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The robustness of medical professional ethics when times are changing: a comparative study of general practitioner ethics and surgery ethics in The Netherlands

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ABSTRACT

Society in the 21st century is in many ways different from society in the 1950s, the 1960s or the 1970s. Two of the most important changes relate to the level of education in the population and the balance between work and private life. These days a large percentage of people are highly educated. Partly as a result of economic progress in the 1950s and the 1960s and partly due to the fact that many women entered the labour force, people started searching for ways to combine their career with family obligations and a private life (including hobbies, outings and holidays). Medical professional ethics, more specifically: professional attitudes towards patients and colleagues, is influenced by developments such as these, but how much and in what way? It was assumed that surgery ethics would be more robust, resistant to change and that general practitioner (GP) ethics would change more readily in response to a changing society, because surgeons perform technical work in operating theatres in hospitals whereas GPs have their offices in the midst of society. The journals of Dutch surgeons and GPs from the 1950s onwards were studied so as to detect traces of change in medical professional ethics in The Netherlands. GP ethics turned out to be malleable compared with surgery ethics. In fact, GP medicine proved to be an agent of change rather than merely responding to it, both with regard to the changing role of patients and with regard to the changing work life balance.

Norms and values change over time. Not just over the course of centuries (we can no longer sympathise with Aristotle's views on slavery), but also over the course of decades. To name a few obvious examples: in western liberal societies people's norms with regard to racial equality, gender equality, homosexuality, abortion and euthanasia have changed substantially between the 1950s and the present.¹

It seems plausible that what goes for norms and values in general also holds for medical professional ethics: it can change. Present day medical doctors no longer subscribe to Hippocrates' reference to "Apollo, Asclepius, Hygieia, and Panacea", nor will they understand Hippocrates' adamant refusal to "cut for stone, even for patients in whom the disease is manifest."² Many doctors' views on abortion are not just different from the ones proclaimed in the Hippocratic oath; they also differ from the ones professed by many of their predecessors in the 1950s and 1960s.

One of the mechanisms or causes of change in medical professional ethics, identified by Kenneth Calman¹ in an interesting article in this journal, is societal change. Public attitudes change, public opinion changes, the division of power and interests is altered and these developments may take medical professional ethics along, changing professional norms and values as a result.

This article focuses on two societal developments: (1) The changing work life balance. Partly as a result of economic progress in the 1950s and 1960s and partly due to the fact that many women entered the labour force, people started searching for ways to combine their career with family obligations and a private life (including hobbies, outings and holidays). This development occurred in society at large but also within the medical profession.³⁻⁵ (2) The changing role of patients. The level of education has risen steadily since the 1950s, and patients are generally thought to have become better informed, more aware of their rights and less deferential toward medical authority.⁶⁻⁸

In this article we want to find out how these two societal developments have changed medical professional ethics in The Netherlands. We expect that the ethics of medical doctors who are more deeply involved in society change more quickly than the norms and values of doctors whose everyday work takes place in more isolated corners of the hospital. We thus chose to study two specialities within the medical profession that differ with regard to their involvement in societal developments: general practitioners (GPs) and surgeons. Dutch GPs work in independent practices in the neighbourhood 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 gate-keeper to hospital care). Surgical work is more specialised than GP work and involves less personal contact with patients.

METHODS

To answer our research question we performed a qualitative analysis of Dutch medical journals. We studied the volumes of the Dutch scientific journal for GPs *Huisarts en Wetenschap* from 1957 (when the journal was first launched) to 2008 as well as the three successive journals of Dutch surgery: *Archivum Chirurgicum Neerlandicum* (1949-79), *The Netherlands Journal of Surgery* (1980-91) and the

Nederlands Tijdschrift voor Heelkunde (Dutch Journal of Surgery; 1991–2008).

All editions of the journals were read and analysed in a three-stage model. In the first stage one researcher read all the subsequent editions of the volumes mentioned above. She wrote down the main argument and illustrative quotations of all articles that did not deal exclusively with medical technical issues, which led to a data book of summarised articles. In the second stage the data were coded as relating to either or both societal developments that we studied. Within these broad categories all data were inductively coded until no new categories derived from the material. In the third stage the two other authors checked the coding process by reading and analysing the first stage data book, so as to enhance the validity of our analysis.

RESULTS

The changing work–life balance

The Dutch historian Hans Righart⁵ describes the first years after World War II in The Netherlands as all work and no play. Between 1955 and 1967 this changed. Economic progress brought prosperity and more and more people wanted to spend money on cars, trips, holidays and vacations.⁵

Much later, from the 1970s onwards, women entered the labour market. In 1970 30% of all women were active in the labour market. Only 10% of mothers of young children held a job. In 1997 these percentages had risen to 52% and 55%, respectively, although a majority of women does not work full time.⁹

Both developments have led to a re-evaluation of the work life balance. How did these developments influence medical professional ethics in The Netherlands?

During the 1950s and the early 1960s the picture of the good doctor in the GP journal closely resembled the good doctor portrayed in the surgeons' journal: a good doctor is fully dedicated to his patients, puts their interests before his own and works long hours. In the GP journal in the 1950s we can read that the GP has long working weeks. "[B]esides, he may be 'disturbed' at any time during his leisure time".¹⁰ Authors in the GP journal approvingly cite Huddleston Slater's 1940 classic *Recommendations of a family doctor*:¹¹

"The doctor cannot—as others are wont to do—end his daily duties at a specific hour. He must also spend the evening at his work and is obliged to be ready and waiting at ungodly hours, to allow himself to be lifted from his bed when somebody falls ill or needs him in any other way. The clock of the healthy man runs from 8 a.m. till midnight, that of the ill from 8 a.m. to 8 p.m."

Surgeons in those days published obituaries of totally dedicated doctors:

"In the mornings [professor Noorderbos] went to his clinic by public transport and he did not return until late in the evening. He worked throughout the day, giving lectures and performing exceptionally difficult and tiring operations [...] His evenings, too, were devoted to study and to the preparations of his lectures."¹²

"[Doctor Boerema] was a very ambitious man with pronounced features, a man of strong convictions and rigid principles. It was by no means an easy task to satisfy him as a resident or a staff member. He demanded absolute discipline and devotion and he ran his department with authority. Many admired him and some criticized him for this reason. He was the personification of discipline, devotion, self-sacrifice, timeless energy and the highest standards in all respects."¹³

For GPs the ideal of the totally dedicated doctor suffered its first blows in the 1960s. Before 1960 GPs used to have their office at home, close to their private quarters. Patients from the adjacent neighbourhood could easily come by whenever anything was wrong with them. GPs for their part also frequently paid house calls to their patients. Each GP had his own home/office and his own patients. Often the GP's wife worked as his assistant.

During the 1960s GPs started thinking about reorganising their work. They pondered about group practices instead of their traditional solo practices. In group practices they would share medical tasks and serve their patients in turns. In 1960 one GP wrote in his journal:

"The group practice system allows every doctor a free afternoon in which he can practice a personal hobby."¹⁴

In 1963 another GP felt that:

"[The family physician] will be less and less prepared to sacrifice his family life to his practice. For him too, the psychological well-being of his family has become more important. Hence he will strive to organize his practice in such a way as to give family life its due. One expression of this is the growing desire to have a vacation."¹⁵

Yet another GP confessed in 1968:

"We are not that happy anymore with the role of the counselor available at all hours, even though some patients still expect us to fulfill that role."¹⁶

In 1968 the GPs started questioning the use of house calls:^{17 18}

"One should investigate whether we could not save an enormous amount of time by reducing the number of house calls. No doubt this will entail lesser service, but this is what we see happening in all sorts of service activities, because of their labor intensive character."¹⁷

As a result of this quest for a better life, the working conditions of general practice medicine in The Netherlands have changed dramatically since the 1950s. Many GPs chose to work in a group practice, which enabled them to work part-time. In 1971 little more than 2% of GPs worked in a group practice or health centre.¹⁹ In 1995, the number of group practice GPs had risen to 54% and in 2007 to almost 80%.²⁰ Between 1970 and 2007 the number of female GPs increased from 4.2% to slightly over 35%.²⁰ One would expect a lot of discussion about these new circumstances, addressing questions such as: is it possible to stay a good doctor if one practices one's skills only 2 or 3 days a week? What does part-time devotion to one's job mean for the doctor's devotion to his patients? However, we found no traces of such a debate in the GP journal.

In 1959, at an influential conference, Dutch GPs had identified the core values of GP professional ethics: continuity of care, personal attention to the needs of the individual patient, and knowledge of the patient as a human being, that is, not just his medical record but also his family background, job situation and housing conditions. Although GPs kept referring to these labels and never actually relinquished them, the concepts have gradually, without discussion, acquired a new meaning. Continuity of care no longer entails having your personal GP, who knows your history and is taking care of you. It gradually came to mean that there is a GP available at all hours, somewhere, somehow, in a group practice or at a central GP

office. This GP can look up your medical file to become intimately acquainted with your personal history.²¹

By contrast, in surgery the ideal of total dedication held out much longer. There has been much more discussion about working hours and continuity of care. The debate among surgeons was triggered by government regulation in 1992 and has not come to rest ever since. The new regulation determined a maximum number of working hours and the intervals between them. Although some surgeons are glad that the bleak sides of total dedication (such as having to operate in a state of near exhaustion) have disappeared and others reluctantly embrace modern times because they feel that change is inevitable,²² many other surgeons fear that professional standards will suffer as a result.²³

“Surgery is a wonderful, but demanding profession. It is very rewarding when things go well, but it causes a lot of grief when an operation does not end as it was meant to or when a treatment is no longer useful. It is an emotional business, in which every surgeon individually is held accountable, despite his being a member of a large collective. It is a knowledge craft and at the same time a craft demanding manual dexterity, characterized by practice, training and the endless repetition of certain actions. It is the duty of the present generation of surgeons to express how wonderful our profession is, but at the same time we have to point at the duties and the dangers accompanying our craft. Ours is a tough business, demanding enormous investment and effort; it does not suit just anybody.”²⁴

Authors in the surgeons’ journal observe that humane working conditions for doctors will threaten the continuity of care for patients.^{25 26}

“Compensation days, part time work, the sanctity of quality hours and the 40% acute care after office hours; these things all oppose the old adage in general surgery: patient exposure is quality time for the patient.”²⁷

“Continuity of care for seriously ill patients can only be guaranteed by full time surgeons. Those who want to work part time should specialize in one specific area, such as inguinal ruptures, or knee operations, that can be done.”²⁸

Combining surgery with family obligations is much more difficult than being a parent and a GP simultaneously (between 1991 and 1999 slightly over 12% of newly registered surgeons were female²⁹).

Whereas GPs in their journal anticipate societal developments and adjust their principles—continuity of care, personal attention for patients—accordingly, surgeons feel cornered when change is forced upon them; they try to resist it and hold on to their traditional values (although younger surgeons show a different attitude, and accept limited working hours and availability).

Modern patients

Many studies have drawn attention to the increasing level of education and the emancipation of patients, which have presumably led to the birth of the well-informed and empowered patient.⁶⁻⁸ The Dutch government has encouraged the empowerment of patients time and again.³⁰ How did this societal development influence professional ethics in surgery and GP practice in the Netherlands?

The pattern we found in the GP journal with regard to the work life balance—anticipating change and playing into it—was even stronger with regard to our second causal mechanism. Patients appear to have been changed by their GPs rather than

the other way around. In the GP journal we read several accounts of GPs who set out to empower their patients. In 1975 the GP journal writes:

“These days the patient is subject, partner, his autonomy and own responsibility is maintained. He is allowed to talk, think and contradict the doctor.”³¹

During the 1970s GPs started to think that patients should take responsibility for their own problems; patients ought to be able to solve their problems themselves. A 1977 article derides the traditional role play between patient and doctor:

“The client’s role. I suffer from pain, feel sick. You, doctor, should solve my problems with your powerful knowledge, medicines, techniques, research and advices.”³²

The GP is no longer the right person to determine the good of the patient.

“The goal of medicine is not to formulate objectives, nor to make decisions about health care. ‘The doctor knows best’ does not fit in this view.”³³

It seems that many patients had difficulties with their new role; they did not ask for it.

“The patient has to get used to his new role. What do I see when I go to the GP? The GP asks: what do you think is wrong? He asks: what precisely do you feel in your body, and what do you think it might be? I thought the doctor knew best. [...] I am responsible for my own problems, the doctor says.”³⁴

According to the GPs some people are grateful for their new role as autonomous, empowered patients, but it appears to be a role bestowed upon them by GPs.

“It is certainly less easy for patients. [...] Initially, patients who feel comfortable in a dependent position will not enjoy it.”³⁵

GPs have to educate people to enable them play their new role.

“One of the basic rules of health care is to increase patient autonomy and independence.”³⁶

Besides the individual contact between GP and patient other means of communications are used to realise this. A GP explains his weekly section in the local newspaper.

“My articles are meant to increase people’s responsibility by providing critical medical information [...] I presuppose everyone’s responsibility, also for his health, and I question medical authority.”³⁷

Again, in surgery, the picture is different. During the first decades we studied, patients play a very minor role in the surgeons’ journals. Their medical conditions are discussed, usually by means of pictures, taken before and after surgery. From time to time their gratitude towards their surgeon is mentioned, also often in obituaries.

“Many are the patients—here as well as abroad—who commemorate him in gratitude, knowing that they owe him their lives.”³⁸

“Here his warm heart showed itself at its best; his modesty and discretion has made his grateful patients feel that he sympathized with them in their distress; that he truly was their doctor.”³⁹

Assertive and demanding patients come to the fore as late as 1993, when a new law is introduced that grants patients the right to information and informed consent.

An information committee is established to promote and develop communication facilities for surgeons in order to fulfill the requirements of the new law. Not all surgeons approve of the new law. They think the obligation to inform patients is too strict. Surgeons argue that the truth should not be forced on patients.⁴⁰ Meanwhile the information committee develops different instruments to support surgeons in order to help them meet the requirements of the new law.

“Communicative skills become more important. [...] The [new law] requires us to improve our information to the patient and stimulates patients to ask more questions in order to give their informed consent.”⁴¹

Providing information is considered a time-consuming⁴² and difficult task.

“The surgeon ought to inform the patient. However, we know from experience that there are a lot of pitfalls.”⁴³

The change in medical practice towards shared decision making (shared between doctor and patient) took place in surgery as well as in general practice and it seems not unlikely that many surgeons endorsed the new ideas and moved away from paternalist medicine. However, in their journals Dutch surgeons mostly discuss the disadvantages and problematical aspects of this development. Although the debate about information and informed consent among surgeons never became as heated as their discussion of the working hours regulation, we can still see a similar pattern of opposing and resisting change.

DISCUSSION

Welcoming or resisting change?

Our findings seem to confirm our assumption. Medical professional attitudes seem to change faster in a professional group that works in the midst of society than in a group operating in relative isolation. In fact, with regard to GPs, we found that GPs were pioneers of change in health care rather than merely incorporating change demanded by others or adapting to it.

Obviously it is impossible to generalise on the basis of a study of only two professional groups (GPs and surgeons) in one particular country (The Netherlands), employing one particular method (a study of professional journals). Some of our findings (notably surgeons' reaction to the changing labour regulation regime) have been reported for the UK⁴ but, obviously, that does not wholly make up for the limitations of our study.

It seems plausible that GP ethics changes more rapidly because GPs are in close contact with society, whereas surgeons can withdraw from it much more easily, but there are other differences between these professions, such as the characteristics of surgical work (hands on, technical) as opposed to the characteristics of GP practice (more reflection and conversation). These may also account for the differences that we found.

Although we feel that analysing volumes of scholarly journals offers important advantages over interviewing practitioners (people's memory can fail them and the passing of time may colour their recollections), there are disadvantages too. The GP journal is different from the surgeons' journals, which may reflect differences between the two professional groups (something we set out to study) but which might also be due to

simple differences in editorial policy, which we did not investigate. Because of the differences between the GP and surgery journals it did not seem to make sense to quantify any of the differences that we found. As the GP journal is much more comprehensive this would have distorted any quantitative comparison.

From an ethical perspective it might be worthwhile to reflect on the proper attitude towards societal change. This is a study of empirical ethics, which entails that our contribution to that debate is mostly empirical. What might be said about moral change induced by societal change? Old professional norms are not necessarily ethically laudable norms, new norms may be better. Societal change (including moral change) is often seen as inevitable; something that should be canalised and justified rather than opposed.³ The Dutch GPs' flexible, evolving ethics corresponds with this attitude. GPs reinterpreted their cherished principle of continuity of care so as to make it suitable for modern times. Continuity of care no longer referred to round-the-clock availability; it referred to a careful transmission of patient files and good cooperation with one's colleagues.

Obviously it can also be worthwhile to oppose certain forms of societal change, to resist them, or at least think twice before embracing them. Traditional moral ideals have not become moral ideals by chance; it would be strange to assume that they could simply disappear without regret, and without a fight. Dutch surgeons seem to embody this attitude. Perhaps round-the-clock dedication has become a relic from the past, something that makes too great demands on our doctors. Total devotion to the job, or continuity of care, was a significant moral ideal. Surgeons cannot let go of this ideal without pain, anger and regret. How can they be sure that the values of modern times outweigh the values they inevitably lose?

Dutch GPs may have been right when they anticipated well-informed, empowered and better educated patients and chose to facilitate, help along or even bring about this development. Probably modern ethical principles—patient autonomy, informed consent, shared decision making—are to be preferred over traditional medical paternalism. Still the surgeons' resistance was not incomprehensible here either. Surgeons were probably right when they argued that informing patients takes up costly time because time is scarce in any healthcare system. Surgeons also drew attention to the fact that some patients do not want to hear the whole truth about their conditional situation and fate, even though a majority of patients prefers to be informed and to be actively involved in the decision-making process.

Dutch surgeons could learn from GPs about being adaptable, reflexive and willing to change. New circumstances may require new norms. Likewise, GPs could learn from surgeons about clinging to tradition, sticking up for cherished values and taking one's medical professional principles seriously.

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