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Professional autonomy demands professional cooperation

EDITORIAL

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There are major differences in referral practice among general practitioners, but professional guidelines are not enough to resolve the problem

Norwegian legislation, both the Health Personnel Act and the new Act relating to municipal health and care services, places great emphasis on the individual doctor being willing and able to practise in a professionally sound manner. As recently as in June 2011, a unanimous Standing Committee on Health and Care demonstrated its confidence that health personnel can assume responsibility for their own activities, also in the future, by stating: «The committee shares the view that there is a need to stress the responsibility of the individual to provide services in accordance with sound professional standards» (1). This confidence is based on the belief that both doctors and other health personnel will be capable of developing their own practice «in pace with knowledge in the health and care disciplines», to use the committee's own words.

This can well be read as an urgent request to doctors to maintain order in their own ranks. The individual doctor cannot simply proceed professionally as he or she might wish to. Doctors must as a general rule align themselves with what is generally acceptable within the branch of medicine to which the individual belongs. This does not only apply in Norway. The Swedish Health and Medical Service Act states that such practice shall be in «accord with science and proven experience» (2). This indicates that the patient must be able to expect an

examination and treatment that are based on something more than the opinions and experience of the individual doctor. The requirement also means that it should be possible to distinguish good from poor practice.

An article published in this number of Tidsskriftet shows major differences between the practice of various general practitioners when it comes to referring patients to the specialist health service (3). The authors have taken as their starting point the public statistics in the Norwegian register of patients, which reveal wide geographical variations in the use of the specialist health service (4). They have then gone into the material in more depth and considered the data on the referral practice of the general practitioners, all of them primary doctors, in three municipalities in the county of Sogn og Fjordane.

The authors show that extensive use of elective inpatient spells leads to a high level of admissions to the hospitals in the county. They also show that there are major differences in the referral practice of clinics in the specialist health service, both among the three municipalities that they have studied in detail and among the individual doctors in these municipalities. Despite a number of methodological challenges, the authors put forward a good argument to the effect that the distinctive features of the services in the county can be explained more by varying local and personal referral cultures than by differences in the community's needs with respect to specialist health services. This is a message that the whole medical community in each municipality and each individual health enterprise, not just in Sogn og Fjordane, must take very seriously in the time ahead.

General practitioners have an important responsibility to ensure equitable access to the specialist health services. Olav Helge Førde and his colleagues maintain that in the interests of attaining important political goals, it must be possible to make professional requirements that will restrict the professional autonomy of the individual general practitioner (3). It is naturally difficult to argue against this. But it may be fruitful for both the individual general practitioner and the professional community to look at it a little differently. The general practitioner has never really been autonomous in the sense of being able to act as an entirely free agent. All doctors are constrained in many ways, irrespective of professional guidelines from the authorities. As mentioned initially, doctors are constrained by what is professionally sound, and by the patients' own wishes and choices.

Instructions and professional guidelines from central authorities such as the Directorate of Health and the Norwegian Medicines Agency may be safe and useful to follow, but are by no means sufficient to bring about a more uniform practice among general practitioners. Neither Storting (parliamentary) resolutions nor documents from the authorities can replace the professional communities. It is the latter that should be the most important source of professional standards from day to day. It is in these communities that guidelines issued by central authorities should be read in the light of updated professional knowledge, and these communities that must ensure that they are implemented. There is little reason to believe that even quite detailed circulars will lead to any strong adherence to norms if they are merely interpreted by the individual doctor alone in his or her office.

The door-opener function of the primary doctor and the more logistical aspects of general practice are discussed at length in the Storting report on the Coordination Reform (5). In the practical work of implementing this reform and introducing a new Act on Health and Care Services, the same amount of attention, at least, should be focused on the medical challenges at the interface between the primary and the specialist health service. Success in this respect is contingent on the general practitioners and hospital doctors themselves finding durable forms of cooperation that inspire confidence and are based on sound medical knowledge. Without stable structures for professional cooperation, it will be difficult to arrive at a professionally sound practice at the interface between these two levels of medicine. If local coordination is based on guidelines provided by the central authorities, I think these guidelines could strengthen real professional autonomy by creating a sound platform for professional practice. All doctors need such a platform in order not to be passive victims, being pulled this way and that between political reforms and the different wishes of patients.

The general practitioner's role in relation to the specialist health service could then be not merely to be a door-opener who must prioritise correctly, but equally to be a quality assurer who can guarantee that the individual patient is assessed and treated in accordance with updated requirements regarding professionally sound activities –in accordance with the Storting's expectations.

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