

Self-regulation: a cognitive perspective towards restoration of medical practice.



The doctor by L. Fildes

In so far only as men live in obedience to reason, do they always necessarily agree in nature.ⁱ

Introduction

Once upon a time there was a consensual belief that doctors always acted on behalf of their patient's well-being.ⁱⁱ It was held to be their duty and they were generally seen as dutiful caring persons exemplified in the famous picture "The doctor" by Sir Luke Fildes.ⁱⁱⁱ This picture of doctors was disrupted by the Second World War. The experiments of the Nazi's became publicly known in the Nuremberg trials. Doctors could harm people. Actually it were not only the German experiments which asked for regulation of the behavior of doctors. During these trials it became clear that also the medical experiments in the USA asked for it. Doctors did not always act in the interest of their patients. The Nuremberg trials lead to the Nuremberg Code (1947), the Declaration of Helsinki (1964) and further regulations concerning medical experiments on humans. The call for regulating the behavior of doctors became also audible in the context of ordinary medical practice. This practice was and still is of course the most important reason for performing medical experiments. Regulations appeared for ordinary medical practice. The history of which is to be read in *Strangers at the bedside: A history of how law and bioethics transformed medical decision making*^{iv}.

In this contribution I will outline a view on regulating ordinary medical practice inspired by ideas on self-regulation. Because of the author's practical familiarity with the Dutch NHG guidelines for general practitioners, these will be used as an example of regulating of a common practice. It will be argued that although these guidelines are seen as paradigmatic examples of self-regulation, the way they are introduced suggest they should not be seen as such. It will be shown how they

undermine the professionalism which they aim to protect. This is a problem to be recognized for professional guidelines in general. Following the basis of the ideas of Braithwaite a.o. on restorative justice and responsive regulation, it will be shown that practical cognitivism is a promising perspective on self-regulation and NHG guidelines. The simple norm of reducing bias has some important practical consequences. These consequences are at odds with those introduced nowadays by the Dutch Ministry of Health, Welfare and Sport.^v

NHG guidelines as self-regulation, the standard view.

The call for regulation of health care became an important issue not only because of the atrocities committed by doctors, but also because of the development of the welfare state, in which the state was held responsible for the provision of a health care system. Criteria became important to delineate health care. It had to be defined and evaluated. This demand for definitions of the proper health care products were seen to be important not only in a welfare state in which products were allocated by a public body. They are held to be equally important in a system in which a free market mechanism is responsible for the allocation.^{vi} For the definitions and evaluation of health care there is no other way than to rely on the ideas and opinions of the health care providers themselves. In this process of defining and evaluating a leading idea is uniformity. Differences between diagnostic procedures and treatments are seen as an indication of poor quality for some patients. Diversity in treatments means diversity in quality. If some treatment for a disease is good, it is good for all those suffering from that disease. A variety in treatments means that some receive less quality than could be and so should be the case.^{vii} This reasoning was an important idea behind defining and evaluating health care.

In the Netherlands the scientific organization of Dutch general practitioners, the NHG (Nederlands Huisartsgenootschap), plays an important role in the development of standards of care for general practitioners. The organization articulated the specific problems general practitioners have to cope with. General practitioners have to deal with patients suffering from diseases in early stages of a disease unknown to the medical specialists in the hospitals. Furthermore, their patients make up a different population than the one seen in the hospitals and this accounts for different incidences of diseases, which imply different predictive values of examinations and tests.^{viii} So, general practitioners formulated their own guidelines now widely known as the NHG guidelines.^{ix} These guidelines were introduced as guidelines for the general practitioner in order to determine which examinations, tests and treatments he should perform given a patient's medical problem. For example the guideline on urinary tract infections describe which symptoms to attend to, which examinations to perform and which treatments to start with. They also describe the indications for a check after treatment and they describe the indications for a referral to a medical specialist in the hospital. The guidelines were meant to reflect the

scientific insights. In this sense these guidelines are like classical textbooks on diseases as they are used in the medical curriculum. They give medical information and also inform about the best available treatments. Actually the NHG guidelines do not consist of normative rules at all. They are a source of information formulated in the form of hypothetical instrumental norms aiming at restricted medical goals. Only conditional on these goals are the rules normative just as rules of chess are only normative for those playing chess.

This restriction to merely an informative function of NHG guidelines has been changed. It is claimed that these guidelines should be seen as norms with general practitioners as norm addressees. The director of the NHG wrote time and again that the NHG guidelines, once they were widely accepted, should be used as one of the criteria for registration for general practitioners.^x The NHG guidelines were seen as rules defining the proper professional actions of a general practitioner. They determine the product of care provided by general practitioners. By this role they become information addressed to third parties, patients, insurance companies, government, in general the lay-man. It informs them what they can expect from general practitioners. Furthermore it enables them to determine whether the health care actually provided is according to those guidelines.^{xi}

These guidelines interpreted as normative rules instead of hypothetical instrumental rules suggest to be representing an ideal treatment to be given by general practitioners. But apart from this meaning the guidelines have some other functions. The guidelines also demarcate the general practitioner's product from the care products delivered by other health care professionals for example those professionals working mainly in the hospital, the medical specialists. The NHG guidelines helped general practitioners to compete more successfully with other health care professionals. They can position themselves in the health care market. On the other hand competition among general practitioners is also restricted by these guidelines. Among general practitioners open competition was not done. You should not seduce patients to come to your practice for example because you refer patients to medical specialists in the hospital just on the patient's request rather than acting according to the professional guidelines.^{xii} In this way the NHG guidelines restrict competition. They help general practitioners in dealing with what is called the "shopping of patients".^{xiii}

The NHG guidelines interpreted as normative rules also function as a natural basis for performance indicators in quality improvement.^{xiv} For example the guideline urinary tract infections is the basis for such an indicator. The indicator developed and proposed by the NHG is the percentage of prescriptions for patients with a simple urinary tract infection receiving the first choice treatment mentioned in the NHG guideline which is nitrofurantoin 50 mg q.i.d. for 5 days. The next step in the development to be expected is that the insurance companies will pay a bonus if general practitioner prescriptions keep up with the norm which is

set for this indicator. This idea of payment for performance has been advocated by the Dutch Ministry of Health, Welfare and Sport.^{xv}

The regulatory function of NHG guidelines for ordinary medical practice is undeniable. It can be interpreted as a kind of self-regulation according to the definition of Black's voluntary self-regulation. There is a group of persons or bodies, acting together, performing a regulatory function in respect of themselves and others who accept their authority. It is voluntary because there is no state involvement in promoting or mandating this regulation.^{xvi} So it seems to fit well in the theory of the regulative state presented by Braithwaite among others.^{xvii} But this is merely apparently so as will be argued in the next section.

NHG guidelines as self-regulation, the doubt.

Are the NHG guidelines proper examples of self-regulation? Prima facie they are. They are developed by general practitioners and addressed to general practitioners. The development of the NHG guidelines can be seen as exemplifying voluntary self-regulation.^{xviii} The general practitioners took the initiative for the development and implementation of these NHG guidelines. But this is prima facie. Now it is time to question whether it is self-regulation indeed.

First, it is not clear whether the norm addressee is just the general practitioner. It happens to be an instrument of regulating the demands and expectations of third parties. Second, in interpreting the voluntary self-regulation as a kind of self-binding it is questionable whether there is a homogenous group of general practitioners rather than a heterogeneous group in which others are bounded than those who initiated and developed the NHG guidelines. Furthermore, in using the NHG guidelines by third parties for the evaluation of the actions of general practitioners it is highly questionable whether there is self-binding. Third, using the NHG guidelines as basis for performance indicators undermines the professionalism which was to be protected. Because of these issues it is doubtful whether we can see these NHG guidelines as examples of self-regulation. These issues will be discussed subsequently.

The first issue concerned the addressee of the NHG guidelines. The NHG guidelines determine the health care products that general practitioners provide. The content of these guidelines determine what others can expect from general practitioners. The guidelines limit the freedom of other agents such as patients, insurance companies and public agencies. The NHG guidelines regulate what can be asked for by patients. Actually the norm addressees also include those third parties. They should adjust their expectations. The guideline on urinary tract infections makes clear that after the treatment of for example a simple urinary tract infection patients should not expect a further check of their condition. They should not expect a referral to a medical specialist if they have two of such simple infections within two months and they should not asked for it. The guidelines have relevant consequences for third parties. But what is the

role of these parties in the process of NHG guideline development? They are not represented in the NHG committees that develop these guidelines. Self-regulation of the couple “doctor-patient” is clearly not the case. Patients and others are as well the implicit norm addressees but they do not belong to the “self” of the self-regulation.

Even if patients and others are represented in committees which develop the guidelines as is actually the case in some organizations, what is their role? Are they merely some other experts of whom it is expected that they read the relevant scientific literature? That is not a specific function of representatives of patients, the experts can do it by themselves, maybe they can even do it better than the representatives of the patients. Maybe the representatives can have a role in giving some minor non-scientific information. But the guidelines were meant to be based on scientific evidence only. The role of patients is a priori limited because of this meaning of guidelines. The organizations in which patients are represented actually have no clear idea what their role is.^{xix} The representation seems to be fulfilling a formal requirement of some kind of patient participation. Until now the main influence of the patient is in the consulting room, restricted to the application and use of the guideline in his own particular case. But this influence is limited too because of the second issue mentioned. The guidelines influence the actions of the doctor. Not the professional judgment but the guidelines become the basis of treatments. The doctor as spokesman of these guidelines becomes one of the strangers at the bedside with whom the patient is not familiar with.

The second issue concerned the homogeneity of the group of general practitioners. Self-regulation implies a kind of self-binding. If there is no self-binding there is no self-regulation. So, the question to be dealt with is whether the NHG guidelines indeed are proper examples of self-binding or not. The answer is negative, the binding is not self-binding for two reasons. The NHG guidelines limit the decisions of all general practitioners. Actually there is one group of professionals who by means of the NHG guidelines codify what they argue good medicine consists of.^{xx} They consider these codifications to be guidelines of good practice and restrict the judgments to be made by those other general practitioners. Disagreement and diversity among general practitioners is transformed into uniform guidelines. But not every general practitioner subscribes to the contents of all the guidelines.^{xxi} So beyond the self-binding of a small group of general practitioners who developed those guidelines, there is the binding of a large group of practitioners, namely all the other general practitioners, by this small group of practitioners. It can hardly be called self-binding of the Dutch general practitioners.

The second reason for denying these NHG guidelines to be self-binding can be seen by looking more precisely at the character of the binding. The NHG guidelines are felt by general practitioners to be forced on them, despite the remark at each introduction or revision of a guideline that a practitioner can deviate from the guideline. In the same remark accompanying the introduction of guidelines, it is stated that in case of deviation the general practitioner has to argue why he deviates. This

means that the guidelines are held to be binding for a general practitioner. He has to follow the NHG guidelines. They are seen as binding not because the offering of reasons in case of no compliance is considered to be a kind of sanction. They are seen as binding because they are interpreted like rules used in legal reasoning by this “comply or explain” remark.

In legal contexts as in a judicial judgment a decision is good because it is argued for in the correct way. It is a common format in legal contexts in order to end conflicts. But this format has never been accepted as the basis of good medical decision making. There is a difference between acting well and acting according to an explicit argumentative format. The explicit arguments in a special format are not the good making characteristics of a decision. One can pose a question like the one Socrates does in Plato’s dialogue *Eutypbro*: “The point which I should first wish to understand is whether the pious or holy is beloved by the gods because it is holy, or holy because it is beloved of the gods.” The relevant question in our context becomes, is something good because the NHG guideline says it is, or is it the other way around, is it in the NHG guideline because it is good? Of course the answer is clear, the guidelines are secondary. An action is good not because it is in accordance with the NHG guidelines but because it is a proper medical action. The proper medical actions are the basis of the guidelines.

By holding the NHG guidelines to be the good making characteristic professional thinking is distorted.^{xxii} The binding of the NHG guidelines become externally imposed because of this. The whole question whether or not acting according to the guideline, does not belong to basic clinical reasoning. The binding of guidelines is not self-binding. If interpretations of guidelines which are normal in legal contexts becomes more and more the leading ones, the binding cannot be considered to be self-binding of professionals. This is even more clear if the evaluation of compliance with the guidelines is performed by others than professionals. The clinical problem is changed in a radical way, because it introduces distorting reasons for the professional such as the evaluators’ interpretations of his decisions with respect to the guidelines interpreted by those evaluators, instead of the clinical problem simpliciter presented by the patient.^{xxiii} The anticipation on the interpretations of the guidelines by the non-professionals ironically undermines the idea of acting on professional reasons only, while acting on professional reasons only is the kernel of self-binding. In this way the idea of self-binding of the professional to professionalism is undermined. The next issue shows this distortion even more clearly.

The third issue concerned the undermining of professionalism by using performance indicators based on the NHG guidelines. In order to improve the quality of care insurance companies are allowed to give an extra payment to the general practitioner if some performance indicators are conforming a preset norm. For example in case of the simple urinary tract infection, a preset norm proposed by the NHG is: 75% of prescriptions are nitrofurantoin 50 mg q.i.d. for 5 days. The income of the general

practitioner will be higher if he reaches this preset norm, he receives a bonus. Not receiving the extra payment is a kind of a sanction, a malus. Of course, this distorts the professional reasoning also noted by patients. Patients object to an advice: “But sir you prescribe nitrofurantoin instead the trimethoprim 300 mg qd for three days, which I prefer, because you get paid for it?”.

The structure of reasoning is augmented and distorted by these payments as noted rightly by patients. The decision-making is complicated and becomes distracted by this use of performance indicators.^{xxiv} Furthermore it undermines the professionalism because using this element as indicator of quality, suggests this indicator to be a most important aspect of the NHG guideline on urinary tract infections. Actually the choice of the medicament in simple urinary tract infections is not a serious and difficult question. It is rather strange to stress this element of care as the most important element of quality of care. Because of the financial consequences it becomes an implementation focus distracting from more important aspects of the guideline such as being alert on signs of complications or other diseases mimicking urinary tract infections as for example an appendicitis, a grawitz tumor, or an ectopic pregnancy. The latter is of course more important than a trivial choice in case of a simple urinary tract infection.

Are these arguments not arguments against the whole idea of self-regulation? The stated arguments seem to apply not just to the NHG guidelines but to all kinds of self-regulation. There is however another possible view on the NHG guidelines. The NHG guidelines as presented in the story above represent an ideal of general practice. The NHG guidelines are considered to be implementations of that ideal.^{xxv} The NHG guidelines define that ideal. But following the philosopher Bernard Williams, we can discern another style or tradition of regulation. This style consists not in implementing an ideal, but in trying to solve conflicts and reduce the disturbing effects of conflicts. It is a reactive style.^{xxvi} The ideas on responsive regulations developed by Braithwaite and others in order to improve the quality of care in residential care can be placed in this tradition.

Braithwaite was impressed by the difference between the reaction on street crime and corporate crime.^{xxvii} In the former punishment and sanctions were the main reactions. In the latter persuasion, bargaining, settlements and agreements were the reactions. Braithwaite was also impressed by the difference in efficacy. The latter was more effective and led to the idea of his responsive regulation instead of control by punishment and sanctions. Punishment and sanction are often encountered with what is called ‘reactance’ by norm addressees. This consists of actions directed against the center of control in order to undermine the effects of the regulations which are held up by sanctions and punishments.

The idea of responsive regulation was also used as a way of improving the quality of care in nursing homes.^{xxviii} The central idea is to track the kind of motivations of the professional. The antisocial profit maximizers type

of professional should be encountered by sanctions, the incompetent one who does not know how to act should receive help and those who are susceptible to professional arguments should be discussed with. Responsive regulation is essentially a reaction on problems and the necessity of coping with these problems. Self-regulation, for example public monitoring in a standard format in order to make comparisons possible and ask for preset norms for results to be reached is such a response in order to improve quality of care. Finally if this is not enough, sanctions can be used.

This idea of responsive regulation doesn't assume a preset formulated ideal, it is responsive to problems. Although it is responsive to problems it seems to remain equally vulnerable to the critical remarks made in this section. In order to improve quality of care professionals are invited to formulate norms. If they don't accept the invitation they will be forced to. It is enforced self-regulation. Furthermore the professional norms as they are formulated by themselves are used to evaluate their performances. This evaluation is performed by regulators which are as regulators non-professionals and sanctions follow if professionals do not comply to these norms. So finally the NHG guidelines are interpreted within a context of evaluations in proceedings like legal ones in which legal reasoning with guidelines is the format. They evolve into a system of sanctions and punishments even in this responsive regulation style. It is the old mythical Rex using the NHG guidelines as law with its inherent uniformity and sanctions covered up by representing it as self regulation.^{xxix}

There is still an alternative view on the NHG guidelines and self-regulation.^{xxx} One that is more in accordance with the basic idea of responsive regulation which is less vulnerable to the problems mentioned above. It is self-regulation not based on sanctions and punishment. Its central feature is its attention to real problems instead of distraction to those aspects that can easily be measured as was seen to be the case in the performance indicator of simple urinary tract infections. This view will be explained in the next section.

Cognitivism and reducing bias: the alternative.

In the former paragraphs it was shown that the NHG guidelines as an example of self-regulation became less attractive because of the tendency to interpret them as expressions of an ideal of general practice and because they evolve finally into system based on sanctions and punishments. Furthermore interpreted as rules in legal reasoning they bring with them the idea that a decision or action is right or good if it is argued for in a predefined format based on rules i.e. NHG guidelines. As was mentioned, rules and principles are not prior to right decisions. A decision is not right because of it being a kind of rule following.^{xxxi} A rule or principle is good because of the decisions this rule or principles advocates. A right decision assumes knowledge and a cognitive faculty. This is acknowledged in

practical cognitivism. In practical cognitivism problems are formulated in ^{xxxii}terms of truth and knowledge rather than in terms of choice and preference and procedures.^{xxxiii}

The question to be posed within a cognitivist perspective is: "Do we see it in the right way?" instead of "Did we follow the proper rules and procedures?"^{xxxiv} It is not because of rules but because of particular aspects of the situations that a decision or action is right. Recognizing these aspects is the kernel of professionalism.^{xxxv} Actions and decisions are right because of their being responsive to these particular aspects. The meaning of a rule is based on the particular decisions. The rule is not the reason for the particular decisions. Rules are considered to be secondary within this cognitivist perspective.

Furthermore, giving explicit persuasive reasons is not a condition for a decision to be right. Just as you can recognize your own language without being able to define your language, you can recognize what is to be done without being able to formulate the norms and principles. The relevant aspects of a particular situation form the reasons for a decision to be right. A moral theory or principles do not constitute the "good making characteristics", it is the situation itself. Interpreting the NHG guidelines as rules as is common in legal proceedings disturbs the reasons and aspects calling for actions. The NHG guidelines or the reasoning with those guidelines shouldn't count. Recognizing the relevant aspects as proper reasons is central to professionalism. As was mentioned in the former paragraphs, the guidelines introduce distracting and biasing elements in the decision situations. They lead to professionals taking an external perspective on their professional judgments. Performance indicators as basis for payment undermine the professional susceptibility to the important aspects of the situation. At least they are complicating the reasoning, they are a kind of motivation pollution.

There is however an often mentioned problem for practical cognitivism and that is the problem of disagreement. It is held that cognitivism presupposes a consensus. Without convergence of opinion cognitivism would make no sense. It doesn't help in dealing with disagreement if this disagreement cannot be solved by a consensus and convergence of judgments. Remaining reasonable disagreement should not be possible within practical cognitivism. But in fact there is disagreement, ergo practical cognitivism makes no sense, thus the argument from disagreement.

Although the question whether or not reasonable disagreement could be possible has not to be treated here^{xxxvi}, disagreement has to be dealt with here because it can illuminate what cognitivism means. Cognitivism does not claim or promise to propose a procedure to arrive at knowledge and to put an end to disagreement once and for all. But it sticks to the idea of aiming at knowledge and truth. It cannot be denied that we have some ideas on how our ways of arriving at truth and knowledge are distorted. Self-interest is an example that is known to lead easily to a bias. It is also known that we can put ourselves in situations in which we will be biased

in our judgments, for example by making it difficult or even impossible that some kind of information will reach us, or put ourselves in situations such that we will not look further than those aspects that we can easily observe. We can distort our judgments and consequently we can also attempt to diminish these distortions.

Within the practical cognitive point of view for example an important function of the state is diminishing distortions on our judgments. A function of the state is facilitating and stimulating the cognitive capacities of its citizens in order to arrive at knowledge and truth. This means at least the reduction of bias. Within cognitivism it is argued for example that a certain egalitarian distribution is important because it reduces bias in judgments on distributional questions.^{xxxvii}

The ideas of restorative justice and responsive regulation can be interpreted in and based on practical cognitivism. Sanctions and punishment as deterrents are not the most effective instruments as was argued for by Braithwaite, but restoring proper judgments and sensitivity to the important aspects of situations are effective. The aim within cognitivism is furthering the possibility to arrive at true knowledge by reducing bias. Diminishing the role of prejudice, undue self-interest etc. was seen to be more efficient to reduce criminal actions. In restorative justice this is reached for example by education in showing consequences of criminal actions and by meetings with victims, restoring as much as possible the damage, by arrangements in which “would be criminal agents” are less vulnerable to biased judgments. This background of reducing bias and restoring the proper sensitivity to the important aspects of a practical situation are the key elements of responsive regulation. Within this interpretation of responsive regulation the basis of quality improvement is not a set of rules but the furthering and restoration of the susceptibility of professionals to the important aspects of a situation. By demanding rules and the special format of reasoning, this professionalism is undermined by motivational distraction. This will not mean that sanctions play no role at all but they have to be far away from the professional motivational structure which should be just being sensitive to the important aspects of situations.^{xxxviii} Restoring and enhancing this susceptibility to the important aspects of a particular situation is genuine self-regulation. It is an internally structured regulation in contrast to the external perspective introduced by rules as reasons and performance indicators.

The main criticism on the NHG guidelines as proper examples of self-regulation was that they are dependent on an external perspective and an external motivation. How can we interpret those NHG guidelines as self-regulation in this cognitivist perspective? First, the NHG guidelines are not to be seen as end products defining the activities of general practitioners. It is not the NHG guideline itself but the cognitive abilities and reasoning behind those guidelines we expect doctors to develop. The guidelines are to be seen as examples of possible treatments, they are suggestions. The discussions about them are the most valuable aspects improving knowledge in order to make better decisions. These discussions

make clear what is important in those guidelines and what is less important. Divergence of opinion helps to prevent the bias of short sightedness. The use of the NHG guidelines as outlined in the former sections with their emphasis on uniformity and their external motivational structure is not the most helpful way to reduce bias. It is even furthering the bias caused by self-interest and prejudice by directing the attention to obedience to the guidelines and by redirecting attention to the external point of view as furthered in legal proceedings. These interventions change the structure of professional judgment and it complicates the decision structure.

The same goes for performance indicators as basis for an extra payment. The bonus for a certain prescription pattern is just the bias which had to be avoided in trying to diminish the influence of the pharmaceutical industries in the office of general practitioners. It distorts the abilities to arrive at correct knowledge on what to do. But does it mean that all performance indicators are useless? Distortions of judgments should be diminished by regulation and keeping up to performance indicators can be of help. They can help reducing bias caused by prejudice of ourselves and our predecessors. But it would be highly suspicious if this should be the same indicators for every professional as if they all had the same bias or bias structure. Even if we accept the motto cited above from Spinoza's *Ethica* we should allow a variety of guidelines, because of the actual variety of prejudice and bias. Spinoza himself argues clearly in his *Ethica* that everyone has his own particular history of connections and associations between passions and ideas.^{xxxix} And because of these particular histories we can conclude that each has his own particular prejudice and particular bias.

Within practical cognitivism it will mean that regulation aiming at bias reduction will allow and even require a variety of guidelines and performance indicators. Because the bias is not the same for everyone, a variety of guidelines should be available. Uniformity is suspect and could even be considered as an indicator of poor quality in health care. The attention should shift to the development of techniques to discover bias in treatments. Instead of asking for a particular percentage of nitrofurantoin prescriptions in case of a simple urinary tract infection, it would be better to ask for and reward the developing and using analytic tools to find out the bias structure, for example to uncover the relation between prescription and income of professionals. These instruments although quite natural are not yet available. Most electronic information systems used by general practitioners don't have the practical possibility to monitor the effects and correlations of medical interventions.

The continuous monitoring is necessary for the improvement of quality because actually every medical decision is an experiment. It should be followed and assessed and it should be discussed with the patients what kind of experiment is more reasonable to perform and what monitoring should be done in order to facilitate a right decision. The regulations for experiments and treatments developed after the Second World War in which informed consent is the main element can be interpreted as aiming

at reducing the bias of self-interest in the decisions of treatments.^{xi} But the development of uniform guidelines and a bonus malus system based on uniform preset norms of performance indicators undermine this function and should be abandoned. The regulation as bias reduction could help come true the picture of Fildes' Doctor in which the doctor is no longer the stranger at the bedside but is one of the companions of the patient. It is still an ideal as seen to be implied by the lively and informative descriptions of the ordinary work of a general practitioner in the study '*Family Medicine*' by one of the founders of general practice as an academic discipline in the Netherlands.^{xli}

Conclusion

In the development of regulative styles of the state, self-regulation is an important way of regulation. This way of regulation was also seen to be developed in the medical sector in order to inform lay-men what the health care is and what products doctors provide. Uniformity was a leading idea. The development of the NHG guidelines could be interpreted in this way. They were presented as guidelines defining good health care provided by general practitioners. Performance indicators were developed on the basis of these guidelines. In order to improve the quality of care, financial incentives were introduced for reaching the norms set for these indicators.

The development of NHG guidelines and preset standards of performance indicators seemed well to fit in the regulative style proposed by Braithwaite and others. The main idea in this style is that sanctions and punishment are less effective ways of regulation than persuasion bargaining and negotiation. This style is called responsive regulation. It is a process in which self-regulation and benchmarking by the agent is asked for. It was argued that the way in which the NHG guidelines were used only apparently fit in this idea of responsive regulation. The so called self-regulation turned out to redirect the attention of the professional to an external non-professional point of view finally referring to an external motivation. It had the same distracting and undermining effects as sanctions and punishment not in the least because of its call for uniformity. An alternative approach promised to be more fruitful.

Responsive regulation as a regulative style is better to be interpreted within a cognitivist perspective. In this perspective knowledge and truth are the key concepts rather than preference and choices and procedures. In this cognitivist perspective regulations can be seen as aiming at reducing bias in judgments. This view on regulation has some consequences for the regulations in the medical sector. The NHG guidelines are no longer seen as defining a product of health care but as means to improve knowledge in order to arrive at right decisions. The development of a guideline in which it becomes clear what is important in a particular problem is more important than the end product i.e. the NHG guideline itself. Uniformity is suspicious. Variety is a source of improvement of care and it is highly improbable that all health care professionals have the same kind of bias to be reduced by the same kind of benchmarks and incentive structures.

Instead of a bonus for reaching similar preset norms of performance indicators in this view it is held to be more important to improve the possibilities to detect and explore bias. It calls for permanent monitoring actions and awareness of prejudice. This can help to make the doctor a companion to the patient as pictured in Fildes; “The Doctor” instead of the stranger at the bedside.

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ⁱ *Quatenus hominis ex ductu rationes vivunt, eatenus tantum natura semper necessario conveniunt.* (Spinoza, *Ethica*, Part 4, Prop. XXXV).

ⁱⁱ See (Callahan a.o., 2005).

ⁱⁱⁱ See (Barilan, 2007) for a short study of this picture. This picture was based on his own experience with the death of his son. The picture expresses gratitude to the doctor who cared for his dying son.

^{iv} See (Rothman, 1991) and see also (Tröhler a.o., 1997) The American Medical Association used the picture “The Doctor” by L. Fildes together with the slogan “Keep politics out of this picture” against the reform Truman proposed in the USA in 1949, see (Barilan, 2007).

^v See Ministry of Health, Welfare and Sport, 9 juli 2009, *Ruimte en rekenschap voor zorg en ondersteuning*, <http://www.minvws.nl/kamerstukken/mc/2009/ruimte-en-rekenschap-voor-zorg-en-ondersteuning.asp>

^{vi} Arrow argued that this asymmetry of knowledge was the main problem for a market of health care in: *Uncertainty and the welfare economics of health care* (Arrow, 1971).

^{vii} See (Gezondheidsraad, 1991).

^{viii} See (Hodgkin, 1968) and (Huygen, 1978a).

^{ix} The NHG was awarded the international Carl Bertelsman prize in 2000 for the development of these guidelines. The NHG guidelines can be read on http://nhg.artsennet.nl/kenniscentrum/k_richtlijnen/k_nhgstandaarden.htm.

^x See (Tielens, 1989), (LHV, 1988) and (Voort, 1987).

^{xi} In terms of a principal agent scheme the goal regulations with the agent as norm addressee (the general practitioner) become information for the principal (patient, insurance company etc.) and in this relation they transform into binding norms for the agent. The problems with this principal agent scheme are analyzed in (Westerman 2010).

^{xii} In the Dutch health care system there is no free admittance to the health care in hospitals one has to be referred to a medical specialist by a general practitioner.

^{xiii} This function of guidelines is also suggested as a means of diminishing defensive medicine (Kessler & Clellan, 2000).

^{xiv} See (Braspenning a.o., 2005).

^{xv} See Ministry of Health, Welfare and Sport, 9 juli 2009, *Ruimte en rekenschap voor zorg en ondersteuning*, <http://www.minvws.nl/kamerstukken/mc/2009/ruimte-en-rekenschap-voor-zorg-en-ondersteuning.asp>

^{xvi} See the introduction of this volume. p. 18.

^{xvii} See (Braithwaite, 1994) (Braithwaite, 2002).

^{xviii} See (Black, 1996) cited in this volume p.18.

^{xix} See (Trappenburg, 2008).

^{xx} It is an example of the problem of the complex agents in the principal agent scheme mentioned in (Westerman, 2010), section 5.

^{xxi} Sometimes a disagreement leads to a judicial procedure for example: Rb Utrecht 3 November 1994.

^{xxii} It can be interpreted as an example of “one thought too many” (Williams, 1976) p. 18.

^{xxiii} It is not stated that evaluations by non professionals are distorting, these are natural elements of a decision problem, but evaluations based on such artefacts as guidelines interpreted by non professionals are distorting.

^{xxiv} See (McDowell, 1979) and (McDowell, 1995).

^{xxv} See note x.

^{xxvi} See (Williams, 2005).

^{xxvii} See (Braithwaite, 1984), (Braithwaite, 2002).

^{xxviii} See (Braithwaite a.o., 1994).

^{xxix} See (Gezondheidsraad, 1991).

^{xxx} See (Williams, 2005).

^{xxxi} See (Dancy, 2000), (Dancy, 2004), (McDowell, 1979) and (McDowell, 1995).

^{xxxii} See also (Baier, 1985) on the functions of rules and moral theory.

^{xxxiii} See (Hurley, 1989), (Hurley, 2000) and (Hurley, 2005).

^{xxxiv} The distinction between these questions is the main issue in the discussion on moral particularism as can be seen in (Wiggins, 1975) and moral realism in the Davidson

Wittgenstein tradition of interpreting rules in for example (McDowell, 1979), (McDowell, 1984), (Hurley,1989).

^{xxxv} See (McDowell, 1979) and (McDowell, 1995).

^{xxxvi} See for example (Tersman, 2006).

^{xxxvii} See (Hurley, 2005).

^{xxxviii} See (Sutherland, 1937) p. 216 in which is stated that the professions have ethical standards which minimize the pecuniary motive, of which the professional thief remarks that if that was a criterion for membership the medical and legal professions would have few members.

^{xxxix} See *Ethica* part 3. Especially proposition L ff.

^{xl} In the cognitive perspective the consent in the end is not the not most important aspect but the discussion before the consent.

^{xli} See (Huygen,1978).