

## **The doctor and the market**

### **About the influence of market reforms on the professional ethics of surgeons and general practitioners in the Netherlands**

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#### **1. Introduction**

During the nineteen nineties and the first decade of the 21<sup>st</sup> century many governments in Western European countries introduced market elements in their health care systems. Numerous politicians and policy-makers argued that health care should be ‘consumer-driven’ and ‘consumer-oriented’. Care providers should become entrepreneurial; they should cater according to consumer preferences with regard to prices and quality of care. The market reforms have been studied extensively, mostly in order to establish their cost-effectiveness or their effects on solidarity, equity and equal access (for an overview see Callahan & Wassuna 2006; Maarse 2006). Much less attention has been paid to the effects of a market ideology on medical professional ethics.

In a recent article in the *Journal of the American Medical Association* Robert Berenson and Christine Kassel emphasize the importance of this forgotten aspect of the change towards a market-based system:<sup>2</sup> “What has not received attention is that the consumer-driven model implicitly calls for a fundamental reordering of the patient-physician relationship, placing increased reliance on commercial ethics while eroding professional ethics as the guiding force for patient-physician interactions. Such a development risks more than nostalgic loss for physicians. Professionalism has economic and social value as a mediating force in a health care system – and the move to a more market-oriented, consumer directed model threatens to erode this important influence.” (Berenson & Kassel 2009). Similar concerns were raised by the Council for Public Health and Health Care in the Netherlands. The Council observes that the introduction of market elements in the Dutch health care system has enlarged

the influence of insurers and hospital managers on the attribution and the distribution of health care services. Although the Council does not think there is immediate cause for alarm it stresses that we have to be vigilant, since further marketization may challenge medical professional autonomy as well as medical ethical principles (Council for Public Health and Health Care 2007).

We agree with the Council for Public Health and Health Care that the interaction between consumer driven health-care and medical professional ethics is a topic that merits attention and we agree with Berenson and Kassel that it has been under-researched at present (although some publications do touch on this issue, cf. e.g. Freidson 2001; Duyvendak, Knijn & Kremer 2006). In this article we want to find out how market reforms have changed medical professional ethics in the Netherlands. Within Western Europe the Netherlands has gone farthest in introducing markets and managed competition in health care (cf. Rice et al. 2000; Bartholomé & Maarse 2008), which makes the country very suitable for a study of the relationship between demand driven care and medical professional ethics.

## **2. Method**

We chose to study two specialties within the medical profession that differ with regard to their working conditions: general practitioners (GPs) and surgeons. Dutch GPs work in independent practices in the neighborhood of their patients. Most Dutch citizens have their own GP whom they can consult for health-related problems. Dutch surgeons work in hospitals. Patients are referred to surgeons by their GP (who functions as a gatekeeper to hospital care). Surgical work is more specialised than GP work and involves other contact with patients. We assumed that working conditions might influence the way in which doctors are confronted with elements of marketization. GPs might be confronted most directly with demanding patient-consumers whereas surgeons might have to deal with eager hospital managers, looking for quick wins.

Since this is a new topic (the complete overhaul of the Dutch health care system took place in 2006 although elements of market-driven care were introduced earlier) we chose to do qualitative research. We performed 27 interviews with surgeons and 28 with general practitioners. We strove to interview both male and female doctors, doctors of different generations, doctors working in different regions of the country (more and less urbanized) and surgeons working in different types of

hospitals (academic hospitals as well as smaller hospitals “in the periphery”). Obviously the number of respondents is too small to establish correlations (such as: surgeons in the periphery are more affected by the marketization of health care than surgeons operating in academic hospitals), but our attempt to achieve variation will at least prevent us from drawing conclusions based on the experiences of one particular type of doctors in one particular hospital or one specific municipality. Table 1 provides an overview of the respondents and their background.

Table 1

28 General practitioners

Male	15
Female	13
Between 25 and 40	9
Between 40 and 55	8
55 and older	11
Urbanized	17
Non urbanized	11

27 surgeons

Male	16
Female	11
Between 25 and 40	9
Between 40 and 55	9
55 and older	9
Academic hospital	6
Non academic hospital	21

The interviews were semi-structured and part of a broader research project, relating to two other topics besides marketization.<sup>3</sup> With regard to marketization we asked our respondents whether they had noticed any changes in their work as an effect of marketization. After their first answers we asked them to elaborate. If they had noticed change as a result of marketization we asked them to give examples and to describe their thoughts and feelings about the changes they saw. If they had not noticed any change we would ask them if they had witnessed changes outside their direct environment, that is: in other hospitals, other GP practices, other parts of the country or other specialties.

The interviews were transcribed verbatim and were then analysed in a two phase model. During the first phase the first author coded the interview material using the computer programme Atlas-ti. Atlas-ti allows the researcher to first establish broad categories and then subdivide these into smaller categories. For our research project we used three broad categories, related to the three topics we want to investigate. For this paper we selected all interview fragments related to market developments in the health care system (one of the three broader categories). The first researcher coded these fragments in smaller categories.

During the second phase the two other researchers read all interview transcriptions and checked the codes attributed to the interview fragments by the first researcher, so as to enhance the validity of our analysis.

### **3. Results**

#### *1. Change or no change?*

A few respondents (1 surgeon and 7 GPs) reported that they did not notice any difference caused by marketization in their day to day work. The surgeon and two GPs explained that in certain environments it was possible to ignore the changes.

“Many people seem to think, let them talk all they want, we will just do our work” (SU JV4)<sup>4</sup>

“In [my village] everything stays the same. People still have thirteen children [...] I noticed no great difference. Perhaps changes just go past me.” (GP JV5, p. 6-7, 36)

Two GPs found that the market elements in the new system were too small to cause any real change, and the remaining three GPs explained that market elements (such as marketing and competition) were also prominent when they first started their professional career.

“When I first started [other doctors] were very hesitant. There was certainly no shortage of GPs, so it may be a bit much to say that you had to fight your way in, but for sure there was rivalry in the beginning.” (GP OM7, p. 38)

“Female doctors were competitors back then. When I applied for this practice, there was much resistance among other doctors, because in fact they did not want to have a female colleague.” (GP OV3, p. 39)

All other respondents told us that marketization had changed their work.

## *2. Marketing yourself (advertising)*

The most important change for surgeons, mentioned by eleven of them, pertained to the fact that they now had to sell themselves, they had to advertise or market their performance. Before the marketization took place the doctors’ association in the Netherlands (the KNMG) had always stated that physicians should not draw attention to themselves by advertisements. The doctors’ association saw to it that doctors adhered to this rule. The introduction of market elements in Dutch health care not only made the anti-advertisement principle obsolete, it made it against the law for the doctors’ association to uphold this traditional rule of medical professional ethics. Hence the fact that marketing was often mentioned as a major change is not surprising.

Surgeons described the advent of several ways of marketing in health care. Some of them did a visiting tour among GPs in the neighborhood, so as to encourage these GPs to send their patients to their hospital. One surgeon reported that his hospital had managed (with quite some effort) to become the first google hit for certain types of operations. Other public relations activities involved publishing advertorials in local newspapers, distributing leaflets, inviting a pop group to sing in the hospital to generate more publicity and buying advertising space on the back of a local bus.

Two surgeons were quite positive about this change of morals.

“So yes, well, you may be proud if you perform so well.” (SU JM1)

“I always felt it was a pity that we could do absolutely nothing in terms of advertising. You could not say on the radio: come over here, because we’re so good at this or that. So yes, I rather like it that you can promote yourself now. Because you do invest a lot in your work. And then, if you go home nobody

knows what good things you've been doing. So it feels good to make that public." (SU MV1 12, 13)

Four others did not like the self promotion at all.

"So basically you have to show off with your product, and I don't like that at all [...] because I think health care is not something fancy or popular, it's just something that has to be decent all around." (SU JV3 p. 6-7)

"We had this newspaper and they did a feature on the hospital with me on the cover and a little story with it. Truly bad, stupid story. And really, I am old fashioned in this, I think this isn't right." (SU MV2, p. 11)

The remaining surgeons regarded public relations and marketing as developments that were thrust upon them, to which they would have to adjust sooner or later.

"Look, I don't really like this whole idea of competition in health care but if we do it all the same, then, perhaps you have to go along, and advertise. I don't particularly look forward to having my picture on a bus, but hey, if you have to, you have to. We do feature in a health care magazine with a photo ..." (SU MV5, p. 21)

Among GPs the issue of marketing and commercials was less prominent, although six of them mentioned this effect of marketization. A GP explained how she tried to canvass new patients. She studied websites hosted by real estate companies to find out about new inhabitants in her neighborhood, she placed advertisements in a students' magazine and she distributed leaflets throughout her neighborhood. Most GPs reported matter of factly about this new development.

"What we don't do is distribute leaflets throughout the block. Some GP practices in our neighborhood do it though. Including some who first said, no, we're not going to do that because it's unethical. And now they do... whereas we did not take that step. Yet. Look, if others keep doing that, there comes a time ..." (GP JV3, p. 49)

Two GPs morally disapproved of the changes in professional attitude and behaviour.

“The things you want to do to distinguish yourself, you can’t really advertise them. I just want to be a kind and good doctor to people. But you can’t put that in a leaflet. You don’t. So what should you advertise then? I would not want an evening clinic or a drivers’ licence medical examination as attention grabbers for my practice.” (GP JM2, p. 49)

### *3. Shifting priorities*

Traditional medical professional ethics held that health care should be distributed according to medical need. The Declaration of the Rights of the Patient of the World Medical Association clearly states: “In circumstances where a choice must be made between potential patients for a particular treatment which is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination.” (WMA 2005:70). In the Netherlands politicians orchestrated a public debate on choices in health care during the nineteen eighties and early nineteen nineties. Several distribution criteria were discussed such as a fault criterion (should we postpone the treatment of smokers because they deliberately put their health at risk?), economic considerations (should we give preferential treatment to workers or to people of great national importance?) and humanitarian motives (should we accept preferential treatment to parents of young children, because of their children’s grief?). In the end, however, it was decided in Parliament that only medical criteria should apply. If choices are necessary, medical care should go to those most in need of it (Trappenburg 1993). This principle has been reconfirmed by the Dutch doctors’ association ever since (Trappenburg 2009). Is this medical professional principle endangered by the market elements in the new health care system?

Ten of the surgeons we interviewed mentioned that the new system made them pay more attention to minor afflictions than they did in the past. Their hospitals had invested in clinical paths and speedy treatment for patients suffering from varicose veins and inguinal ruptures. The standardization of simple treatments became priority.

“We are organizing a clinical path for varicose veins. Together with the dermatologist we are making a protocol. We want to see to it that if a patient comes in he gets an examination straight away and then arrange the next appointment right after that.” (SU MV3, p. 8)

“They opened a special clinic for inguinal ruptures in X and our varicose veins went elsewhere as well. So that’s when we thought, goodness, we have to get them back and then one of us went all for inguinal rupture surgery. We made sure there was a website and our patients came back. So there you see, you have to fight for your patients.” (SU MV1, p. 13)

“Young colleagues of mine just announce: we’re gonna make a clinical path for varicose veins and we’re gonna make big money there.” (SU DM 3, p. 16)

Less popular but also mentioned occasionally were special clinics for people who had taken a fall, for people with urinary problems, and for obese patients hoping for a stomach reduction (bariatric surgery)

“Well yes, the gastric pouch. We don’t really have a clinical path, but we have established a whole centre for that, bariatric surgery is routine practice there.” (SU JV 4, p. 2)

“You see, certain things get priority here, we want to attract extra patients that way. Think of a heart clinic for patients with all sorts of heart conditions.” (SU JM 3, p. 22)

Six surgeons observed that the extra attention for routine surgery was taken away from other patients or other medical duties.

“I think you should do what you’re good at, and that means that we should not take on so many standard operations in an academic hospital” (SU JM2, p. 6)

“Everybody knows that you don’t make money with big challenging operations. [...] So everybody tries to keep his clinical paths for veins and ruptures as neat as possible” (SU JV3 p. 6)

“Of course I am not operating more because of maketization. It’s a shift of attention, at best.” (SU MV2 p. 12)

“Right, and because one patient gets a speedy treatment, somebody else who suffers from something else, will be helped later. That seems logical, don’t you think? But I don’t hear anybody about that.” (Surgeon OM3 p. 17)

“We have indicated that bariatric surgery takes up a lot of time, and that we have less time to spend on oncology. We have asked for extra time in operating theatres to enlarge our capacity. Move bariatric surgery to the evening or to the weekends even. We’re working on that.” (SU JV4, p. 3)

Among GPs investing extra resources seems to be a very prominent effect of marketization. GPs do a lot of things that they did not do before the change of the health care system. To be able to do so they invest in new equipment (tympanometers to be able to measure fluid behind the ear, ECG machines to be able to make cardiograms, sophisticated 24/7 blood pressure meters) and they employ personnel (administrative staff, a physician assistant or another GP). Twelve of our GP respondents mentioned that they had bought new equipment or hired new staff to be able to perform extra medical activities.

“Since January 1<sup>st</sup> I’ve got an assistant in the morning. She can do certain things: blood pressure, that type of things.” (GP MM1, p. 7)

“There are thousands of general practitioners who bought an ECG machine. They make ECGs all the time, because it’s good money.” (GP JM2, p. 13)

“We bought a 24/7 blood pressure meter. We used to borrow the thing from the pharmaceutical industry. When they didn’t lend it as often as before we decided to buy one.” (GP MV1, p. 19)

“It’s a lot of work. There is a lot of administration involved. We hired an administrator to do that for us.” (GP MV3, p. 20)

Whereas surgeons testified about a shift in priorities in favour of patients with minor afflictions, several GPs (n = 5) witnessed a change for the better for patients with chronic conditions.

“Marketization has led to an improvement in the care for the chronically ill. Diabetes care, but even more clearly for COPD patients.” (GP MV3, p. 8)

“In our practice we see it with diabetics. We do much more now. We test their blood every three months. Check all the veins. It sounds much better. People are examined much better. So obviously, you will find more.” (GP MM4, p. 11)

The improvement is probably due to the growing competition in the care for the chronically ill, leading to more standardization of care. Diabetics and people with other chronic illnesses can sometimes seek care in special clinics. When that happens, GPs miss them as well as the income they generated.

“I think it’s a pity that diabetics no longer visit a GP. And that they don’t see their GP for their regular check up. Because if you come to your GP with some ordinary condition I can ask you how you’re doing otherwise. To me those were the nicest elements of GP practice and I know patients feel the same way.” (GP OV4, p. 47).

“You can see it with this clinical path tendency. COPD, diabetes. That is marketization. You create a certain group and then you try to buy health care for them as good as possible. The problem is that not every disease and not every patient fits in a group.” (GP OM6, p. 46).

Within GP practice the shift of priorities is much more in accordance with the traditional distribution-according-medical-need principle. Spending extra money on equipment and personnel probably leads to a net enlargement of the total amount of

medical care, whereas the extra attention to people with chronic conditions might conceivably be construed as offering extra care to those most in need (although this remains debatable; if the extra services would be spent on diabetics rather than on patients with less common but much more debilitating diseases, this would not hold).

#### 4. *Primum non nocere*

One of the first principle of medical professional ethics, featuring prominently in the Hippocratic Oath is *primum non nocere*: first of all, do no harm. It is a principle that might be challenged by the introduction of market principles in health care. If a patient wants a certain operation which the doctor thinks is unnecessary or futile, should the doctor then go along with the patient's wishes (following the rhetoric of demand driven care), despite the fact that an operation might harm the patient (after all, every surgical procedure involves certain risks), or should the doctor refuse? And what if operating – although useless or unnecessary – would bring money, to the doctor and to the hospital? Six of our surgeon respondents pointed out that this might lead to tensions.

“They perform gallbladder surgery here on people with relatively minor complaints. They operate too soon, I think. And why do they do it? Because they like to operate? Because they think it will benefit the patient? Or because this is a rather risk free operation? All three, I gather, but what you see is that many people keep having pain afterwards. A biliary colic is extremely painful, that is a definite indication for surgery, but many people have gallstones and if they are not in much pain, I doubt if an operation will do them much good.” (SU JM1, p. 4)

“Look at oncology. If people suffer from terminal cancer, and you know that an operation won't do any good, many patients will say: all the same, even if there's only one percent chance of success, will you please operate? And as the influence of the market grows, the doctor may say, well, I can sit here and talk for an hour or so, to explain this patient that an operation is pointless. But I may also think: he wants an operation, everybody tells me we ought to deliver patient centred care, so I am politically correct if I operate, I get more money if I

operate, and I prefer operating to talking anyway. So what incentive do I have left to explain my patient that he should not undergo surgery?" (SU OM1, p. 15)

Another surgeon reported that she would hold firm in this respect.

"Sometimes I explain to my patients that surgery would not benefit them. I tell them: 'I like to operate, that's why I chose this profession, I earn money if I operate on you, so sure, I could operate you, but it would not be good for you'." (SU MV3, p. 9)

One surgeon mentioned that his superiors sometimes urged him to be a bit more flexible when treating obesity.

"We are very severe to our bosses. The boss often says, well, put the patient on the list. And we keep saying: why, why?" (SU JV4, p. 3)

Another surgeon pointed out that surgery, unlike other specialties, would not allow for this type of manipulation with indications.

"You can't fool around in surgery. You either have an inguinal rupture or you don't. There is a lump or not. You cannot fake in this profession. It is very difficult to perform unnecessary surgery. It's always been like that. There was a doctor here who specialised in throats and ears. If you do that type of thing you can look in all sorts of body holes and say something about them. Quite easy to cheat. You admit someone, have a look in one of his holes, you say: no lump there and Bob's your uncle." (SU MV1, p. 14)

In Dutch GP practice the do no harm principle used to be interpreted as follows:

- Any medical performance by any doctor is a form of medicalization and thereby potentially harmful.
- If a patient can recover without therapy or medication it is far better to forego treatment.
- If a patient really needs medication or therapy, he should get it, but preferably as little as possible.

- Thus, if a patient can be treated at home by his GP this is to be preferred over hospital treatment. Hospital doctors tend to over treat, a hospital is a sickening environment and hospital treatment takes the patient out of his private surrounding which is unsettling and potentially unhealthy (Mol & Van Lieshout 1989).

This GP interpretation of *primum non nocere* suited the Dutch government in the nineteen eighties and nineties. Hospital care is expensive and GPs were strict gatekeepers to hospital care, thus contributing to the government's intention to cut back on medical care. Likewise the GPs tendency to be frugal with medicines and therapy nicely fitted in the political agenda of those days. Several GP respondents informed us about the traditional GP ideology.

“So, of course, that's the expression: don't do anything unless it's necessary, as we say. I think that really put a mark on Dutch GPs. Don't do anything unnecessary. And I think, this whole idea of let's keep it all affordable, that's also part of what it means to be a GP.” (GP OM3, p. 53)

“It's being reticent, but mind you, for the right reasons. Not just: I don't do it. It's a policy of reticence for good reasons. To prevent unnecessary damage. And also because of the costs. In the Netherlands we have a good education for young doctors, where they learn how to deal with that.” (GP OM6, p. 27)

“The GP guards the natural course of the illness, I would say. That could be a value.” (GP OM2, p. 25).

“Obviously the bottom line is that we know that most illness are cured spontaneously. We use that knowledge. Medical specialists don't do that.” (GP MM4, p. 25)

Many GP respondents (n = 22) felt that this medical professional principle, their traditional GP ideology, was endangered by the marketization of health care. They were treating conditions that did not really need treatment (at least not according to their former ideology). They were performing examinations which they would have condemned as unnecessary in the past.

“Taping an ankle for example. You get money for the material. Ten times the money that you paid for it. And you get money for the actual taping process. When really, it’s a piece of cake if you can do it. Ankles are being taped that don’t need taping.” (GP JM2, p. 8)

“For instance, say you’ve got a metal splinter in your eye. If I take it out with a cotton swab I get 9 euros. If I use a tiny drill to get it out, that is classified as a pseudo specialist intervention, and then I get 51 euros. So you see, it’s kind of tempting to pick up the drill and get it out like that. While actually it’s not necessary, and a drill always creates a little wound ... So that’s a threshold for a doctor. But I am sure there is more drilling going on than necessary.” (GP MM1, p. 14)

“We have a tympanometer now. It doesn’t do much. It’s ridiculously expensive. [...] For just a tiny piece of extra information. Before I did without the meter. I don’t think it was worse. But now the meter offers me 26 euros for two minutes work. And I think that’s strange. For me as a professional, it doesn’t feel right.” (GP MM4, p. 16)

“I do more, I admit that. But it’s not that I say whenever I see a wart: come by and let me fix it. There is a true demand. I try to be as honest as possible in this. Sometimes I think: this was unnecessary. But that’s also because I like certain things.” (GP MM5, p. 18)

“Colleagues of mine want to invite all patients over 50 in their practice to make an ECG. I find that dubious. That is making money with your machine, I think. The same thing happens with a lung function meter.” (GP MV2, p. 13)

“I am rather easy you know. If patients really want something, and they have their reasons, I am fine with that, even though I disagree. [...] If a mother comes to me with a child, and I’ve seen him three times for coughing already, and then in fact, it is pointless to start antibiotics, but if the mother wants it, I’ll explain

that I don't think it's useful, but then if she still wants it, I'll give the prescription anyway." (GP JV5, p. 22)

"A full blood examination. In the past I would wonder: what do you want with it? What do you want to know? Because otherwise it's pointless. And now I say: okay, patient wants it, fine. Fine. I am not the one who's going to pay for it." (GP MM3, p. 24)

Some GP respondents reported that they still want to cling to their traditional reticence and that they don't want to give in.

"GPs try, but you have to be really strong to be able to do that. GP medicine is like rowing upstream. Against the patient's demand even. That may sound strange, because you have to think along with your patient, but I think that patients do ask a lot of unhealthy things." (GP OM2, p. 31).

"I am a reticent doctor. I don't prescribe medication easily. And I think, if you can explain that well, it can be explained." (GP JV5, p. 27)

"I think you should just hold firm. I sometimes say to a patient, look you're not in a supermarket here where you can come in and just take whatever you want. It doesn't work like that." (GP MM3, p. 25)

However, the same GP also told that he felt he had no choice but to give in, because he feared that patients would leave him and find another GP.

"It's a consumer society. My patients seem to think ... well you know, I can try to draw a line, but there are consequences. Because a patient. ... he could just think, this doctor doesn't give me what I want. Fine, I'll find myself another doctor. In the past patients were loyal, but that has changed. They shop around now." (GP MM3, p. 27).

The majority of GPs seem to be reinterpreting the do no harm principle. They have discovered that patients are not harmed by examinations and blood tests. Quite the

contrary, patients seem to like it. GPs have bought equipment which enables them to examine patients in their own office, rather than referring them to a hospital, which contributes to the idea that patients will not be harmed, as patients don't have to spend half a day waiting in a hospital, they can be examined on the spot.

“Before I had to send people to a hospital. Maybe now, I will say more quickly, let's run an ECG, just to be sure. In the past I would have thought: is it worth it? No, I am not going to have my patient go to hospital on top of all. So sure, supply creates demand. But no dubious demands.” (GP MV2, p. 10)

“Patients like the extra tests. So fine, you can say, just measure it, because they're worried.” (GP MM1, p. 12)

“The quality of care has improved. We now measure certain things in a more transparent way.” (GP MV3, p. 11)

“People are busy offering screenings. They want to do things.” (GP MV1, p. 19)

“The funny thing is: patients are very happy about it. [...] They are very satisfied with our practice. You can have an ECG here and we really examine you. People feel that they are taken seriously.” (GP MM4, p. 13)

Although screenings and examinations do not harm patients and many patients rather like to be examined thoroughly every now and then, screenings and examinations do cost a lot of money, while it is unclear whether they will improve public health. In the past the costs of health care were an integral part of the GPs ideology, of their particular interpretation of the do no harm principle. This seems to have changed, due to marketization.

“They [politicians] hoped to lower the costs of health care. But what you see is the opposite. There's a rising demand for total body scans and the like. Because everybody wants to have everything and everything is being refunded by health insurers. That's a different demand than the need for necessary care.” (GP MV 3, p. 55)

“You should not make GP care commercial. The minister is completely wrong doing that. He takes a top down perspective and he says: well, the market is usually good. You can do it perhaps, with certain things, but not with GP care. Because GPs will then try to please their patients and that is not always what’s best for the patient.” (GP MM4, p. 33)

“I think the argument that you should not harm your patient will remain prominent. But cooperating to keep down the costs of health care; that’s not appealing any more.” (GP MM1, p. 29).

#### **4. Conclusion**

Although we have to be careful in drawing conclusions from a limited number of interviews our research shows that Berenson and Cassell and the Dutch Council for Public Health and Health Care were right when they pointed out that the introduction of market elements in health care would challenge traditional medical professional ethics.

The ‘do not advertise principle’ has been abolished. Marketing activities seems to be widespread in hospital surroundings and some marketing also goes on in GP practices. Both GPs and surgeons are divided about this. Some physicians abhor the self-promotion involved, others welcome the new opportunities, whereas yet others consider this a fact of life, with which they will learn to live eventually.

The ‘distribute according to medical need’ principle has been all but abolished in hospitals. A lot of medical time and energy is spent on minor, routine operations with which hospitals can make a lot of money. This goes to the detriment of patients in need of major, risky surgical procedures. In GP practices more attention goes to patients with chronic conditions who may arguably qualify as those most in need of medical care.

Lastly, the *primum non nocere* principle is still being upheld in surgery. Among GPs this principle gradually acquires a whole new meaning. Whereas it used to mean: do not examine or treat a patient unless this is really necessary, it now comes to mean: you may examine and treat a patient as he or she prefers, you may offer examinations and treatment which may be beneficial (even if you don’t know that yet). It’s all alright, as long as you do not actually harm your patients. The traditional

GP ideology, which may be conceived as a very broad interpretation of the Do no harm principle, is challenged most by the market elements in the new system. Supply side reticence does not befit a medical entrepreneur.

Our findings are summarized in table 2.

Table 2

<b>Principle of medical ethics</b>	<b>Surgeons</b>	<b>GPs</b>
<b>You shall not advertise</b>	Substantial change: marketing has become normal although some surgeons dislike it	Small change: marketing is not very widespread, but GPs feel (and some fear) this may change
<b>Distribute according to medical need</b>	Substantial change: much more attention to minor afflictions	Small change in favour of patients with chronic conditions, but this may concur with the moral principle
<b>Primum non nocere</b>	Small change: surgeons feel tempted to operate more, but do not give in	Substantial change: the do no harm principle is reinterpreted. Medical attention is no longer considered harmful per se

If the costs of health care are allowed to rise, the effects of these changes may be limited. It will take some getting used to for many patients to have to reinterpret information provided by hospitals or physicians as mere propaganda, but as long as the marketing budget does not decrease the amount of money spent on actual care, patients might adjust. They may even like to compare websites or leaflets to make an informed choice between medical providers.

If the extra attention for varicose veins and inguinal ruptures is provided in after office hours, if doctors and nurses want to spend their weekends on standard surgery (rather than paying attention to their children, their ageing parents, or their hobbies), than that should not be a problem either. If the government would decide to spend extra money on training more doctors and nurses, to generate more capacity, the breach of traditional medical ethics should be in even less danger.

If the government would decide not to worry about the rise of health care costs the abolishment of GP frugality and reticence could be a positive development, leading to happy patients and to happier doctors who would no longer have to worry about being strict and spending as little money on medical care as possible.

However, health care (despite all the market elements and the accompanying rhetoric about consumer choices and preferences) is still largely paid with public money. Chances are that the government will not be too happy to finance unlimited growth and if resources are scarce all three breaches of traditional professional ethics can become truly harmful. If money is spent on advertising rather than medical care, if it is spent on varicose veins rather than oncology, and if it is spent on fancy screenings rather than necessary treatment, we do have a problem.

We feel that it is about time that both doctors and policy makers acknowledge what is happening to traditional medical professional ethics. Physicians may decide to uphold their traditional principles despite the presence of incentives luring them in opposite directions (this can be done, as the surgeons in our findings have shown with regard to the do not harm principle). And politicians may decide to re-order or reorganize the incentives, so as to make it easier to cling to traditional principles. This seems first of all warranted with regard to the GP reticence principle, that has been very beneficial for the health care budget and might be coveted by politicians for that reason. GPs, as our research have shown, are not able to uphold that part of their professional ethics without political support.

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<sup>2</sup> In European health care systems health care is never completely marketized. Reform usually consists of: more incentives for care providers so as to make them work more efficiently, more choice for patients (health consumers), more competition between providers and/or insurers, more co-payments

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etcetera. In this article we will use the terms market based system/model and consumer-driven model interchangeably.

<sup>3</sup> See for an outline of the general project

<http://www.margotrappenburg.nl/onderzoek/projectbeschrijving%20juni%202006.pdf>

<sup>4</sup> The page number in the references at the end of interview quotations refer to our code books (the interview transcriptions).