

## **1. PROJECT INFORMATION**

The robustness of medical professional ethics

In the old days (say up till the nineteen seventies) doctors were taken to be devoted to their patient's best interest. In typical paternalist fashion they assumed that they would be able to establish the patient's best interest themselves, but they were not in the habit of weighing the patient's interest against competing claims. No doubt this attitude was partly caused by personal idealism and by professional socialization (vocational training). However, it was probably also caused by the institutional and societal environment in which medical work was taking place: doctors enjoyed professional autonomy, both individually and collectively as a profession. As professionals they were highly respected by their patients and their expertise and authority were taken for granted.

During the last three decades the societal environment has changed. Patients have changed; many of them have become highly educated. Modern patients tend to question their doctors' authority. Doctors have changed. Whereas in the nineteen fifties an overwhelming majority were married men, with a wife who took care of their family and their household needs, these days many doctors are women who have to combine their professional life with family responsibilities. And last but not least, the organizational structure and societal climate surrounding professionals has changed considerably. A neoliberal ideology has led to the introduction of all kinds of pressures which are meant to induce professionals to perform efficiently and cost effectively. Professionals have to deal with hospital managers, who are much more profit oriented than professionals used to be. Following neoliberal orthodoxie or market incentives introduced by the so-called new public management approach professionals have to answer consumer demands rather than patients' needs. According to Eliot Freidson, we can witness a decline of professionalism. Is he right?

The research goal of this (multi-disciplinary) project is twofold.

1. We want to find out – empirically – whether this combination of societal developments (changed patients, changed doctors, changed institutional and societal environment) has led to the withering of professional ethics. Do doctors still put the interests of their patients first or have they come to see their work as just that: a line of work? Do they now weigh their patients' interests against other interests (e.g. hospital profits, their own family)? This characterisation (withering; decline) is, of course, normative in nature and requires further conceptual analysis.

2. We therefore also want to find out – normatively – how we should judge the changes that have taken place. Are these (ongoing) developments fully in conflict with fundamental principles of medical professional ethics, are they simply undesirable, or can we reformulate or transform professional ethics, so as to make it fit the new circumstances? And if so, how should we institutionalize such a transformed professional ethics? With help of normative background theories on professional roles and professional ethics we will shed light on this question and give a normative assessment of the changes.

## **2. PRIMARY APPLICANT:**

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## **3. CO-APPLICANTS:**

Dr. M.T. Hilhorst (department of medical ethics and philosophy Erasmus MC)  
Dr. M. Schermer (department of medical ethics and philosophy Erasmus MC)

#### **4. PREVIOUS AND FUTURE SUBMISSIONS**

This proposal has not been submitted to other NWO departments or programs. Nor will it be submitted elsewhere.

#### **5. INSTITUTIONAL SETTING:**

The research will be carried out at the Institute for Health Care Policy and Management (iBMG) and at the department of Medical Ethics and Philosophy (two departments of Erasmus MC Rotterdam).

#### **6. PERIOD OF FUNDING:**

september 2005 – september 2009.

#### **7. COMPOSITION OF THE RESEARCH TEAM.**

<b>Name</b>	<b>Scientific background, NWO code</b>	<b>Institute</b>
Prof. Dr. M.J. Trappenburg	52604, 51605	Institute for Health Care Policy and Management
Dr. M.T. Hilhorst	51603	Department of Medical Ethics
Dr. M. Schermer	51603, 61300	Department of Medical Ethics
Junior researcher (aio)	Social scientist with an interest in ethics, or a medical ethicist with some expertise in social science; Trappenburg will be his/her supervisor.	

Panel of experts, to be invited (see further, sub 11 third year of the project):

Prof. David Miller PhD, Political philosophy, Oxford University

Prof. Julian Le Grand, Economics, London School of Economics

Prof. Soren Holm, PhD, Ethics, Cardiff University

Prof. dr. M. Berg, Medicine, philosophy, social sciences, Institute for Health Care Policy and Management (iBMG)

Prof. dr. J. Legemaate, Health law, Royal Dutch Doctors Association (KNMG)

Mr. J. Kasdorp, Council for Public Health and Care

#### **8. THEMATIC CLASSIFICATION WITHIN THE RESEARCH PROGRAMME EO&B:**

1. General theoretical and methodological questions, theme 1.1 'empirics and ethics', and theme 2.1 'selfregulation by organisations and professional bodies and the supervising role of the government',
2. Ethics of care and health, theme 3.1 'the ethical evaluation of market incentives in health care'.

## 9. RESEARCH QUESTION, AIM AND DESIGN

### Research aim

During the last three decades the medical profession and the world around it have changed enormously. The average medical doctor in the fifties was a married man. His wife would take care of his children and his household needs. Generally speaking, his patients would be less educated than he, most of them knew very little about illness and medication. And, at least in the Netherlands, this average doctor in the fifties could follow his own medical insights without having to worry much about financial incentives or management directives provided by the government, insurers or hospital management.

These days, all this has changed. Many doctors are women, or men whose wives have their own career. The level of education of the average patient has risen. There is medical information freely available, on the internet, in newspapers and weeklies and in television programmes. And many medical doctors have to deal with hospital managers, government and market incentives and insurers' demands, which infringe on their professional autonomy.

The research goal of this project is twofold.

We want to find out – empirically – whether this combination of societal developments (changed patients, changed doctors, changed institutional and societal environment) has led to the withering of professional ethics. Do doctors still put the interests of their patients first or have they come to see their work as just that: a line of work? Do they now weigh their patients' interests against other interests (hospital profits, their own family)?

We also want to find out – normatively – how we should judge the changes that have taken place. Are these (ongoing) developments fully in conflict with fundamental principles of medical professional ethics, are they only undesirable, or can we reformulate or transform professional ethics, so as to make it fit the new circumstances? And if so, how should we institutionalize such a transformed professional ethics? Using normative background theories on professional roles and professional ethics we will consider this question and give a normative assessment of the changes.

### Research design

#### I. First stage: concepts

We will first establish a rough idea of traditional medical professional ethics, based on literature by medical ethicists. We expect to find values such as 'patients' interests should be put first' and 'adherence to standards of medical-professional expertise', as well as 'vocation' and 'trust between doctor and patient', and views on health (and the fulfilling of need) as an individual and public good.

This first round will be undertaken by the senior researchers, who will also formulate hypotheses about the changes that may have taken place in medical professional ethics during the last thirty years. Obviously, this will warrant in depth research, but we will formulate three provisional hypotheses, to give a rough impression:

- *From vocation to business as usual.* We assume that women doctors and part time work have changed medicine from a vocation to a normal job.
- *From trusting the doctor to trusting scientific evidence.* We assume that highly educated patients do not simply believe their doctor, they expect their doctors to explain their actions in relation to scientific evidence. This may lead to medicine becoming overly scientific (guidelines for general practice suggest that general practice is very much evidence based, perhaps more than it really is).

- *From independent judgment to 'at your service' mentality.* We assume that market incentives have partly transformed medical treatments in consumer goods, to be provided on demand.

We will predict what medical professional ethics could look like, if these alleged developments in our hypotheses were indeed to take place.

## II. Second stage: empirical work

Following up on these ideas a junior researcher will start an empirical research project along the following lines. He/she will investigate the changes in medical professional ethics within two different medical professional groups: general practitioners on the one hand and surgeons (e.g. orthopaedy, plastic surgery, transplantation surgery, general surgery) on the other hand. These two groups differ with regard to the societal developments described above.

- About 25 % of GPs is female. In ten years time, almost half of the GPs will be women. General surgery on the other hand is still assumed to be a male stronghold, although women have entered this specialty too (about 6 %) and will continue to do so in the near future (according to the NIVEL research institute, by 2015 25 % of the surgeons will be women).
  - GPs meet their patients often in a very personal way. Surgeons on the other hand mostly have less contact with their patients. When they meet they talk largely about technical issues concerning the operation. A change in professional ethics due to patients' higher educational level may have affected GPs much more than surgeons.
  - Also the setting in which care is given differs. The majority of GPs work in independent practice, either alone or with one or a few other GPs. Surgeons on the other hand, invariably work in a hospital environment, either employed or independent, either in a public or a private organisation. We assume that they have to deal more with hospital managers, management directives, and other incentives. This is not to say that GPs' setting is free of any inducement: governments expect them to play the gatekeeper's role in health care, and insurance companies increasingly try to control GPs' prescriptions.
- We will investigate official documents issued by the Royal Dutch Medical Association, starting with the first documents after World War II (the so-called 'little green book', the Code of good behaviour) till the present documents published on cd-rom. We will investigate all volumes of the physician's weekly *Medisch Contact*. We will look at contributions by general practitioners and surgeons respectively, in order to find out whether their view of their professional ethics has changed in a different way or a different degree.
  - Meetings and conferences organized by the Royal Dutch Medical Association will be attended and observed, with special attention for the input by GPs and surgeons.
  - We will study documents published by the NVVA, the Dutch Society for Female Doctors, and attend meetings and conferences organized by the NVVA.
  - We will investigate all volumes of the journal for general practitioners *Huisarts en Wetenschap* (GP and science). Meetings of the associations for GPs (the Landelijke Huisartsenvereniging LHV and the Nederlands Huisartsengenootschap NHG) will be attended and observed.
  - Official documents issued by the associations for GPs will be studied.
  - Similarly we will investigate all volumes of the journal for surgeons *Tijdschrift voor Heelkunde* (Journal for Surgery). Meetings of the associations for surgery will be attended and observed.

- Official documents issued by the associations for surgeons will be studied.
- We will organize three so-called three generations meetings. In these meetings we will interview three generations of GPs, orthopedic surgeons, and general surgeons. The first generation should consist of retired doctors, the second should be the now leading generation of doctors, and the third would consist of advanced medical students or doctors in training (the Royal Dutch Medical Association has an active studentboard, who could provide help in this respect).

<b>Research group/research action</b>	<b>Official documents by organisations</b>	<b>Attending and observing official meetings and conferences</b>	<b>Studying volumes of relevant journals</b>	<b>Three generation interviews</b>
Doctors in general	X	X	X	
Female doctors	X	X		X
General practitioners	X	X	X	X
Surgeons	X	X	X	X

### **III. Third stage: normative debate**

The data acquired in the empirical research will enable us to describe in more detail what professional medical ethics looked like in the nineteen fifties, how it has changed during the last decades, and whether (and in what respect) the path of change is different for different kinds of medical doctors. Also, it should give the senior researchers material to corroborate their hypotheses or reasons to revise them. It could provide them with more material to build on, when they try to construe a new medical professional ethics.

In the last year of the project we will organize an international workshop and invite leading scientists in this field. We will present our own findings and invite them to comment on them. Also, we want to invite scientists who have done research on the medical profession and its ethical codes and/or the effects of market incentives in health care in West European countries. This will hopefully enable us to determine whether our findings are typically Dutch or similar to patterns elsewhere.

### **Theoretical framework / State of the art?**

The data which we hope to find can be analysed in a wider context, so as to contribute to international theory and research in this field. Eliot Freidson (2001) has published extensively on professionalism and its alleged decline. In his opinion the logic of professionalism is threatened by both the logic of the market and the logic of bureaucracy. Whereas Freidson in his latest work takes a profession centred approach Julien Le Grand (2003) writes from a state centred perspective. His research focuses on the question how a government (a principal) should steer professional agents in a certain direction. He is especially interested in the issue of quasi-markets; that is, he has tried to find out whether there exists an incentive structure which will discipline wicked, lazy or self-serving professionals without discouraging good, hard working, dedicated professionals. With respect to personal motivation and human nature, he takes a realistic point of view. He does not consider the public environment a better setting *per se* for medical practice than the private environment. Applebaum (1999) sees the rules of doctoring as largely conventional, so that a new and social meaningful role might emerge. Mark Cherry takes this debate one step further by concentrating on current developments towards commerce and market medicine (2003). Cherry points to the benefits that the market

can have for health care delivery and distribution, also in ethical respect. According to his (optimist) view and fundamental criticism of inadequate and even unjust government control in health care, a market setting accommodates pluralist views on health and life, individual preferences of patients, and the requirements of efficacy and efficiency of modern societies. Our research will also contribute to political philosophical research, initiated by Michael Walzer (1983). According to Walzer, societal spheres such as education and medicine have their own moral logic, e.g. higher education ought to be distributed according to merit and medical care ought to be distributed according to medical need (cf Elster, Elster and Herpin). According to Walzer societal spheres such as health care and education ought to be shielded from the market as much as possible. In our research we not only focus on market influences that might threaten the sphere of health care from the outside, we also look at developments which take place within the sphere of health care itself. Thus, we hope to contribute to the Walzer literature, by considering whether Walzerian spheres of justice can 'evolve', and how such an evolution should be evaluated.

### **Scientific relevance**

The method of 'relevant document research over a long period' has been proven very useful for research on changing morals (cf. Brinkgreve & Korzec 1978, Brinkgreve 2004, Mol & Van Lieshout 1989, Trappenburg 1993). The three generation interviews and the observation of relevant meetings and conferences will be an interesting addition to this method. The detailed comparison of two groups within the medical profession will hopefully provide more insight in societal and moral developments than a secondary analysis of existing opinion research.

### **Societal relevance**

The societal relevance of the project seems obvious. Dutch health care will be changed in the years to come; there will be much more room for market incentives. Patients will more and more make their own choices with regard to health care providers and insurers. This may strengthen effects of the educational level of patients. It seems highly relevant to know what all this will mean for medical professional ethics. We will invite members of professional groups and policy advisors to participate in our expert panels, and consult them on the dissemination of our findings.

## Literature

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- Commissie Modernisering Curatieve Zorg (1994), *Gedeelde zorg: betere zorg*, Rijswijk.
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- Freidson, E. (2001), *Professionalism: the Third Logic*. Cambridge: Polity Press, 2001.
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## 10. WORD COUNT:

1999 words

## 11. INTERNATIONAL PERSPECTIVE

Our own empirical research is restricted to Dutch developments, materials and documents, but our conceptual and normative analysis is embedded in international debate. This is not surprising since our project deals with developments and fundamental questions that can be observed everywhere in the western world. In the third year of the project we want to invite leading authors in the field (such as Freidson, Applebaum, Holm, Cherry, LeGrand, Miller) and ask them to comment on our findings in a workshop. This will enable us to put our findings in a broader comparative perspective and to contribute to the ongoing international and theoretical debate. We know some of the leading authors in this field personally (Soren Holm has contributed to several projects undertaken by the department of medical ethics and philosophy; David Miller was a keynote speaker on a conference organized by the research school for ethics and is a Walzer expert; Trappenburg will meet him in april in another international workshop

## 12. WORK PROGRAMME

Year	Junior researcher	Senior researchers
1	Reading, starting empirical research, document analysis, observing meetings and conferences	Studying philosophical literature, writing article, formulating hypotheses in working paper
2	Continue empirical research, document analysis, observing meetings and conferences, organizing three generation interviews, writing chapters of thesis	Preparing international workshop, hold lectures on findings for professionals, and groups of policy makers, in order to test robustness and validity of the findings
3	Finishing empirical research, writing chapters of thesis, preparing and presenting paper for international workshop	Preparing and presenting papers for international workshop. Organizing international workshop.
4	Finishing and defending thesis, rewrite workshop paper for international journal	Rewrite workshop papers for international journal. Hold lectures on findings for broader audience, so as to share the results and invite comments.

## 13. PLANNED DELIVERABLES AND KNOWLEDGE DISSEMINATION

We intend to present our findings in international scientific journals such as *Ethical Theory and Moral Practice*, *Journal of Medical Ethics*, *Medicine, Health Care and Philosophy*, and/or the *Journal of Political Philosophy*.

The junior researcher will write at least two articles for international journals and write a thesis.

All researchers will present their findings in lectures and conferences for a broader audience. Both Trappenburg and Hilhorst have ample experience in holding lectures for a non academic audience and are capable of communicating scientific or philosophical findings to non specialists. Schermer has worked for Centre for Ethics and Health (a council in which the Health Council and the Council for Public Health and Care participate jointly). She knows the policy agenda and will be able to inform the research group about moments or opportunities where the research group could make a useful contribution.

Year	Planned deliverables/dissemination
1	Working paper by Hilhorst, Schermer, Trappenburg
2	Paper international journal by Hilhorst, Schermer, Trappenburg; lectures for professional groups and other relevant parties such as policy makers by Hilhorst, Schermer, Trappenburg
3	International workshop. Papers for international workshop by Hilhorst, Schermer, Trappenburg, and junior researcher. Lectures and participating in conferences for lay audience: Hilhorst, Schermer, Trappenburg and junior researcher.
4	Articles for international journal by Hilhorst, Schermer, Trappenburg and junior researcher. Thesis by junior researcher.

#### 14. SHORT CURRICULUM VITAE OF PRINCIPAL APPLICANT

Margo Trappenburg defended her thesis about the emergence of new norms in medical ethics in 1993. She did extensive research on the evolution of norms in health care, she published on euthanasia and other medical assistance in dying, on reproductive technology, and on choices in health care. She was involved in several other NWO projects e.g. the project on Medical Behaviour that Potentially Shortens Life', chaired by professor John Griffiths (sociology of law, Groningen University), the project 'Theories of Justice: What is the Use' chaired by prof. G.A. den Hartogh (ethics, University of Amsterdam) and the project on reproductive technology, chaired jointly by professors den Hartogh and De Beaufort (medical ethics and philosophy, Erasmus University). In her research she combines ethical and empirical studies, which should make her particularly qualified for this research project.

#### 15. TEN KEY PUBLICATIONS BY THE RESEARCH GROUP:

Hilhorst, Medard. *Er dokter bij blijven: medisch-ethisch handelen in veranderende omstandigheden*. Assen: Van Gorcum, 1999 [a].

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#### **TEN KEY PUBLICATIONS BY LEADING AUTHORS IN THIS FIELD:**

Applebaum, Arthur I. *Ethics for adversaries: the morality of roles in public and professional life*. Princeton: Princeton U.P., 1999.

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Wispelaere, Jurgen de, Altruism, morality and moral demands. In: Seglow, J. (ed.). *The Ethics of Altruism*, London: Frans Cass Publ., 2004, 9-33.

#### **16. SAMENVATTING IN HET NEDERLANDS**

De arts van 2005 is in veel opzichten niet meer de arts uit de jaren 50 en 60. Dat heeft ten eerste te maken met maatschappelijke ontwikkelingen zoals het gestegen opleidingsniveau van patiënten en de emancipatie van de vrouw. Het gestegen opleidingsniveau zorgt er mogelijk voor dat arts en patiënt meer gelijkwaardig tegenover elkaar staan en dat de arts zijn handelen veel meer moet uitleggen en verantwoorden. Hoger opgeleide patiënten zijn mogelijk minder dan lager opgeleide patiënten geneigd om de dokter simpel op zijn woord geloven.

De emancipatie van de vrouw heeft ertoe geleid dat de arts van 2005 vaak een vrouw is en part time werkt, of een man die minder uren kan maken dan vroeger omdat zijn vrouw haar eigen carrière heeft.

Veranderingen in de gezondheidszorg worden ook veroorzaakt door overheidsbeleid. Men kan zich indenken dat de steeds grotere nadruk op marktwerking, transparantie en prestatie-indicatoren het medisch handelen op enige wijze beïnvloedt.

Wat gebeurt er met de professionele ethiek onder invloed van macrosociologische veranderingen, sectorinterne ontwikkelingen en het ingezette overheidsbeleid? Dat is de centrale vraag in ons onderzoek.

Blijft de beroepsethiek van de arts intact als het vak van medicus niet langer een roeping is, maar gewoon een beroep, dat part time kan worden uitgeoefend? Verandert de medische beroepsethiek als patiënten goed geschoold en mondige patiënten zijn? Welke invloed zullen prestatie-indicatoren hebben op de beroepsethiek, als artsen onder druk komen te staan om de cijfers van hun ziekenhuis zo gunstig mogelijk voor te stellen, om de toekomstige concurrentie in de zorg te overleven?

In ons onderzoek willen wij bekijken hoe robuust de medische beroepsethiek is. Als die beroepsethiek bijzonder stevig is, dat wil zeggen: als medici de 'core values' overeind weten te houden, dan is dat een reden om de effecten van ingezet overheidsbeleid (concurrentie, transparantie, prestatie-indicatoren) met enig optimisme tegemoet te zien. Als de beroepsethiek minder stevig is zou dat een reden kunnen zijn om a) het ingezette overheidsbeleid te heroverwegen of b) de beroepsethiek anders/beter te verankeren of c) die beroepsethiek opnieuw te doordenken en bij te stellen.

#### **17. RESEARCH BUDGET.**

- Replacement senior-researchers (Trappenburg, Schermer, Hilhorst): 48.000 euro.
- Junior researcher: 157.683 euro.
- Travel, conferences, international contacts 5000 euro.
- Organization international workshop 10000 euro.
- Bench fee (computer etc.) 5000 euro.

Total costs: 225.683 euro.