Professional Autonomy and medical practice
(running title)

PROFESSIONAL AUTONOMY AND THE NORMATIVE STRUCTURE OF MEDICAL PRACTICE
(full title)

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ABSTRACT. Professional autonomy is often described as a claim of professionals that has to serve primarily their own interests. However, it can also be seen as an element of a professional ideal that can function as a standard for professional, i.c. medical practice. This normative understanding of the medical profession and professional autonomy faces three threats today.
a) Internal erosion of professional autonomy due to a lack of internal quality control by the medical profession; 2) the increasing upward pressure on health care expenses that calls for a health care policy that could imply limitations for the professional autonomy of physicians; 3) A distorted understanding of the profession based on a formal type of knowledge and related technology, in which other normative dimensions of medical practice are neglected and which frustrates meaningful communication between physicians and patients.
To answer these threats a normative structure analysis of medical practice is presented, that indicates which principles and norms are constitutive for medical practice. It is concluded that professional autonomy, normatively understood, should be maintained to avoid the lure of the technological imperative and to protect patients against third parties' pressure to undertreatment. However this professional autonomy can only be maintained if members of the profession subject their activities and decisions to a critical evaluation by other members of the profession and by patients and if they continue to critically reflect on the values that regulate today's medicine.

Key words: benevolence, constitutive rules, formal knowledge, normative practice, pluralism, professional autonomy, world view.

I. INTRODUCTION

Today and in the near future, the central health care policy issue in the Western countries will be how to guarantee a minimal level of health care for everyone. This problem cannot be solved without considering the role of physicians and the decisions they make. In other words, the debate on cost containment in health care cannot avoid a confrontation with the issue of professional autonomy. This is clearly demonstrated elswhere in this issue by the papers on professional autonomy in some European countries [18, 26].

Two main approaches to the concept of professional autonomy can be distinguished. The first is an empirical-sociological one, with the concept of professional autonomy pertaining to the actual power or competences of physicians within the health care system. This approach is dominant in such disciplines as medical sociology. It can demonstrate the actual power of professions, and consequently serves a

critical function. This approach highlights the fact that professional power is a societal reality with important implications [11, 13, 23]. And it shows that professional pretensions can have a veiling function, which are not necessarily borne out in professional practice.

But this approach cannot point in the direction of the effectuation of professional pretensions. Is a high degree of professional autonomy a necessary condition for excellent task-fulfilment by professionals? What are the limits of this autonomy? In order to answer these questions, another approach is called for. We call this a normative approach.

In this second approach, the concept of professional autonomy is considered a professional ideal and related to a standard of excellence for a particular profession. These standards can be found among lawyers, notaries, health care workers, accountants and so forth. All these professions involve personal services marked by a high level of confidentiality. The professional has a duty of secrecy and has to comply with supreme discretion.

The difference between a normative and an empirical approach is that the former provides a view of the professional ideal or profession standard. It addresses the duties and obligations of a profession, over against its claims.

In this article, we will mainly focus on the second approach and present a normative view of the profession and of professional autonomy.

II. THE PROFESSIONALISM IDEAL

Before presenting a normative view of the medical profession, let us clarify what we consider to be characteristic of this profession. (Since we do not focus here on professions in general, but only on the medical profession, we confine ourselves to this profession). In agreement with other authors, we consider three features to be essential. First, a profession is marked by a high degree of "control over the determination of the substance of its own work" [11, p. xvii]. Secondly, a profession is centered around a highly specialized body of knowledge and thirdly, each profession provides a service which is highly appreciated by society and in which a high degree of confidentiality between professional and client is required [13, 23, 36].

A normative view of the medical profession centers around a normative ideal, which we call medical professionalism. It has been noted above that a profession is characterized by legal privileges and competences, which are conferred by the state on the profession because it provides highly appreciated goods to society. In the case of the medical profession, these goods concern human health and well-being [24].

This means that medical professionals, although they earn a living by their profession, are dedicated to a selfless rendering of assistance. This may well seem to be very idealistic and at odds with reality, since medical professionals often charge such high fees for their services. But as we shall see, it is of the utmost importance for the profession to uphold this professional ideal. This does not mean that in itself, it is wrong to earn a living helping people, but it does mean that the internal normative structure of medical practice sets serious limits (see also section 4).[1]

This means there are certain claims inherent to a profession. "First, the claim is that there is such an unusual degree of skill and knowlegde involved in professional work that nonprofessionals are not equipped to evaluate or regulate it. Second, it is claimed that professionals are responsible - that they may be trusted to work conscientiously without supervision. Third, the claim is that the profession itself may be trusted to undertake the proper regulatory action on those rare occasions when an individual does not perform his work competently or ethically. The profession is the sole source of competence to recognize deviant performance, and it is also ethical enough to control deviant performance and to regulate itself in general. Its autonomy is justified and tested by its self-regulation" [12,p.13, 11,p.93ff].

These claims call for a critical attitude towards professions. Freidson says for example: "I believe that expertise is more and more in danger of being used as a mask for privilege and power rather than, as it claims, as a mode of advancing the public interest" [12,p.337, 22,p.69, 23]. The privileges of the members of a profession refer to their discretionary competence and to their autonomy to manage their

own work, their quality control, their education, their disciplinary law/rules and the admittance of new members of the profession. Here we encounter the *paradox of autonomy*. The two poles of this paradox are 1) that autonomy is essential for members of a profession to fulfill their task as members of a profession and 2) this autonomy makes it very difficult to check whether they fulfil their task adequately [17,p.62ff].[2]

In keeping with Freidson, we can say that the success of the profession's self-regulation is a test and a justification of its professional autonomy. This means the societal support for its autonomy will only endure if the medical profession as a whole and its individual members accept accountability for the performance of medical practice.

III. PROFESSIONALISM AND THE RATIONALIZATION OF LIFE

There seem to be three threats to professional autonomy today. The first is the internal erosion of professional autonomy due to a lack of internal quality control by the medical profession and the use of its autonomy for its own interest. This is often analyzed by theoreticians who explain of professional autonomy in terms of social power. The problem is formulated here in the *paradox of autonomy*.

The second is related to the problems of rationing health care systems in the western post-industrial world. One of the main determinants of this problem is technological development. The technological treatment options have increased enormously. There are many techniques that visualize the most inaccessible parts of the human body. This means it is possible to diagnose diseases much earlier (e.g. screening programs for prostate or breast cancer). Genetic tests increasingly enhance to this development [6]. So it is often possible to find diseases before a person falls ill. With some exaggeration, one could say that today everyone is ill until proven healthy. This means people often want to be examined medically just to be sure about their health. Therapeutic possiblities have increased as well, such as new drugs that are sometimes very expensive. These tendencies could lead to an ongoing increase in the demand for health care facilities. Most health care expenditures follow from decisions made by doctors. One way to contain health care costs, would thus be to restrict the physicians' professional autonomy. By influencing their decisions, health care costs could be reduced.

A third threat is related to the knowledge that plays a central role in the medical profession, which Freidson characterizes as ‘formal knowledge’. He uses this term because of its formalization: "In the West, higher knowledge was formalized into theories and other abstractions. (...) Formalization so distinctly marks modern higher knowledge that it is appropriate to call it formal knowledge. Formal knowledge remains separated from both common, everyday knowledge and nonformal specialized knowledge" [13,p.3]. According to Freidson, the character of this kind of knowledge can be indicated by Weber's concept of *rationalization*: "Rationalization consists in the pervasive use of reason, sustained where possible by measurement, to gain the end of functional efficiency. Rational action is organized to address both the material and the human world, and it is manifested most obviously in technology but also in law, the management of institutions, the economy, indeed, in the entire institutional realm of modern society" [13,p.3].

In keeping with Habermas we can characterize the rationality regulating this type of knowledge as technical or instrumental rationality. The core of this type of rationality is the relation between the goal and the means of action. Instrumental rationality is directed at finding the most rational effective and efficient means to reach certain goals. A rational orientation in human action consists in performing the right actions to reach one's individual or collective goals. From this perspective, other human beings with their own goals only serve as means or preconditions or circumstantial factors to reckon with, and never as ends in themselves. Subsystems of goal-oriented rational action are integrated by this means-goal orientation. Their functioning is separated from communicative interaction that aims at mutual understanding. As a consequence, ethics is marginalized. In this view, ethics is only relevant with respect to the choice of goals and the application of acquired techniques to achieve them.

According to Habermas, modern society is dominated by this rationality and the related action coordination. In his view, the subsystems of goal-oriented rational action are colonizing the life-world as

the domain where human beings interpret their existence and give meaning to it. In fact, however, this domain of the life-world needs another rationality to reproduce itself in the right way: the rationality of communicative action.

As regards this formal or instrumental knowledge, there are two things we can say. In the first place, the abstraction level of this knowledge differs from that of the 'narrative structure' of the lifeworld. The patient consults a physician with a complaint embedded in his own lifeworld. His pain or illness prevents him from functioning normally. So there is a frustration of the meaning coherence of everyday life. In consulting the doctor, the patient talks about his complaint in the language of his own experience [14]. This language is `translated' by the doctor into the terms of his medical 'formal knowledge'. The complaint is interpreted and reconstructed in clinical concepts. In this process of interpretation and translation, some parts and aspects of the original message are lost and others are analyzed and rationalized. If the physician neglects this epistemic difference between his formalized knowledge and the 'narrative' of a patient's complaint, and does not `translate' his medical conclusions `back' into the patient's narrative, a communication problem may arise. This may undermine the relationship of trust between the patient and the doctor. But an additional problem may arise.

The meaning and normativity intrinsic in the patient's lifeworld is filtered out in the professional knowledge. This formal knowledge is characterized by goal-oriented rationality and instrumentality. The same is true for technology based on formal knowledge. In itself this technology lacks the meaning coherence and normativity of the patient's lifeworld. It is a means to achieve certain goals set by the user of the technology. The one who manages the medical technology is primarily the physician who, in his eagerness to help, sometimes uses technology merely because it is available. We think this underlies the criticism of Illich and others that modern medicine has become too technical, making patients dependent and failing to do justice to the patient as a human being [19, 16,p.28]. In Habermas' terms, the lifeworld of the patients is colonized by the formal knowledge of the professional. So to the extent that patients perceive the physician as an agent of medical technology based on formalized knowledge, they will want to set the goals themselves. Patients do not necessarily trust the physician to use his professional skills in a way corresponding with their lifeworld. This kind of distrust of the profession can clearly undermine the professional autonomy.[3]

However, in our opinion Habermas' analysis does not solve the problem of the colonization of the lifeworld by instrumental rationality. According to Habermas, the fragmentation and colonization of the lifeworld results from a one-sidedness in the Western process of rationalization. Due to the neglect of the communicative dimension of rationality, only the 'metabolism' (Marx) between mankind and the non-human nature is rationalized in the sense of instrumental rationality. Thus Habermas' solution consists in broadening the rationalization process to communicative interaction. In Habermas' view, the rationalization of the lifeworld (by communicative rationality) means the loss of traditional substantial worldviews, since it can only be based on the rational consensus achieved in a free discussion between everyone involved. Hence, Habermas feels the process of rationalization should be interpreted as an advancement. It diminishes the impact of dogmatic, substantial worldviews and religions in favor of an attitude of seeking mutual understanding by respecting the basic procedures of symmetrical communicative action. Habermas does not seem to realise that this farewell to substantial worldviews results in the loss of the experience of meaning and of basic values. The problem noted by Weber that Western rationalization ends in a total loss of freedom and meaning cannot be solved only by extending instrumental rationality to a broader, communicative concept of rationality. This needs to be accompanied by a substantial view of the meaning of life and reality, which cannot be derived from formal procedures that regulate a rational type of communicative action.

So it is not enough to resist the colonization of the lifeworld by instrumental rationality. The loss of substantial worldviews solidly embedded in a tradition should be dealt with, since it has been this loss that diminished the resistance of the lifeworld to an increasing domination by formal knowledge and technology.

In our view, these threats to professional autonomy require a reflection on the structure and character of medical practice and on the role of regulating views in it. This will demonstrate that medical practice

itself has a normative structure which can only be disclosed under the direction of regulative views on health, health care, medical practice and the professionalism ideal. Such an analysis should provide insight in the normative character of the medical profession and provide the context for a meaningful understanding of the function and limits of professional autonomy.

IV. THE NORMATIVE STRUCTURE OF MEDICAL PRACTICE

A. Normative practices

In this section we briefly present a model of medical practice that demonstrates the normative structure of medical practice [17]. A schematic presentation consists of the following elements.

a) Medical practice is understood as a *practice* in the sense of a coherent form of human activity and related competences. These competences are grounded in rules. Here the concept of `rule' does not refer to rules in the sense of `knowing that', which implies the ability to formulate the applied rules. Rather, it refers to rules in the sense of `knowing how', which is an intuitive awareness of rules, consisting in the ability to act according to a rule and to evaluate the correctness of this application. It will be clear that performing a practice, e.g. playing the violin (by a professional violinist) or practicing medicine, cannot be learned just by theoretical instruction, but that it is indispensable to be engaged in that practice. Thus, a competence exists in the ability to act according to the (usually implicit) rules of the particular practice. These rules have an intrinsic normative nature in the sense that they prescribe a certain way of performing a practice and at the same time constitute the possibility to evaluate the correctness of the actions performed within that practice. In other words, these rules function as quality standards for the performance of the practice

b) Another important notion of practice is derived from the definition formulated by MacIntyre: "By a `practice' I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" [26,p.175]. The term `internal goods', as it is used in this definition, is often interpreted in terms of goals. But goals are always related to individual or collective actors. And the goals set by the actors do not necessarily constitute the `internal goods' of a practice. For example, a person could frequently play billiards with the goal of becoming the best billiard player in a pub. Yet, one cannot consider this goal the `internal good' of the game of billiards. Its internal good is to play the best possible shots within the rules of the game.
To avoid the ambiguity of the term `internal good' we refer to the finality of a practice.[4] A practice's finality determines what goals are appropriate within that practice and it contains standards which are decisive for the kind of performance that is adequate within a practice.

c) Integrating the two previous elements, we describe a practice as a coherent form of human activity in which (usually implicit) rules, related to the internal nature and finality of the practice, define the competences and standards of adequate performance of that practice. We refer to rules that combine these characteristics as `constitutive rules'. The `constitutive rules' make a practice recognizable as a specific practice and determine its finality. The normative structure of a practice, its constitutive side, can be considered the `playing field' for concrete goals and actions within that practice.

d) How do we find the normative constitutive rules for a practice? In every practice a number of aspects can be distinguished. Here the concept of `aspect' refers to an irreducible mode of human experience that at the same time constitutes a way of evaluating human activity, e.g. the performance of practices [9]. The way a person, for instance a professional violinist, performs a practice can be assessed from a logical-analytical, a social, an economic, a legal, an aesthetic and an ethical point of view. How do we find the criteria for the assessment from these points of view?

Each of the modal aspects has a core meaning that is a normative principle. These normative principles can be used as criteria in the evaluation of a particular performance of a practice. The

constitutive rules can be derived from these normative principles (Fig. 1).

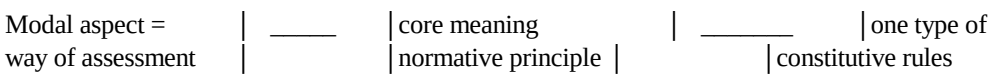

Fig. 1. Relation between modal aspect and constitutive rules of a normative practice
Step (1) follows from the philosophy of H. Dooyeweerd, step (2) does not involve a logical derivation but an elaboration of the normative principles in normative rules.

So each of the aspects in which practices function provides a normative principle and related constitutive rules that define an adequate performance of the practices.

All practices function in all aspects, but the aspect-related rules do not apply to all practices in the same way. The constitutive rules can be divided into three categories: qualifying constitutive rules, foundational constitutive rules and conditional constitutive rules.

The qualifying rules are derived from the normative principle of the aspect that gives a particular practice its own typical character, the qualifying aspect. This qualifying aspect and its normative principle are directly related to the finality of the particular practice. For example, the practice of the manager of an enterprise is economically qualified with efficiency as the normative principle and efficient production (of goods or services) as its finality.

The founding constitutive rules are related to the founding aspect of the practice. They pertain to the `technical' activities appropriate for a specific practice. This founding aspect is generally the technical aspect, e.g. the specific techniques that form the basis of a professional violinist's practice.

The rules related to the social, economic and the legal aspects are the conditioning constitutive rules. Adherence to the founding and conditioning constitutive rules should be guided by the normative principle of the qualifying aspect, which is related to the finality of the practice.

Competent performance of a practice requires the *simultaneous realisation of the rules* (that function in the assessment as *norms*) related to the various aspects. Since the constitutive rules also function as quality standards, this model can serve as a basis for integral quality management for medical practice.

Before we elaborate upon this analysis for medical practice, one more element should be added to the model. The constitutive side of a practice pertains to the normative constitutive rules that relate to the various perspectives (aspects) a performance of a practice can be assessed from. However, an assessment always involves a specific *interpretation* of the rules. (The interpretation of a piece of music also depends on the ideas of the performer on how the piece should be understood and performed.)

In other words, the performance of a practice always takes place from a wider interpretative perspective on the meaning of that practice to human life and society, and hence on the *direction* performances of that practice should take. We call this the regulative side of practices. At this level, worldviews have a regulating function: depending on their view on the meaning and coherence of reality, people act differently in concrete practices. The (constitutive) *structure* of a practice does not determine the *direction* of their performance; the rules of a game do not determine the course of an actual game but only which courses are correct. It is part of the character of normative practices that they can only be `opened up' by regulative ideas about the meaning and structural coherence of human experience.

B. Structural analysis of medical practice

Constitutive rules

What does this theoretical framework of social practices mean as regards medical practice? To trace the constitutive rules of medical practice, we start from what the Dutch physician/ethicist G.A. Lindeboom called `the core medical situation': "the core medical situation is where a sick person summons a physician for help. The sick person is a human being in need, because of his physical or mental

condition. In his need he seeks help from someone whom he believes is able and willing to give it" [35,p.121,122]. This `core medical situation' consists of three elements: (1) the appeal of the suffering patient, his complaint (2) the special competence of the physician; and (3) the professional character of medical practice.

The third element is basic for the other two. A profession can be described as a `body of persons engaged in a calling' in which the calling can be formulated as `the rendering of a public service'[5] (cf. section 3). The oath professionals take before they begin to practice their profession should be seen in this context. It has to assure the (potential) patient/client that the professional will use his specialised knowledge and skills in the best interests of the patient/client.[6] This guarantee of the professionals' trustworthiness is required because they address the vital interests of their patients/clients (the first element), who cannot assess whether the service rendered is in their best interests because of the specialised character of the professional activities (cf. element 2 above; see also section 2 of this paper). To maintain the confidence of its (potential) clients, the profession clearly needs to control the quality of the services rendered by its individual members and be willing to be accountable for their activities and policy to society at large.

From this analysis of the core medical situation, we conclude that the physician-patient relationship is essentially a relationship of assistance and care. In our view the principle of care, or more specifically, the principle of benevolence, is the normative principle of the ethical aspect [32].[7] So in terms of our analysis, medical practice is ethically qualified. In other words, the finality of medical practice is determined by the normative principle of the ethical aspect, benevolence. This means the ethical way of assessing medical practice regulates the assessment corresponding to the other constitutive rules. We will briefly elaborate upon this with respect to the technical and economic rules, since they play an important role in the context of the theme of this issue, the relation between professional autonomy and health care systems.

The technical rules are indicative of the correct application of medical knowledge and skills. They define the field of competence of the physician and are the founding constitutive rules.[8] This means the justification for a medical intervention is not the request by the patient but the professional medical indication. The request or consent of a (competent) patient is an essential precondition for treatment, but it is not its ground. In other words, informed consent is one of the legal rules that also needs to be observed in medical practice. But the legal rules are conditioning, and neither founding nor qualifying. If the legal aspect were to qualify medical practice, the request and the right to self-determination of the (informed, competent) patient would be the justification for medical interventions. The professional autonomy would only apply to *how* the interventions were performed. Medical care would essentially be medical service. However, our normative model for medical practice requires the simultaneous observance of all the rules. Medical techniques and skills should not only be used competently, but should also be directed at actualizing the finality of medical practice. This finality is not the fulfilment of medical demands in themselves, but the protection and promotion of the health status of the patient [17,p.14-29].[9]

Our analysis also has consequences for the economic aspect of medical practice. In Western societies, physicians earn a living by their practice. Yet nobody will claim the specific character, i.e. the finality of medical practice, consists of making money. Nor will anyone evaluate the quality of a physician's work in amounts of money. This is because the finality of medical practice is determined by the ethical aspect, of which the normative principle is benevolence, care. Yet the economic aspect is inherent and important to medical practice. The fact that physicians earn a living by practicing medicine means they can fully dedicate themselves to that practice. Making efficient use time and of the available resources is part of a competent performance of medical practice. However, what is viewed as economic waste within medical practice should not just be determined by cost-effectiveness, but by checking what is necessary and efficient from a medical-ethical point of view. It is contrary to the constitutive elements of medical practice to demand from the physician that he select patients for certain treatments on other than medical grounds. The physician has to do everything in his capacity to help and assist the patient. This means the health system should not remunerate physicians in a way that can generate a conflict

between the financial interest of the physician and the health interest of the patient. (The implications of this norm are elaborated in the paper by Polder and Jochemsen in this issue.)

Regulative rules

Normative practices, like medical practice, not only have a constitutive or structural side but a regulative one as well (cf. section 5.1). This pertains to views of life and worldviews that provide an interpretative framework for human experience and action. In medical practice, the regulative ideas of physicians and patients alike about health, sickness, medicine and the good life all influence how the constitutive rules are practiced.

Often the regulative ideas or conceptions in medical practice remain quite implicit. Nowadays, ideas that transcend the positive knowledge of the sciences and humanities have lost much of their legitimacy in public debate. Worldviews and religious beliefs are now usually viewed as subjective perspectives which cannot be rationally justified. However, the fact that it is impossible to give a scientific justification of our more fundamental beliefs and convictions does not mean they are unimportant. However, when medical practice is no longer regulated by a common worldview it is threatened by unrealistic expectations. In our post-modern age, only scientific reasoning seems to be compelling. Science has become its own regulative framework. This is why science and technology can play a seemingly autonomous role in medical practice. We hold that it is important to make predominant regulative ideas explicit, and to discuss them in society. From a medical-technical and an economic point of view, a realistic notion of what medicine can do for the human condition is required to maintain a health care system that is not only economically sustainable, but ethically justifiable as well.

V. DISCUSSION

Professional autonomy has traditionally been a central characteristic of professions, and certainly the medical profession. However, today medical professional autonomy is facing three main threats.

1) Internal erosion of professional autonomy due to a lack of internal quality control by the medical profession and the use of its autonomy for its own interest.

2) The increasing upward pressure on health care expenses due to growing technical options. This requires a policy of financial restrictions (possibly by introducing more competition into health care) that could have consequences for the professional autonomy of physicians. In several countries, changes have been made in health care systems that aim at cost control but somehow limit professional autonomy [18, 27, 34].

3) A distorted understanding of the profession based on a formal type of knowledge and related technology, but neglecting other normative dimensions of medical practice and the difference between the ‘narrative structure’ of the patient’s lifeworld and the expertise of the profession.

We think it is important that the profession deal with these threats, since we feel the well- regulated professional autonomy of the physician is essential for the field of medicine. In the long run, dissolution of professional autonomy will not be in the interest of patients. It can easily give way to the `technological imperative', which means patients will request treatment because they seek certainty and hope for a positive effect [20]. Sometimes the chance that a certain treatment will have a positive effect is, however, very small indeed and it will almost certainly be harmful [4, 25, 1]. Without professional autonomy and professional limits to medical technology, and with a strong emphasis on patient autonomy there is a danger that physicians and patients will both be lured into the technology trap [7]. The physician would then become a medical technician instead of a professional care-giver. This would not only lead to high medical costs, it would be harmful to patients. Furthermore, respect for professional autonomy is important to protect the patient against third parties' pressure to undertreatment for financial reasons [28, 29].

So it is important to deal with the threats to professional autonomy. An analysis of the normative structure of medical practice, which we presented the main lines for above, can be pertinent in this connection, because it demonstrates which principles, norms and rules are constitutive for medical

practice, and make it what it should be. The analysis also demonstrates the role of the medical professional. It is of the utmost importance that the medical profession formulate its own standards and codes, and that its functioning be well-controlled. Professional autonomy is only compatible with patient autonomy if it is embedded in a generally accepted, normative structure and if professionals are willing to be accountable for their policy and practice.

Our analysis also demonstrated that the primary medical relation should be seen as structurally asymmetric. The patient finds himself in a situation of diminished functioning and comes to the physician for his knowledge and skills. In essence this cannot be considered a contract relation between two autonomous persons, since it is qualified by the principle of benevolence or care. This means it is not the request by the patient that is the grounds for medical treatment, but the professional decision. The fundamental value of respect for patient autonomy should be primarily understood to mean patients are not treated without their informed consent. It should not mean patients can get any treatment they want. The request or consent of the patient is thus a necessary requirement, but not sufficient grounds for treatment. Physicians should resist pressure to use certain treatments if they are not indicated.

Finally, our structural analysis demonstrates that a good practice of medicine is impossible if physicians do not reflect on their regulative ideas that direct the development of medical practice, such as their concept of medicine and health and view of life. Of course this reflexion does not take place in a social vacuum, and therefore is partly of a public nature.

In our opinion, this constitutes a central problem. Clearly the development of medical practice and health care is highly dependent on worldviews. But it is not easy to reach a consensus on these views, and thus make it possible for them to really give direction to that development. Although it is generally acknowledged that medical technological advances should not autonomously determine the direction health care develops in, the consensus in worldview necessary to effectively influence these developments is lacking. Habermas' opinion that normative questions can only be solved by a power-free dialogue does not bring solace. He rightly notes that the lifeworld can only be maintained by communicative interaction. However, his idea that the procedural rationality of communicative interaction is enough to determine the normative limits of medical and medical technological advances, is not justified. In communicative interaction, it is similarly impossible to form an opinion without reference to a substantial tradition, no matter how much Habermas rejects `substantial' worldviews or metaphysics.

The contemporary social-cultural situation can be characterized by the term pluralism, and it not only pertains to a pluralism of worldviews. The importance of worldviews is diminishing. Modern man often has no coherent view on life and reality. His own life and worldview is highly fragmented. This means modern man has no well-defined vision on medical practice and on the ethical limits of modern health care [5]. We believe this is the main cause of the implicit imperative that almost everything that is technically feasible in health care will sooner or later be applied. More and more doctors feel pressured to put all the available technical possibilities at the patients' disposal. It proves to be rather difficult for present-day doctors to withhold treatment. Even if it threatens to cause more harm than good to the patient. The inherent normativity of the practice is overruled by the subjective goals of physicians or patients. And the doctor who has reasons for witholding a certain treatment can be replaced by another who is willing to give the treatment the patient wants.

This kind of pluralism, which is not so much a pluralism of worldviews but one that results from worldviewish indifference, is clearly fatal for a consensual view on a profession. Professional quality tends to be increasingly judged by an apparently neutral standard of instrumental and technological knowledge, since it is too precarious to have a substantial view on the profession.

The same applies to the development of medical technologies. The ethical dimension is mostly involved in technology assessment processes if the application of a new technique is considered. But ethics is already relevant to the question of whether or not *to develop* a certain technique [15, 10].

Part of the solution can be to devote attention to the normative structure of practices. This makes it clear that medical practice primarily has an ethical function: to serve the well-being of patients as far as

their physical or mental health is concerned. The limits of technical intervention should be determined by the ethical qualification of medical practice.

However, this can only partly solve the issue at stake. A clearly structured public debate should also take place on the developments in health care, enabling the various participants to justify their views based on the more fundamental concepts and ideas of their worldview.

If there continues to be a lack of concensus regarding certain issues, the participants in the debate will have adhere to an `ethics of restraint'. By this we mean an ethics characterized by a high degree of caution with respect to treatments and technologies that are seriously open to dispute in any sense. There are three points to consider in this connection.

1) To maintain a substantial publicly financed health care package, it is important to be restrictive in adding provisions. This means disputable treatments should not be included in the basic package. 2) A reserved attitude should be demonstrated with respect to treatments and therapies that are ethically controversial, such as certain techniques for artificial procreation. Competition among physicians with respect to their willingness to provide certain ethically controversial treatments should be avoided. Thus patients can be kept from shopping around in an effort to get the treatment they want. 3) Physicians should be reluctant to provide or apply treatments and therapies with minimal or uncertain effects or treatments that experts (physicians, ethicists) agree are like to have an effect that is disproportional to the invasiveness and expenses (e.g. resuscitation for certain categories of patients).

This kind of ethics of restraint should be incorporated into professional codes, so that it becomes part of the procedures of professional self-control. Without an ethics of restraint, in our pluralist society physicians observe widely varying limits of treatment. This undermines professional autonomy and the professional control of the members of the profession, which will have an overall detrimental effect on medical care.

In conclusion.

1) The professional autonomy of the physician is a fundamental value in our present health care system. Hence, the organisation of the health care system should devote ample attention to professional autonomy and see to it that the profession can be effectively called to account for its use of its autonomy.

2) Professional autonomy can only be justified if members of the profession subject their activities and decisions to a critical evaluation by other members of the profession and by patients.

3) To maintain professional autonomy, it is necessary that the professional organisations continue to reflect on the character of the profession and to regulate their professional activities accordingly.

NOTES

1. Nearly all the ethical codes that address the professional ideals of medicine include passages which thematize the question of what a justified renumeration is for medical services and what to do if the patient is not able to pay for the treatment. Cf. World Medical Association, `Twelve Principles of Provision of Health Care in any National Health Care System' (as adopted by the 17th World Medical Assembly, New York, U.S.A., October 1963 and as amended by the 35th World Medical Assembly, Venice, Italy, October 1983).

2. "(H)ence, unlike all other comparable fields of societal practice, the quality of medical services both needs to be externally controlled and remains to a considerable extent inaccessible to such controls. Subjective, i.e., ethos-directed selfcontrol, seems therefore particularly important. At the same time a closer examination reveals that such self-control is very difficult to achieve. Ethical obligations do not come with earmarked limits" (Delkeskamp-Hayes, 1993; p. 293).

3. It is doubtful whether a shift to patient autonomy is a solution to the problem of the technological interpretation of professionalism. We will briefly return to this point in the last section. A full analysis of this problem is unfeasible in the context of this paper.

4. For the difference between goal and finality, see: Dooyeweerd, 1958; p. 570, 571.

5. See entry on `profession' in Webster's Third New International Dictionary; see also Unschuld, 1978; p. 519, 520. Unschuld concludes that the central meaning of profession is the selfless rendering of a public service and independence in practicing the work typical of the particular profession.
6. This ethical commitment of the medical profession is also formulated in medical ethical codes. The Geneva Declaration of the World Medical Association states: "The health of my patient will be my first consideration" and the Helsinki Declaration says in its introduction: "It is the mission of the medical doctor to safeguard the health of the people".
7. Puolimatka defines benevolence as "a normative attitude which regards the well-being of others as intrinsically valuable", p. 144. Often the principles of benevolence and beneficence are contrasted, in which case benevolence is defined as `wishing the patient's good' and beneficence as `doing the patient's good'. This distinction is connected with the difference between a virtue-based ethics and a duty-based ethics. In Puolimatka's view the principle of benevolence covers both of them. Puolimatka does not draw a distinction between a formal legal approach that only deals with outward action and a substantial ethical approach that concentrates on moral intentions (Cf. Pelegrino & Thomasma, 1988; p. 111.)
8. The observation that the medical profession's field of competence has changed in the course of history does not contradict this structural analysis. It just demonstrates that the structure in itself does not prescribe how it is worked out and made concrete. This changes as medical science and technology develop.
9. We realise this is not a sharp distinction. However, as a regulative idea we think it will involve a delimitation of medical practice, which will change as medical techniques develop and society changes. But it will remain different from `medicine on demand'.

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