Clinical autonomy includes the responsibility to channel resources appropriately

However, it is necessary to limit clinical autonomy: patients should be treated not only individually but also equally, and limited resources should be concentrated in an appropriate manner, taking into account healthcare as a whole. When a physician treats a patient, he should also consider other patients needing care.

Therefore, it is important that we have the most uniform caring practice possible, planned in such a way that limited resources can be used as a whole in an appropriate way. If, as a professional organization, we are unable to draw these boundaries, it is obvious that parties outside our professional organization do so in accordance with standards that do not fairly consider the clinical situation.

An important feature of physicians' autonomy is the profession's own role in regulating care practice. Extremes are the full autonomy of the profession and the full external regulation of the profession. The reality of all health systems is somewhere in the middle. However, both socially and professionally, a sign of effective autonomy is that the profession plays a strong role in regulating caring practice.

In Finland, it has been accepted that the autonomy of the medical profession includes responsibility for maintaining good practice of patient and community care that doctors use in their work. According to the ethical instructions of the Swedish Medical Association, a physician should only use and recommend tests and treatments that, based on medical knowledge and experience, are effective and purposeful.

The Standing Committee of European Physicians (CPME) developed guidelines for alternative and complementary care at its meeting in May 2015. The CPME believes it is important that care is evidence-based, effective and safe. The organization also states that national health budgets should not support therapies whose effect has not been proven.

Who ultimately aligns healthcare practices with healthcare resources?

The central mechanism of self-regulation of the medical profession is, in addition to continuous training, also adherence to the recommendations of Good Medical Practice.

However, tensions create differences in opinions among the profession about appropriate caring practices and adapting caring practices to healthcare resources. For example, in the case of drugs in outpatient treatment, care practices have been regulated outside the profession, e.g. through the drug reimbursement system.

As physicians, we may wonder if there is anything we can develop in this. It is the responsibility of the medical profession to care for healthcare and to ensure its sustainability in the future. We know that public spending should be cut and available resources used more efficiently. This requirement covers healthcare as a whole and thus also the supply of medicines. So would it be wise for us as caring physicians and professionals to take greater responsibility for adapting care practices to the resources available?

This would mean less need for external regulation, but also an active dialogue on savings targets between the profession and society before deciding on budget cuts.

The doctor's autonomy enables more efficient care practices

It is our responsibility to ensure that the economy is not the only measure to regulate the development of healthcare in Finland. The government has set a target of 150 million euros in drug reimbursement spending in the current government period.

The simplest tool in the government's toolkit to achieve the goal is to continue to increase patient deductions. The problem is that, if the deduction increases are implemented, they can lead to neglect of pharmacological treatment and deterioration of health, which in turn leads to increased expenditure on health care.

Perhaps we can find better tools in the doctor's autonomy. Can we prove the strength of our autonomy ourselves by improving the use of resources in the drug reimbursement system in such a way that the pressure to increase deductions drops? What if we get a savings target that, if we hit it, will result in the gains not being realized? Can we find concrete means

together? The doctor's pen plays a key role in regulating the use of medications. Do we have any measures to improve pen use to adapt care practices to diminishing resources?

Instead of hitting, it is important to lure a carrot and work together to do the same

A specific activity is the full use of biosimilars in outpatient care. Can we jointly switch to more frequent use of biosimilar medicines, if there are no contraindications for a specific patient? Then there would be no need to regulate externally, e.g. by incorporating biological drugs into drug exchange.

However, other measures are also needed. The program of implementing rational drug addiction treatment in accordance with the government program is in its infancy. Within this framework, it is possible to research, instruct and also promote specific savings measures through incentives. Overall, incentives can lead to better outcomes than the cuts themselves. This challenging situation is also a good opportunity to show the strength of the autonomy of the medical profession: for the patient's benefit, with the doctor's knowledge, and at the same time serving the interests of society.