

remain indifferent to the repercussions of the cost of health care on the economics of the state. They believe it is their duty to collaborate in researching measures which aim at a better use and rationalisation of resources set aside for health care, on the express condition that in all circumstances, the freedom of prescription of the doctor, the natural defender of every patient, should be respected.

Indeed, the doctor cannot, in the context of an individual case, place the interests of society above those of the individual. Medicine is impossible without mutual confidence between the doctor and his patient. This confidence is based on fundamental freedoms: for the patient, the freedom to choose his doctor, and for the latter, the freedom to choose the necessary investigative and therapeutic methods. This confidence, which is indispensable, ceases to exist when confidentiality is not scrupulously respected and guaranteed.

As economic responsibilities are the province of political power, doctors cannot, without imperilling the technical and moral independence vital for the practice of their profession, associate themselves with the economic and political decisions which are taken by the public authorities with regard to the budget allocated to health care.

But expert advice must be taken before those concerned decide, and at this stage the medical profession intends to be consulted. Equally, when decision has been taken, the medical profession intends to make known its assessment of the consequences of these choices.

The medical profession is prepared to assume the responsibility of advising those who must ensure the best use of the resources of health insurance and of the budget allocated to health care and in this regard also, it reserves the right to publish its remarks and comments on the choices thus made.

Furthermore, the Standing Committee of Doctors of the European Economic Community alerts governments to the dangerous consequences of decisions taken on purely economic grounds. It recalls that a medical policy cannot be founded simply on the criterion of prolonging the span of life, but above all it should evaluate the quality of life that medicine can give to the sick, the handicapped, the chronically ill and the aged.

The function of medicine is to participate, now and in the future, in the betterment of the life of Man and Society. The medical profession is ready to appeal to the population of all the Member States so that this fundamental aim should be respected by the political powers of the states.

3.2 Towards a health care economy founded on social and individual responsibility (1983)

For a health economy based upon social and individual responsibility

Health costs are increasing faster than the GDP

1. In all countries with scientific and economic development, the evolution of health expenses covered by health insurance is developing more rapidly than the GNP. The present low rate of this increase, and the economic constraints forcing all industrialised countries to seek back to major balance and a fight against inflation, no longer permit a continuation of this tendency. However, a study of the rates of increase of expense towards health insurance in the EEC compared to the rate of increase of the GNP shows that in the nine member states for which statistics exist, five states still show a *considerable gap between these two rates*, the freezing of health expenditure in member states with a national health scheme being only due to a decision on the part of the responsible authorities (Cf. enclosure 1).

The social security schemes contribute to social balance

2. In spite of the economic constraints, and because of the world crisis, no sensible policy could even consider watering down the social protection schemes and reducing their role. On the contrary, it is important to maintain them at the level they have attained.
- 2.1. Social protection schemes are, *historically*, the means for *liberal industrial societies, governed by the laws of marketing*, to provide a means of escape for the worker and his family from the hardest consequences of these laws, when the risks of life jeopardize the ability to earn for him and his kin.
- 2.2. In the course of a crisis reducing or eliminating the growth of the workers' primary income, *social benefits* make it possible for their *average available income* (2) to maintain, and even *slightly increase*, their purchasing power through the increase of the benefits in the average income. In France, for instance, social benefits in 1960 represented $\frac{1}{5}$ of the available income as against $\frac{1}{3}$ today (3).
- 2.3. Thus, social security indirectly plays an economic role, contributing to the resistance of a population to the world crisis, *making it accept the hard effort of competing* that it must continue making.

1) Report presented by the standing committee of Doctors in the European Community to the Commission of the EEC and to the Council of Europe in October 1983.

2) Primary income after deduction of compulsory levies and addition of social benefits.

3) 2nd report on income in France (Centre d'Étude des Revenus et des Coûts, 1979).

Enclosure 1. Evolution, in current price index, of costs for health in 1982 compared to 1981 – in comparison with that of the GDP.

Country	Health costs %	GDP %	Inflation %	Gap %
B-Belgium	+8.4	+5	+6	+3.4 (1)
DK-Denmark	+9	+11	+8	-2 (2)
D-Germany	+1.2 (3)	-1.2 (3)		+2.4
F-France	+17.3	+11.2	+9.7	+6.1 (4)
G-Greece		- no figures available -		
IRL-Ireland	+15.2 (NHS 24.3 hospitals 10)	+12.3	+12.3	+2.9
IT-Italy	+22	+22	+17	0
L-Luxemburg	+11.03	+3.6	+9.4	+7.4
NL-Netherlands	+9.5	+3.8	+3.8	+5.7
UK-United Kingdom	+8.2	+9.5	+8.6	-1.3 (2)

1. Evolution in 1981 in relation to 1980.
2. In both these countries, following upon changes in political majority, the government decided to stop the increase of health costs (cf. enclosure 2).
3. At constant prices.
4. In april 1983, the annual growth rate for health costs dropped to 15.1% and the gap to 3.9%.

Does the control of supply allow the rate of growth of GDP to be imposed upon the benefits?

- 3.1. This is the problem facing the governments. The *most tempting means* adopted more or less by all is the *control of the "offer of care"*, in other words, *preventing the development* of the present health care system (Cf. enclosure 2):
 - limiting the demography of medical and health staff,
 - setting a ceiling to or even reducing their remuneration,
 - blocking the number of hospital beds
 - blocking heavy equipment, be it hospital equipment or not,
 - forcing upon hospitals an overall budget frozen at a level that takes or does not take into account the rate of inflation.
- 3.2. The medical profession would like to be sure that before touching expenses towards health care, a similar and rigorous effort has been made with respect to administrative expenditure.

The role of ageing and scientific progress in the increase of costs in the health sector

4. However, the theory of "control of supply" *chooses to ignore the deeper causes of growth of costs in the health sector.*
 - 4.1. The first cause is the *general and increased ageing* of the populations following upon reduced birth rate (4) and prolonged life, no less general,

4) "Because of ageing alone, and if we maintain the present birth rate, health costs for social security will increase by 13%" (Alfred Sauvy – Cahiers de sociologie et de démographie médicales avril-june 1983 – p. 119).

5) Ageing in France, Cf. "Population and societies" – March 1983: composition of the population, proportion of elderly people (65 years or more) and of very old people (75 years and more) – 1946 14.7% – 1982 20.2%.

in the Europe of ten. The elderly (with women and children), are the major consumers of care, in particular hospital care (the most burdensome). This tendency can but accelerate with the oncome of generations that throughout their active life have become accustomed to efficient and modern medicine (5).

- 4.2. Progress in medical technologies – founded on all sciences, in particular biology – provides medicine with new means of examination and treatment, even before the older equipment has been written off.
- 4.3. Industrial civilisation brings with it the *drawbacks* linked to *its conditions of life and work*. Fear in the face of changes entices patients to the doctor, patients who are trying to *blame their discomfort upon medical causes*. However, this is a useful opportunity for health education.

What is being done for the elderly? A justification of the productivity effort for present generations

- 5.1. Treatment of the elderly at the present level of

Enclosure 2. Measures related to a control of health costs.

- I – Out-patient medicine.
- 1 – Raising of-compulsory sharing of expenses.
- In figures and in % on certain costs (in particular drug, kinesiotherapy): Belgium (B), France (FR) (with participation to cost of hospitalization/increase in prices for wine and tobacco), Italy (I) (biology, instrumental diagnosis, antibiotics), Luxemburg (L) (consultation – medicine – days hospitalized) Netherlands (NL) (prescription for medicine).
- 2 – Control of supply
- * Numerus clausus.
- At the start of studies: DK – D – FR – NL – UK.
- Access to specialty studies: DK – FR – I – NL (for certain specialties).
- . general medicine: DK (certain regions) – IRL (certain regions) – I (practice/sickness insurance) – NL (certain regions) – UK (specific training – certain regions)
- . specialties: B (biology) – DK – D (specialists in certain Länders) – FR – I and NL (certain specialties) – UK (most, await vacancies).
- * Previous authorization for heavy equipment: B – DK – D – FR – I – L – NL – UK.
- * Medical remuneration: – Stabilization (in purchasing power): D – IRL – L – NL. – Regression: B – DK – FR – I – UK.
- * Hospital capacity: – Reduction in number of beds: B – DK – D – FR – I – NL – UK. – Closures: B – DK – D – FR – IRL – I – NL – UK.
- * Concerted action with doctors to reduce costs:
- B (medicine – biology – profiles) – DK – D (medicine – treatment at home) FR (profiles).
- IRL (biology – aids – ambulances) – I (ambulances) – L (medicine – aids) – NL (biology – aids – ambulances – hospitalization – limited progress through budgetary envelope) – UK (medicine – hospitalization – reduction of time of stay).
- 3 – Transfer of certain hospital treatments to out-patient treatment.
- DK – D – FR (elderly people) – IRL – I (elderly people) – NL (day care) – UK (elderly people – mentally ill).

medical technique, “*filling their days with life, and not just their life with days*” (René Sand), is a human justification of the productivity effort required of the active workers by present, economic constraints. This is also reflected in the tendency to reduce the number of working hours. When workers retire, or during their leisure time, they wish to enjoy the same care that was provided during their active period.

- 5.2. Furthermore, when medicine cannot cure, *it transform ailments into lasting conditions*, thus prolonging conscious and active life, but also prolonging the need for care.

Due to market demands, the cost of technical progress is reduced

- 6.1. Granted, technical progress in the field of medicine and more advanced equipment are *a burden at the start*, but become more commonplace and extend their use to the world market making it possible to industrialize the production. Any country ignoring such progress forces its population to look beyond its frontiers for such advantages, and eventually finds itself obliged to import such equipment, to the detriment of the balance of payments.
- 6.2. Certain economists, councilors to authority in certain member countries, predict an era of grafts, of prosthesis, products of “*the market economy*” (6) that would overtake the action of medicine upon man. Should this prove to be correct, the services of industrial economy would be *cheaper in the long run* than the time of a professional, one highly trained.

The prevention of harm increases the cost of protection without reducing expenses

- 7.1. The prevention of harm, stemming from industrial civilization and living and working conditions, is to the fore in the minds of those who label these as the cause of increased expenditure and think that sicknesses all are of an exogenous nature. What is necessary, and that would suffice, is a change in the environment and education, amending the attitudes of the population towards nutrition, the use of alcoholic drinks, smoking, ones behaviour on the road, hazardous sports, or on the other hand a sedentary existence.
- 7.2. It’s a question of *morals* or even *culture*, unconsidered to a large degree by political power. It

does not yet rest upon a sufficiently developed epidemiology. Such action under certain conditions would, at the best, have the appearance of a questionable civic morality or, at the worst, an *infringement on the fundamental rights* of all (7).

- 7.3. Doctors are ready to co-operate in *epidemiological research* on a scientific basis. Based upon the results of such research, they are also ready to proceed to *health education* of their patients, either collectively or individually, *informing* them of the possible consequences of their behaviour upon their health.
- 7.4. It should be noted, however, that countries already having given a *leading place to prophylaxis*, nevertheless have been unable to reduce their efforts in the field of curative measures. *Primary prevention can prolong the life* of those receiving such care; they grow older, develop endogenous ailments and *prolong their demand for care* (8).
- 7.5. One should not under-estimate the *considerable means* at the disposal of *preventive medicine* in our countries, particularly the considerable developments within *industrial medicine* since the war.
- 7.6. This path towards harm prevention, already largely explored, leads to the addition of a *burdensome effort* to the provision of care. No one can say *if* and *when* it will lead to a far from likely reduction of the overall cost of health. In any case, it does not allay the short term concern of the governments.

The control of supply: a solution without a future

- 8.1. To limit the possibilities of health care can, in the very short term, lead to a *freezing of costs* in the health sector. However, this solution is *untenable* in the medium term, as it voluntarily neglects the *true causes* of the growth of health expenditure. It cannot at length reduce *the elderly* to objects of *infirmity care*, leading a developed country down the path of *medical underdevelopment* (9) making the *troubles* of our civilisation disappear by means of simple, educational *propaganda*.
- 8.2. And anyway, *why* should one *reduce* or prevent the growth of health costs? In a developed society, *health* activity is a *noble* thing, with the same rights as educational or cultural activities,

6) Jaques Attali, “Pouvoir et déclin médecine”, *Prospective et Santé*, no. 9, 3. quarter 1979.

7) Health is not necessarily the ultimate end for all. Let us recall for instance Sartre’s reply to one of his intimates, reproaching him for jeopardizing his health through his actions and work: “Health? What for?”

8) Cf. in the sense: “The organisation, financing and cost of health care in the EC”, *Etudes*, series on social policy, no. 36, 1979, p. 157.

9) This risk should be ignored. Alfred Sauvy remarked recently “the resurgence of death in the East”, since 1970. Those responsible for medical and health care in the USSR explain this by a bureaucratic degradation of the total health system (*Cahiers de sociologie et de démographie médicales* – April-June 1983 – p.117).

the which, according to Engel's laws, gradually replace the primary activities of supply in the broad sense of the word. As counterpart, health activity represents a measurable improvement of the level of the state of health, and life expectancy at birth (10). The *health sector enriches* the national product in line with other branches of activity. Furthermore, it comprises an *exportable part* (the product of health engineering, drugs, prosthesis), most useful to the national economy.

- 8.3. The blocking of a country's resources in the health sector – because of needs that remain unsatisfied – inevitably leads to *waiting lists* that can represent a serious hazard to the patients, “opportunities gone by” because of loss of time, as well as *social inequality* in the choice of urgencies, or because of possibilities offered to the privileged who can seek treatment in other countries. In any case, as we shall see later, such limitations are a *serious infringement* of one of the most fundamental of *human rights*: the right to health, the right to live. So other paths must be found.

The fight against *waste* self-discipline have their limits

- 9.1. To the control of supply, governments have added an appeal to the profession to cease a certain “*waste*” on the part of the practitioners regarding examinations or other therapeutic means they may prescribe. Once this “*waste*” has been overcome, would growth then be halted?
- 9.2. The profession realises that the duty of those responsible for “social money” is to *ensure its best possible use*, and it chooses to respond to this appeal. In the member states, and in various forms, the profession has accepted a *self-discipline* by establishing a system of “medical profiles” or “tables of statistics on activities” in the field of hospital care, this on the basis of American experience. The object of all these measures is to sensitize the practitioners, leading to the only true sanction: an intensification of *continued medical training*, towards which the medical profession in all member states has increased its efforts.
- 9.3. In fact, the F.M.C. intensifies the dissemination of technical progress in the whole health care system, contributing to the development of that system, not the opposite. Basing themselves

10) “There is every reason to think that, at least for one part, the improvements regarding infant mortality and the hope for life stem from a more equal access to medical care. This affirmation is supported by the obvious improvements of health indicators in the USA for the elderly and the needy following upon the introduction of Medicare and Medicaid. The hope for life at birth, relatively stable between 1960 and 1970, has clearly progressed; in France, it has increased between 1970 and 1978 by 1.2 years for men and 2.2 years for women. This increase is even more apparent in the USA: 2.2 years for men, and 2.3 years for women” (Simone Sandier, C.R.E.D.O.C., Consommation, 1982 no. 2).

upon the development of EDP in medicine, some advocate a better training of practitioners in the *science of decision-making*, thanks to *various aids* provided by EDP when diagnosing and choosing treatment. This new path should be further explored. It pre-supposes research still at its start, the setting up of data banks, working programmes, which, as all will know, is a heavy task.

- 9.4. Things being as they were, various demands have lead the doctors to *reflect*, to create. They have *realised* the need for research aiming at *more efficient use* of staff and equipment. Little by little, all that remains in the health-care system is the margin of safety that it must have to give the best possible chances for the sick. However, *the stubborn facts remain*. These are *ageing*, *technical progress*, *various forms of injury*, and the increase in costs continues. The *social partners*, on their part, must realize that the doctors are not the guilty party, that the freezing of costs cannot last, unless one heads towards underdevelopment, and there remains, and will remain, a gap between social financing and the costs of health, because it does not depend upon *waste* and abuse.

The patient has a right to the present resources of medical science

10. The measures introduced by governments have one fault in common: their authors forget one fundamental fact, mentioned by the C.P. in Copenhagen regarding the evolution of the cost of care: the doctors are tied to their patients by precise ethical and legal obligations. They owe their patients proper care, in conformity with the *present scientific facts*, and cannot deprive them of *any chance of healing or survival*. The *collective commitments of the profession* with regard to sickness insurance or with regard to the health system are of another nature, and they *cannot modify* the obligations of each practitioner to each of his patients.

The costs of social protection and health costs follow different laws

- 11.1. Our research shows that the costs towards health on the one hand, and the costs of social protection – in particular sickness insurance – on the other hand, obey different, autonomous, economic laws, and naturally cannot evolve in parallel. The fact that an increase in the *GDP*, extraordinary in the light of economic history, made it possible for the social protection effort, for more than a decade, to follow the growth in health costs in most industrialised western countries, should not hide reality, the rate of growth of the *GDP* stemming from rates prior to this exceptional period.

II – Hospital medicine.

- B: Financial means at the disposal of hospitals are reduced “contractual” methods. Doctors have to defend their “work tools” and take part in decision-making. They protect the interests of the sick against the healthy.
- DK: Because of a lack of confidence in doctors, health, “rationed” by the politicians, makes it impossible for all the population to benefit from technical progress. Doctors are obliged to make choices with regard to the access of sick people to certain therapeutics. Such choices are morally difficult.
- D: Efforts to rationalize have been made in order better to use available means. Hospital costs, mainly staff, have nevertheless increased by 8.3% in 1982. More stringent methods are being considered. The purchasing of heavy equipment is subordinated to the equipment plan (thus financed by the state).
- FR: A bill from 1983 introduces an overall budget, of external origin, generally frozen, except for major and unforeseeable changes in economic conditions or medical activity. The application edict of this bill appeared on 12th August. The reform will be applied in 1984. According to the minister, this is an effort to rationalize. The growth of costs during the last twelve months was 21.6% in February 1983. Many consider this measure a financial tutelage of the establishments.
- G: No overall hospital budget. Hospital costs are increasing at a dangerous rate. The overall budget could not contribute to controlling these costs without creating problems of responsibility towards the sick. The perspective of having “rationed” health is a central problem of the health system in a period of crisis, not only financial, but also sociological and political.
- IRL: The financing of hospitals is centralized: costs must not go beyond those of 1982, in spite of the 12% inflation. So there are reductions (on staff, extra hours, ambulances, training expenses).
- I: Since the reform, there is no longer a budget, not even a hospital structure. Doctors and establishments depend upon the local health unit. A project aims at correcting this distinction.
- NL: The hospital budget for 1983 must be greater than for 1982 plus the rate of inflation. Working groups are drawing up priorities, therapeutical protocols, and looking for a more efficient use of staff and equipment.
- UK: The hospital budget is decided every year within the framework of the NHS budget, between the minister of health and the treasury as a function of the GDP. A distribution is then undertaken among the regions. There is an overall lack of funds, and it is necessary to choose among priorities.
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p11.2. Those responsible for our economies no longer want the social budget to follow the natural rate of evolution of health costs, not wishing to impose on their countries excessive burdens and triggering off inflation, and seeking space in the national revenue for state expenditure (11).

11.3. However, doctors, on the other hand, every effort having been made to discipline their prescriptions, state, in the face of any reduction, any curtailment of medical consumption according to their own data, a “non possumus” based upon the imperative rules of their mission.

11.4. It would be *contrary to* the most fundamental

11) “The growth (of the national social budget) registered at present cannot eternally be greater than that of the state budget and of the GNP, since, in the long term, the whole GNP would certainly collide with the social budget” (D. Bertrand, *Le budget social de la nation*, Masson, 3rd quarter 1978).

of human rights, the right to health, the right to live, to deprive the sick in a developed country of the present possibilities of medical science offered to them, of the chance of being healed or of surviving, the purpose being to force health costs into the limited framework of social expenditure. The *socialisation* of health costs, *the source humanization*, should not become, when it reaches its limits, a *source of infringement of human rights*.

Health economy requires a plurality of financing

- 12.1. The states will not reduce the level of social protection so far achieved in the form of purchasing power, but at the best will only let it grow with the *true rate of increase* of the GNP. Health costs will continue growing at a different and *faster rate*.
- 12.2. Health activity, a dynamic branch of national activity, is a service to the population and increases the national revenue. Why limit its development, even if social financing has reached its limit? *The social effort should be linked to the individual effort* the efforts made by families to face the cost of *rationalized but not rationed* health costs.
- 12.3. Social financing is evidently a priority for special categories or social cases that are needy, this according to modalities for covering their health costs. The plurality of financing (in the form of participation in the costs, or voluntary contributions) can only be carried out according to modalities such that no one is refused access to care for financial reasons. But then the *notion of personal responsibility* with regard to health costs would be diffuse.

The average growth of incomes since the founding of social security schemes justifies this effort

- 13.1. Today, this effort cannot be considered abnormal. The period of economic expansion in Europe, even if it has come to an end, has brought the average available income of households in EC member countries to a level never before achieved. The crisis has halted this growth but without jeopardizing what has been achieved. In France, for instance, the *average available income* for households has *doubled (at constant prices)* from 1960 to 1970 (12). The founders of the social security system had not foreseen, nor could they foresee, a development of that kind, the order of which justifies a change of statute.

12) 2nd report on incomes in France, C.E.R.C. (Centre d'Etudes sur les Revenus et les Coûts), 4th quarter 1979.

13) Survey Louis Harris-TFI-La Croix, 27th-29th June 1983.

- 13.2. According to a sample survey recently conducted in France (13), the economics of social protection should first consider unemployment benefits and then health costs. 46% of the households in the survey are against the suppression of advantages acquired, while 51% are in favour.

Beyond social measures, the individual participation of the insured parties?

- 14.1. However, globally, health costs have a structure: according to studies carried out by C.R.E.D.O.C and by social bodies in France, 5 to 10% of the insured “consume” 50% of the benefits, whereas 50% only consume 5% (14). In other words, half of the benefits cover the cost of burdensome care for a small number of insured, generally *hospitalized*: half consists of elderly people, sometimes at a terminal stage. Because of the analogy in the economic and social development in the countries of the EC, and a similar evolution in the demography, phenomena of a similar order must be noted in other member states. Generally, such costs are fully covered.
- 14.2. This being so, in the case where society no longer can increase the taxes financing the social spectrum of necessary care, the medical profession is not against studying, with society, all forms of supplementary financing coming from the insured parties, this in order to guarantee the maintenance and development of the quality of medical care for all.

Social solidarity and personal participation strengthen the chances of healing and survival

15. In certain member countries, ideas for work are being suggested in order to introduce, in the supplementary participation of the insured, variations that take into account their contributive faculties (15). This problem is beyond the remit of the medical profession. All it wants is that solutions to which one arrives, combining social solidarity and a personal effort, offer to all *true access* to care in conformity with the *present scientific data*, thus increasing their chances of healing and survival.

14) Who consumes what? An approach based upon a regional sample of 2000 people (Caisse Nationale d'Assurance Maladie, March 1982).

15) Cf. in particular talks between Simon Nora, General Inspector of Finances, Head of National School of Administration, and Edmond Maire, Secretary General of C.E.D.T. (Le Débat, no. 26, September 1983).

Solutions depend upon national governments

- 16.1. This being the case, it would be unseemly no longer to accept that social protection schemes are the responsibility of national sovereignties, and that any reform must be enshrined in the history of these schemes, taking into account the economic, social and political situation in each country.
- 16.2. Our analysis had but two purposes: to try to find a way out of the present *dead end*, where state, populations and medicine are all involved. The logic behind the facts leads us to examine the path we consider necessary to indicate. We provide the political powers in our countries with this *hypothesis of work* in the spirit of the declaration made in Copenhagen by the C.P. (Cf. enclosure 3). The medical profession has no intention of interfering with the *political responsibilities* of the “decision makers”. It just wishes to be consulted and heard, so that political decisions can be made in a clarified manner, in possession of the facts, and that the “healthy population” take into account the rights of sick people that medicine takes care of.

3.3 Health care costs

Adopted in Paris, 1984 (CP 84/110)

Declaration

Après avoir pris connaissance des prises de position de l'Union Européenne des Médecins Omnipraticiens (UEMO) et de l'Union Européenne des Médecins Spécialistes (UEMS), l'Assemblée plénière du Comité Permanent des Médecins de la C.E., représentant les 650.000 médecins des 10 pays membres, a voté à l'unanimité, le 24 novembre 1984, la déclaration suivante:

Le Comité Permanent des Médecins de la C.E. rappelle que l'argumentation des dépenses de santé est due, en Europe comme dans tous les pays développés, au vieillissement de la population, au progrès des sciences et des techniques au progrès culturel et à celui de l'information.

Les médecins européens sont conscients de leur responsabilité économique et ont déjà fait connaître (déclaration de Copenhague de décembre 1978) leur volonté de participer à une maîtrise des soins, afin d'apporter au meilleur coût des services de qualité à l'ensemble de la population. Mais tous les médecins ont avant tout leur responsabilité professionnelle et l'impérieux devoir de mettre à la disposition de chaque malade tous les services que peuvent apporter les données actuelles de la science. S'ils manquent à ce *devoir*, les médecins sont condamnés par les tribunaux.