within the professional group, preferably laid down in standards, guidelines and protocols. These are based on the principle that each individual patient should receive optimal care – as cheap as possible, expensive when necessary. This principle can generate tension on the part of patients, insured parties, insurers, supervisors and government authorities, all of whom have their own views as to what constitutes good and qualitatively sound care. The fear of doctors is that non-medical professionals will to an increasing degree determine the actual care provided. The opinion of the professional group itself as to what the best care for a given patient would be does not become the leading opinion as a matter of course. Doctors experience this as a curtailment of their professional autonomy (RVZ 2001; Holland 2005; Hoogervorst 2005; Vierhout 2005).

That others also wish to play a part in determining what constitutes good care is understandable in view of the problems, usually presented through the media, with regard to the performance of medical professionals and the consequences those problems can have for the quality of care. A characteristic feature of these

incidents is that many colleagues and care professionals were aware of the situation for a long time and intervention occurred far too late. This characteristic has undermined trust in the professional group.[1]

The discussion about the limitations of doctors' professional autonomy is always ongoing. Literature on the subject indicates that various definitions and perspectives are applied in the matter of professional autonomy. Discussions involve indiscriminate concoctions of political, economic, medical, sociological, ethical, ideological and social arguments. Countering medically substantive arguments with economic lines of reasoning only serves to obscure the debate (NRC 2007; Vierhout 2007).

In view of the developments outlined in the foregoing, the Royal Dutch Medical Association (KNMG) is of the opinion that the importance of these developments in terms of the exercise of the medical profession by doctors and professional autonomy must be made clear to doctors and to society at large.

Question and aim
The central question of this manifesto is: 'What does medical professional autonomy mean for doctors and society?' In order to be able to properly answer this question, it is first necessary to answer another, namely: 'What makes a doctor a medical professional?' The medical professionalism of a doctor constitutes the foundation of his or her practice and of the trust accorded to doctors by patients and society. The term 'trust' is a core element of this manifesto and is further elaborated upon in several places. Medical professionalism entails responsibilities, one of which is being accountable. By accountability, doctors demonstrate what their medical professionalism means and that they are worthy of the trust placed in them by patients and society. Being accountable is a key pillar of professionalism. For this reason, the following questions will be addressed: 'What are the objectives of accountability?' and 'What does accountability to the patient, professional group, the institution's management and society mean?'
Medical professionals who assume their responsibility, carry out their work well and render account in this regard are given the trust by patients to act autonomously within their respective professional contexts. This is not only a privilege; it is also a doctor's duty. The last chapter deals with this aspect.

The aim of this manifesto is to perpetuate and promote the trust that society should be able to place in medical professionals.

Target group
This manifesto is intended for doctors and other professionals working in healthcare, patients, insured parties, insurers and government authorities.

Status of the memorandum
This manifesto was adopted by the board of the Royal Dutch Medical Association (KNMG).

Reader's guide
Chapter 2 elaborates upon medical professionalism and indicates that it is a prerequisite to medical professional autonomy. In this connection, two important core elements, namely accountability and responsibility, are discussed. Chapter 3 describes medical professional autonomy and the meaning and limitations associated with it. Chapter 4 addresses what medical professional autonomy means for doctors and society.

It goes without saying that where 'he' is used to refer to doctors, this should also be read as meaning 'she'. The same applies with regard to references to patients.

'Doctors' refers to all doctors, i.e. also to specialists in public health medicine, company doctors, insurance company medical advisers and medical specialists in society and health.

'Treatment' and/or 'act' include research and the provision of advice with the aim of protecting and/or improving a patient's state of health and/or increasing the degree of social participation.

[1] This trust is undermined just as strongly when issues are not revealed to the public. The social impact and disquiet is greater when such issues do receive news coverage (see *NRC Handelsblad* 2006).

Chapter 2 Medical professionalism

After describing the doctor-patient relationship, this chapter offers a definition of medical professionalism and subsequently addresses the various roles a doctor has in practice. The focus then shifts to the responsibilities arising from medical professionalism.

2.1 Introduction

The doctor of today differs from his counterpart of the previous century and works under different circumstances. 'The doctor then was male, a one-man act, had his own practice and was available 24/7. He took decisions about his patients himself; no one else had a say in the matter' (Groenewegen 2007). Today's doctors always work as part of a team of doctors and/or other professionals. This can be a small team comprising the doctor and his assistant or a large team in a hospital. More than was previously the case, the doctor works on a part-time basis as an employee and more often than not is a woman rather than a man. Treatment decisions are increasingly team decisions made within the context of multidisciplinary guidelines and institutional frames of reference. The doctor of the present and future works and will work together with others: practising in 'splendid isolation' is not an option.[II]

2.2 The doctor-patient relationship

The most important collaborative partner of the doctor is the patient. After all, by virtue of the Medical Treatment Contracts Act (*Wet op de geneeskundige behandelingsovereenkomst*, Wgbo) the doctor requires the patient's consent. This is the patient's autonomy. Patients are critical consumers who wish to be well informed in a timely manner and participate in decision-making about their treatment. Sometimes patients require (acute) care to survive or to solve an urgent medical problem. Other patients, or the same patients at different times, will tend more towards the stance of critical consumer who, depending on supply, determines what he does or does not wish to consume. Patients want to be partners in the care process, expressly involved in decision-making within that process and assume their own responsibility for a well-considered choice (RVZ 2001). Patients may have high expectations regarding a doctor's social and communication skills. Moreover, evidence-based medicine makes a doctor's acts transparent to patients. Sources available to patients like the Internet constitute an additional dimension in this regard.

2.3 Medical professionalism

Although patients are more vocal and critical, they are also often individuals in distress in need of care and support precisely in order to preserve their autonomy and in the making of choices. Patients remain, though more vocal, dependent on their doctors, and doctors must handle this vulnerability with due care. The patient must be able to rely on the doctor to direct his knowledge, clinical and specific skills – also in terms of practical acts – as well as capacity for sound judgement towards the protection and restoration of his patient's health.

The professional demonstrates that he is worthy of trust through daily acts. Medical professionalism is (KNMG 1992; ABIM 2002; KNMG 2002a; RCP 2005):

'The values, forms of conduct and relationships with society as a whole that support and justify people's trust in doctors.'

The values and standards for the acts of doctors are established in the solemn affirmation or the medical oath and the Royal Dutch Medical Association's rules of conduct (KNMG 2002b; Medical Oath Review Committee 2003). Medical professionalism assumes mutual respect, individual responsibility and accountability. Medical professionalism is the cornerstone of the covenant between the medical profession and society. For the patient, the doctor's professionalism is the bedrock of his trust in the doctor; a trust that must be earned anew every day.

[II] The term was originally used to refer to British isolationism with respect to international politics in the 19th century. Britannia ruled the waves; she needed nobody and had nothing to fear.

The daily acts of doctors are based on roles and skills arising from competencies accepted by all specialised professional groups (ABIM 2002; CanMEDS; RCP 2005; KNMG General Competencies).[III] These roles are elaborated in terms of operational behaviour, with respect to which the doctor is a role model (Van Diemen 2006). Medical professionalism is the encompassing role within which roles that doctors fulfil in practice can be distinguished (see Figure 1).

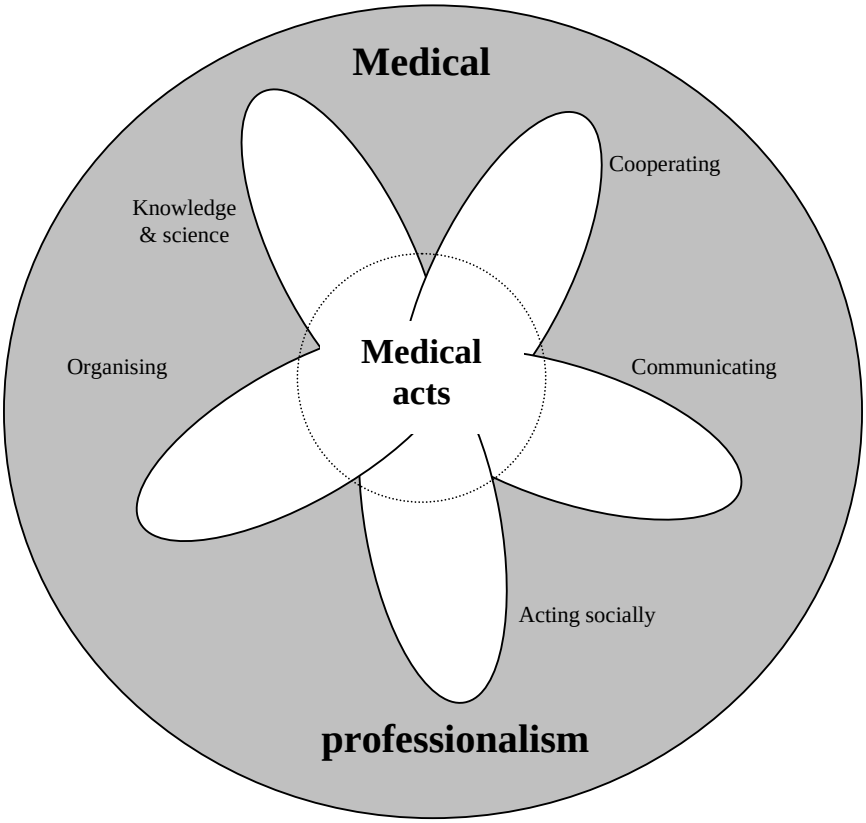

Figure 1. Medical professionalism is the encompassing role within which six roles can be distinguished: medical acts, knowledge & science, cooperating, communicating, acting socially and organising.

A good doctor is a medical professional: he is a medical expert, he keeps his professional know-how up-to-date, communicates in an empathic way with his patients, cooperates with colleagues, exercises his profession within the (moral) boundaries of the professional group, organises quality in his practice and renders account.

The doctor needs society to place trust in him. Trust is necessary for the proper operation of the healthcare sector as a whole, for the doctor-patient relationship *and* for the intrinsic motivation of medical professionals. The medical professional's intrinsic motivation is the most powerful driving force for qualitatively sound, meaningful and efficient care.

2.4 Assuming responsibility

In the interests of the patient's health, the doctor aims to provide the best possible care and is personally responsible for his (own) medical activities in this regard (KNMG 2002a; NVVA 2004; Wesseling 2005). Assuming responsibility therefore requires the medical professional to adopt an entrepreneurial stance; to be someone who undertakes action when it comes to the continuity of cooperation, harmonising activities, exchanging information and communicating.

The medical professional's responsibility also includes shared responsibilities: responsibilities shared with the patient, other medical practitioners, the management board, the professional group and society.

[III] The occupational profile is the foundation of a doctor's training, through which he learns to unite these roles.

The assumption of responsibility by every medical professional is the basic principle. At the same time, he bears a joint responsibility with the parties referred to above. This requires ensuring that the shared and distributed responsibilities are linked effectively. Clear and balanced agreements must be made, established in concrete terms and complied with in respect of duties, responsibilities and management (Joeloemsingh 2007). In doing so, doctors manifest medical leadership. In the interests of the patient there must be clarity about who is responsible for what and when. It is precisely a lack of organisation that can have far-reaching consequences for the quality and continuity of care.

2.5 Accountability

Performance and quality must be demonstrable. A doctor provides explanation, ensures that his acts are verifiable and renders account. The medical professional has a natural desire to see and show how he acts in terms of the actual provision of care and performs with respect to applicable standards and colleagues. The systematic monitoring and improvement of quality are part and parcel of the work, and doctors give this process concrete form (Council for Public Health and Healthcare 2006; Jeurissen 2006). Doing so forms part of professional responsibility, not because doctors are asked to do so but precisely because it is an integral facet of their professional habit. Accountability legitimises a doctor's acts. By accountability, doctors show what their medical professionalism means.

2.5.1 Aims of accountability

Making healthcare transparent is central to the current quality policy (Council for Public Health and Healthcare 2006). Society at large must be able to see how the collective resources invested in healthcare have been used. By accountability, doctors can contribute to that transparency.

When rendering account, it is necessary to distinguish between two aims in advance: 1) learning from experiences and 2) monitoring, because if information intended for learning purposes (for internal use) were used for (externally conducted) monitoring this would constitute a breach of trust. Doing so would undermine the willingness to gather data and make it available (Hoek 2007). When rendering account, the following must therefore be clear: the aim of such rendering, the type of information being gathered, the frequency with which and the way in which this is done, the party registering the data, the party for whom the data is intended, and the way the data is to be used. Last but not least, the usefulness of the data to the medical professional himself must be determined. In other words, how does accountability contribute to the quality of care? In this connection, the parties involved must ensure that accountability does not become an end in itself and lead to unnecessary bureaucracy.
The adequate rendering of account requires medical professionals to assume responsibility for the systematic organisation of quality within their practices. In order to do this properly, doctors and their professional associations require the cooperation of patients, the management of the institution in question, health insurers and government authorities.

2.5.2 Accountability to the patient

It goes without saying that the doctor renders account of his medical acts to the patient. This is preceded by the provision of necessary information to the patient, on the basis of which permission for medical treatment is granted. In other words, the doctor explores the care requirement with the patient, determines the diagnostic process, and explains his diagnosis and the proposed treatment (including the risks and benefits and drawbacks). It is important in this connection for the individual patient to know that the information he has provided to the doctor will not be used for other purposes without his permission (professional secrecy). Professional secrecy is a patient's right *and* a doctor's duty.

2.5.3 Accountability within the professional group

The adequate rendering of account within the professional group concerning medical practice forms part of a doctor's professional habit. An important method for doing so is testing by peers based on consensus about professional medical practice and applicable standards, preferably established in guidelines or sets of standards. Inter-peer testing is primarily a responsibility of the medical professionals. The doctor must also be able to justify his medical policy to testing bodies such as the Healthcare Inspectorate, the euthanasia review committees and the disciplinary court.

Accountability within the professional group also means calling colleagues to account when they act incorrectly, even if such action does not lead to risk or damage to patients. After all, the issue is that incorrect actions have been observed, and ignoring such situations would be inappropriate. Groups of general practitioners, partnerships, sections, medical staff and other collaborative arrangements in which doctors participate must conclude agreements in this regard. Doing so makes it easier to address a colleague about his professional conduct and prevents this step from being taken only when it is too late. For this purpose, it is important to have procedures in place aimed at the systematic evaluation of professional conduct in a way that respects the interests of all parties involved (KNMG 2005). The formulation, implementation and supervision of such procedures is a joint responsibility of professionals and institutions.

2.5.4 Accountability to management

The Care Institutions (Quality) Act (*Kwaliteitswet zorginstellingen*) stipulates that the institution is responsible for the provision of responsible care. Care providers (professionals and institutions) are themselves primarily responsible for putting the term 'responsible care' into practice. For the doctor, the cardinal point is the health of the patient. In addition, the doctor is of course also bound to institution-based agreements. Doctors working in an institution, irrespective of whether they are doing so as an employee or by virtue of an admission agreement, are obliged to adhere to (policy) agreements concluded or that apply within the institution, partnership, section, department or otherwise. Doctors render account of their acts to management. An institution's medical policy is, after all, established in consultation with and with the consent of the doctors.

If a doctor is of the opinion that a patient requires treatment that deviates from the medical policy, for example with a medicine not provided by the institution, it is the doctor's duty to refer the patient to a colleague or institution that does provide the medicine in question or where a reimbursement arrangement exists. At the same time, the medical policy must be raised for discussion with management on the basis of expertise and arguments relating to the actual care provided.

2.5.6 Accountability to society

It is also necessary for doctors to render account to organisations in society such as health and income insurers. Account is rendered about the price and quality of the performances achieved in order to secure reimbursement for them. The doctor must also be able to justify his medical policy to the Healthcare Inspectorate, the Dutch Healthcare Authority or in court.

Doctors must aim to act effectively and efficiently. Institutions, insurers and government authorities are entitled to urge doctors on to this end. In doing so, however, they may not compromise legal entitlements, the legal certainties of patients, and doctors' freedom of action in medical terms (Bosch 2004; Wigersma 2006).

Doctors must have knowledge of the care included in the basic health insurance basket. If a certain type of care is not included in the health insurance basket, the doctor must inform the patient accordingly in a timely manner, i.e. before treatment commences. Doctors cannot start a treatment if it is still unclear whether or not the patient's insurance policy covers its cost. The financial consequences must be discussed with the patient in advance so that the patient can take them into account when considering whether or not to undergo the treatment in question.

Chapter 3 Medical professional autonomy

This chapter further elaborates on the meaning of medical professional autonomy for doctors and society. The first point to be addressed is the public interest of health. This is followed by a description of what medical professional autonomy should be understood to mean and the limitations that apply to it.

3.1 The importance of public health

Medical professionalism forms the foundation of trust placed in doctors by patients and society. Due to the importance of public interest of health, members of society wish to have a healthcare system which they can use without anxiety or the fear that interests or considerations other than their individual health needs will play a determining role. That public interest of health must be maintained, even if circumstances change. Patients must be able to trust that the doctor will make their individual health needs the main priority, and that the doctor aims to provide the best quality of care possible for individual patients.

Patients must be able to rest assured that they are receiving the best possible quality from the doctor. Not only the patient and doctor have an interest in this trust, the government does too. After all, the government stands surety for accessible and qualitatively sound healthcare and cannot fulfil this function without the patient's trust in the doctor. This makes medical professional autonomy a matter of wider societal interest.

Moreover, there is a growing population of vulnerable elderly patients. Doctors must handle this vulnerability with due care. In a relationship of dependence, the patient must be able to trust that the doctor will do his utmost to deploy the full range of his knowledge in the service of the patient's individual health needs. Herein lies the doctor's primary loyalty and responsibility. This forms the foundation of professional ethics (KNMG 1992; Trappenburg 2005).

3.3 Medical professional autonomy

In order to be able to serve the patient's individual health needs as effectively as possible, the doctor requires the freedom to form an independent opinion as to what would be best for the individual patient. The decision to commence treatment is made after consultation with and the consent of the patient. In the interests of the patient, the doctor can commence treatment should the patient be incapable of making independent decisions. The doctor must always provide care that serves the health needs of the patient. This means that the doctor can refuse to administer a certain type of treatment if he believes it is not in the best interest of the patient or would even be damaging. The doctor must provide qualitatively sound care that is in any case appropriate, effective and patient-oriented, and attuned to the actual individual needs of the patient.

The doctor's freedom to form an independent opinion is crucial precisely because it serves the patient's individual needs. Given the applicable legal frameworks and professional standards, medical professional autonomy is:[IV]

'The doctor's freedom to form an opinion without the interference of third parties, to make a diagnosis within the context of the individual doctor-patient relationship, and to provide advice about treatment and/or carry out diagnostic and therapeutic acts, all of which includes research and counselling activity with the aim of protecting and/or improving the health of the patient.'

In other words, medical professional autonomy is the formation of an opinion free of influences from the state, church, market, employers, financial principals or, for example, financial incentives aimed at personal or shareholders' profit.

[IV] The term 'professional standards' refers to all of the rules and standards which a provider of care must duly observe in the performance of his work, and includes both technical aspects of the job, standards concerning the relationship with the patient, and social requirements pertaining to scrupulousness (Legemaate 1995; Medical Oath Review Committee 2003).

3.4 Limitations of medical professional autonomy

The freedom of a doctor to make his own decisions is not unqualified. This freedom is, rather, determined by professional standards applicable to him which encompass rules of conduct, standards, guidelines and protocols. The doctor's professionalism means that he must act in an evidence-based way to the greatest extent possible according to the most up-to-date scientific insights. The application of standards, guidelines and protocols is not free of obligation. In carrying out his work, the doctor must 'take the care of a good care provider into account and, in this connection, act in accordance with the responsibility he bears arising from the professional standard applicable to a care provider' (Section 453, Book 7 of the Dutch Civil Code).

But professionalism is also the doctor's ability to adequately respond to unique features of a given situation on the basis of his expertise and in a way that goes beyond standardisation (Jeurissen 2006). Doctors have a duty to decide whether it is necessary to deviate from the standard. If a doctor deviates from the standard, he must be able to justify such a course of action on the basis of care-related expertise and lines of reasoning. In this sense, medical professional autonomy is also a form of 'freedom within given constraints' and forms part of professional responsibility (KNMG 1992; Van Oorschot 1995; Van der Heyden 1998). The degree to which a doctor may act with professional autonomy depends on his expertise and the quality of his arguments, and is as such closely linked to his medical acts. The more (policy) decisions in which doctors are involved become divorced from the treatment of the individual patient, the more the medical professional autonomy of doctors will be corroded.

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