Front runners, but in which direction?

Responses of medical professional associations to a changing health care sector

Master Thesis
Evert Schot
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Preface

> *"Doing research has been called a 'craft', rather than a science or technology. Like learning to ride a bike, it is picked up by doing it, gets better and (possibly) easier with practice, and is difficult to describe in a formal way." (Tonkiss, 2004:377)*

What is the essence of writing a master thesis? In the last months, I have traveled from city to city, written numerous pages and analyzed large quantities of data. It has been a process of thinking and writing, rethinking and rewriting. It was all about putting gained knowledge and skills to use. Maybe even more than these interpretations, for me, it has been an experience about learning a craft. As some argue, a thesis is the 'masterpiece' of academic studies, compared to the final test of an apprentice within historical guilds to become a master craftsman. Or, in other words, to become a 'master of science'.

I gained my first experiences with the (Dutch) health care sector during the thesis project to graduate my Bachelor studies. The many different actors, interests, discussions, logics and personalities that I have encountered have raised my interest ever since. For me, it embodies the core of studying governance: analyzing very different organizations, within an (ever-changing) context of societal, administrative and other important developments.

During this research project, I have not only learned much about my research subject, but also about myself and my future aims. I could never have achieved both without the help of some persons who have guided me throughout this project. First Mirko Noordegraaf, who helped me navigate through the process. Also, the people who made time to talk to me about their experiences. Remco, Wiljan and Anna, because a good focus is essential, and Stavros Zouridis for his constructive feedback. My parents, who have supported me in many ways over the past years. And lastly Wievenlien, who helped me along with my English, and in every way.

So, have I mastered science? As the experiences in my studies have thought me, there are many 'sciences' or perspectives to interpret our surroundings, all with their own merits and pitfalls. For me, this is the core of what I have learned in the past six years: always start with a question and an open view, for there is always more to see.

Evert Schot
August 2012

Management summary

Research focus and set-up

Medical professional associations are often seen as essential institutions for the professionals they represent. Important tasks are allocated to these institutions, both by academia and professional associations themselves. Such tasks include assuring medical quality, keeping doctors up-to-date and making sure members are able to conduct their work in relative autonomy. These associations of practitioners are therefore often interpreted as 'front runners' of their profession.

Studies about these assumed tasks in a contemporary setting are limited. This is especially relevant as the health care sector (in the Netherlands) has changed profoundly in recent years. Three developments in the health care sector have increasingly put pressure on the medical professional domain. Firstly, related to the introduction of regulated market dynamics, medical practitioners are demanded to be increasingly transparent and accountable. Secondly, connections to organizational and managerial values of efficiency and value-for-money have strengthened as professionals are becoming 'encapsulated' within the organizations they are working in. Thirdly, patients are taking on a more independent, critical position and medical service delivery is becoming increasingly complex due to an aging population. These developments present professionals and their institutions with increasingly critical audiences in doing their work.

Within this context, this study sets out to research how medical professional associations respond to these recent developments within a changing health care sector. By doing so, it is aimed to see whether theoretical assumptions on professional associations are (still) resembled in present-day empirical reality. It also aims to raise insights into the challenges these organizations encounter. To achieve these aims, a qualitative study was set up that focuses on the professional group of medical specialists. 23 interviews were conducted with respondents from medical professional associations and with other stakeholders in health care. Due to its qualitative character, the focus has been on uncovering underlying mechanisms that can explain responses of professional associations. A theoretical framework was set up to provide a focus for this study. Three elements of professional associations have been studied: their *role* in their profession, their *relations* to both members and external stakeholders, and their *responses* to contemporary developments in health care.

Research outcomes and implications

Historically, there has been no single professional association that represents the entire medical specialist profession. Medical professional associations are 'layered'. Several independent organizations represent particular interests and groups within the medical specialist profession. The foci of these different layers have been distinct historically, but are converging in recent years. Each association tries to be as complete as possible due to increasing specialization within the medical profession. Associations aim to achieve a role on both substantial and political issues.

Professional associations operate in two ‘environments’. An environment of members poses demands to represent their interests. Associations have to make sure these demands are sufficiently represented. To achieve this, professional associations also operate in an environment of external interlocutors, consisting of actors like the health care inspectorate, health care insurance companies, patient organizations and government. The connections with these stakeholders have grown in recent years, contributing to closer ties of professional associations with a so-called ‘diplomatic service’ of policy- and decision makers in health care. Associational bureaus are growing in importance as external demands both increase workload and request input of professional associations for (new) policy debates. These developments have contributed to a ‘policy bias’, which directs their focus to finding solutions to common problems instead of conflicts over professional interests.

Related to this, medical professional associations respond to contemporary pressures by taking a position that conforms to principles of external demands like transparency, efficiency and value-for-money. They still try to make sure effects (of these demands) do not result in unworkable outcomes for their members however. This illustrates that professional associations understand the need to actively play their part in assuring accessibility, affordability and quality of health care. Advancing professional interests does not necessarily guide the behavior of medical professional associations. Their main interest is in ensuring professional work is not disproportionately infringed. This means that, other than might have been expected, professional associations are not ‘front runners’ in representing the interests of their members. Instead, they are ‘front runners’ in an innovative sense, trying to change their profession in a new direction that connects to new contemporary demands of external parties like hospital management, patients and other stakeholders.

The results of this study point to the need for professional associations to consciously keep forging connections with their members. Innovative ways of representation are indeed visible. This is especially important as the strength of professional associations lies in their ability to connect the professional domain with other interests in health care. An emphasis on either their members or their external interlocutors can limit this strength. This study also points to the need for further research to gain a better understanding of the uncovered dynamics that determine the behavior of professional associations. This is especially important within the context of recent debates on ‘new’ forms of professionalism. It can be helpful to extend the results of this study with a case study focused on one specific association. Secondly, it can be interesting to see whether the insights of this study hold up in other (non-medical) domains as well.

Managementsamenvatting

Onderzoeksfocus en -opzet

Medische beroepsverenigingen worden vaak gezien als essentiële instituties voor de professionals die ze vertegenwoordigen. Academici en beroepsverenigingen zelf dichten hen belangrijke taken toe. Hierbij gaat het onder andere om het bewaken van kwaliteit van zorg, artsen op de hoogte houden van nieuwe ontwikkelingen en zorgdragen voor de juiste voorwaarden waaronder zij hun werk kunnen doen. Deze verenigingen van beroepsbeoefenaren kunnen daarom worden gezien als 'voortrekkers' van hun beroepsgroep.

Er bestaan echter weinig studies die taken zoals deze in een huidige context onderzoeken. Dit is in het bijzonder relevant omdat de (Nederlandse) gezondheidszorg ingrijpend is veranderd in de afgelopen jaren. Drie ontwikkelingen hebben het professionele domein steeds meer onder druk gezet. Ten eerste heeft onder andere de invoering van gereguleerde marktwerking ervoor gezorgd dat van artsen wordt verlangd dat zij transparant te werk gaan en verantwoording afleggen over hun handelen. Ten tweede is de invloed van organisatorische en bestuurlijke waarden als efficiëntie en kostenbewustzijn groter geworden doordat professionals steeds nauwer verbonden zijn met de organisatie waarin zij werken. Ten derde nemen patiënten een meer kritische, onafhankelijke positie in en zorgt een vergrijzende bevolking ervoor dat de zorgverlening complexer wordt. Deze ontwikkelingen leiden ertoe dat steeds kritischer tegen het werk van professionals en hun instituties wordt aangekeken.

Binnen deze context onderzoekt deze studie hoe medische beroepsverenigingen reageren op een veranderende gezondheidszorg. Hierbij is het doel te onderzoeken of theoretische aannames ten aanzien van beroepsverenigingen ook daadwerkelijk te herkennen zijn in de hedendaagse (empirische) werkelijkheid. Daarnaast heeft deze studie tot doel meer te weten te komen over de uitdagingen waarvoor deze organisaties staan. Door middel van een kwalitatieve studie die zich richt op de medisch specialistische beroepsgroep wordt een antwoord op deze vragen gezocht. 23 interviews zijn gehouden met respondenten binnen medische beroepsverenigingen en andere actoren in de gezondheidszorg. Door het kwalitatieve karakter van deze studie ligt de nadruk op het blootleggen van onderliggende mechanismen die de reacties van medische beroepsverenigingen kunnen (helpen) verklaren. Een theoretisch kader is opgezet om een focus voor het analyseren van het vraagstuk te creëren. Hieruit komen drie elementen naar voren die de basis vormen voor dit onderzoek: de *rol* van beroepsverenigingen voor hun beroepsgroep, hun *relaties* met zowel hun leden als externe stakeholders en de *reacties* ten aanzien van huidige ontwikkelingen in de gezondheidszorg.

Uitkomsten en conclusies

Er is historisch gezien geen unieke beroepsvereniging die de volledige medisch beroepsgroep vertegenwoordigt. Medische beroepsverenigingen zijn 'gelaagd'. Verschillende onafhankelijke

organisaties vertegenwoordigen specifieke belangen en groepen binnen de medisch-specialistische beroepsgroep. Het accent in het werk van deze verschillende 'lagen' is historisch uiteenlopend, maar is de afgelopen jaren dichter naar elkaar gegroeid. Elke vereniging probeert haar leden zo compleet mogelijk te vertegenwoordigen door de toegenomen subspecialisatie binnen de medische beroepsgroep. Verenigingen focussen hierbij vooral op medisch-inhoudelijke en politieke thema's.

Beroepsverenigingen opereren in twee 'omgevingen'. Een omgeving van leden stelt eisen om hun belangen te vertegenwoordigen. Beroepsverenigingen moeten ervoor zorgen dat deze eisen voldoende worden gerepresenteerd. Om dit te bereiken opereren zij ook in een omgeving van externe gesprekspartners, bestaande uit actoren zoals de Inspectie voor de Gezondheidszorg, zorgverzekeraars, patiëntenorganisaties en de overheid. De connecties met deze stakeholders zijn in de afgelopen jaren gegroeid, wat ervoor heeft gezorgd dat de banden van beroepsverenigingen met de zogenaamde 'diplomatieke dienst' van de gezondheidszorg sterker zijn geworden. Ook zijn de verenigingsbureaus een belangrijkere rol gaan spelen door de toegenomen werkdruk en de gevraagde input van beroepsverenigingen in (nieuwe) beleidsdiscussies. Deze ontwikkelingen hebben bijgedragen aan een 'beleidsbias', die hun focus heeft verlegd van het aangaan van conflicten over specifieke belangen naar het vinden van oplossingen voor gezamenlijke problemen.

Hieraan gerelateerd reageren medische beroepsverenigingen op externe druk door een positie in te nemen die conformeert aan de principes van eisen ten aanzien van transparantie, efficiëntie en kostenbewustzijn. Toch proberen zij er ook voor te zorgen dat de effecten (van deze eisen) niet resulteren in onwerkbare situaties voor hun leden. Dit illustreert het feit dat beroepsverenigingen inzien dat zij actief bij moeten dragen aan het verzekeren van toegankelijkheid, betaalbaarheid en kwaliteit van zorg. Het behartigen van professionele belangen is niet noodzakelijkerwijs leidend in hun gedrag. Zij zijn er voornamelijk in geïnteresseerd te zorgen dat professioneel werk niet disproportioneel wordt 'geraakt'. Dit betekent dat, anders dan verwacht, beroepsverenigingen geen 'voortrekkers' zijn in het behartigen van de belangen van hun leden. Daarentegen zijn zij 'voortrekkers' op een innovatieve manier. Zij proberen hun beroepsgroep een nieuwe richting op te bewegen die hen verbindt met nieuwe hedendaagse eisen van externe partijen als ziekenhuismanagement, patiënten en andere stakeholders.

De resultaten van deze studie wijzen op de noodzaak voor beroepsverenigingen om bewust verbindingen te blijven leggen met hun leden. Innovatieve vormen van representatie zijn inderdaad in sommige gevallen al zichtbaar. Dit is in het bijzonder relevant omdat de kracht van beroepsverenigingen ligt in het verbinden van het professionele domein met andere belangen in de gezondheidszorg. Een nadruk op ofwel hun leden ofwel hun externe gesprekspartners kan deze kracht aantasten. Deze studie toont ook aan dat nieuw onderzoek van nut kan zijn om een beter inzicht te krijgen in de blootgelegde mechanismen die het gedrag van beroepsverenigingen bepalen. Dit onderzoek is extra van belang in de context van huidige debatten over 'nieuwe' vormen van professionaliteit. Het kan hiervoor behulpzaam zijn om de resultaten van deze studie te verdiepen door middel van een case study naar één specifieke vereniging. Ten tweede is het interessant om te

onderzoeken of de inzichten van deze studie ook terug te zien zijn in andere (niet-medische) domeinen.

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1. Introduction

1.1. A changing health care sector

Health care is a very complex public service delivery sector (e.g. Plsek & Greenhalgh, 2001). Medical services are literally of vital importance to patients. Stakes are high for other parties that are involved as well. Not only does it take enormous amounts of money to maintain current levels of service delivery, in the Netherlands the sector also employs over 1.3 million people.[1] A recent study shows that over 300 organizations are operating somewhere in between governmental policy makers and health care institutions. These organizations alone represent a 'billion euro business'.[2] This still excludes all hospitals, nursing homes, and other organizations actually delivering care to patients. No wonder minister Edith Schippers points out that…

> *"we stand before times in which much is expected of us: good accessible care, high quality, transparency over what we do as well as close cooperation. This doesn't happen by itself. To realize it, things will creak and grind in the coming years."*[34]

The sector is also constantly changing. Its dynamic character can be recognized on many levels. Technical and IT solutions are changing the way medicine is practiced. Consumers confront doctors with their own presumed medical knowledge. Some might even bring their iPad to a consult to 'show' that they know better. Policy makers, managers and the general public all demand insights into the medical process to force practitioners to be accountable. Cutbacks put even more pressure on the way services are delivered. Through a growing emphasis on market dynamics, practitioners will have to show their value for money. Obsolescence and other demographic developments change the demand for care, both quantitatively and qualitatively. Not only do people live longer, their longer life spans also result in multiple and more complex illnesses. More people need more complicated care in a more demanding environment.

Developments like these put pressure on medical service delivery and the way the sector is organized. Not only doctors (can) decide what counts as 'good' medical services. Patients (increasingly seen as consumers) can have a say themselves. In times of financial austerity, values of effectiveness and cost consciousness have risen in importance. The introduction of 'regulated market dynamics' in 2006 has strengthened the position of health care insurance companies in determining what are 'good' medical services, especially in setting quality standards through financing institutions and treatments, a domain historically reserved for practitioners. This has also inevitable changed to position of

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[1] http://www.rijksoverheid.nl/onderwerpen/werken-in-de-zorg, 11 May 2012
[2] http://www.skipr.nl/actueel/id5769-belangenbehartiging-in-de-zorg-is-miljardenbusiness.html, 26 April 2012
[3] http://www.rijksoverheid.nl/regering/het-kabinet/bewindspersonen/edith-schippers/toespraken/2011/09/27/samen-de-zorg-toekomstbestendig-maken.html, 9 July 2011
[4] As this study was conducted within a Dutch context, quotations and fragments from interviews (see chapter five) are originally in Dutch as well. For the purpose of this report, they were translated in English by the author (unless stated differently, or retrieved from an English source. For matters of accuracy, the original Dutch fragments are presented in appendix V at the end of this report.

managers and policymakers. They have to keep an eye on financial and organizational constraints to service delivery, increasing their say in the domain of medical professionals. Some argue that, based on these developments, professionals should not complain: things have just become more complicated.

> *"[Service delivery in health care] has just become more complicated. To cope with this, other coordination mechanisms are needed, and management is one of them. I admit that recruiting […] a manager does not always result in great outcomes, but mostly this manager is not to blame. Unfortunately, professionals cannot be trusted per se, and interference by others, among which managers, is necessary to enforce improvement and innovation."*[5]

Medical practitioners do indeed have some reason to grumble however, as these developments have had an influence on their position within health care and the extent to which they are able to do their job autonomously. Although it has been a long time ago since medical doctors were seen as the only authority in the medical process, their professionalism can still be measured to their autonomous position.

> *"[medical specialists] thought they were the best, knew very well how things should be done, and did not let anybody dictate their behavior. But government wants health care to be more efficient and less expensive […] Now the goose is cooked. Government is stepping in, with quota for medical surgery and demands of transparency."*[6]

In the eyes of many, values of efficiency and transparency are almost naturally conflicting with the craftsmanship of medical professionals (Van den Brink et al, 2005; Ackroyd et al, 2007). Following this argument, to make the best use of the unique expertise, knowledge and skills of professionals, we should let them free as much as possible. How could a manager justify a decision when he is confronted with the professional authority of a medical doctor? Still, in recent years, this balance has shifted. It is no longer the manager (and other proponents of rational decision-making based on the values of the organization and the market) but the medical professional who is forced in the defence in relation to far-reaching developments in contemporary health care.

1.2. The (acclaimed) importance of medical professional associations

Professional associations are seen as important institutions within professional (medical) domains (i.e. Birkett & Evans, 2005:108). Most of Dutch medical professional associations have been around in health care for over a century as 'representatives of their profession'. They have classically been and are still seen as important players in the health care sector (see Merton, 1958; Freidson, 2001; Noordegraaf, 2011a). Even more so, they are regarded as an essential part of a full-swing profession (Wilensky, 1964). The acclaimed natural and strong relation between profession and professional

[5] http://www.innovatieforganiseren.nl/innovatie-en-management/weg-met-de-professionals-leve-de-managers/, 18 June 2012
[6] *Tubantia*, 12 February 2011

association is reflected in the aims of medical professional associations today. The *Orde van Medisch Specialisten* (OMS), the professional association of medical specialists, states on its website:

> *"As a representative party, OMS supports (upcoming) medical specialists in such a way that they are able to realize medical specialist care as experts in all its aspects."*[7]

Similarly, the *Nederlandse Vereniging voor Anesthesiologie* (NVA), states as the first point of its mission statement:

> *"NVA is an association by and for anesthesiologists. It looks after the interests of its members and contributes to a positive image of anesthesiology as well as anesthesiologists in our country."*[8]

Statements like these resemble theoretical roles academic authors have ascribed to professional associations. In the literature on professionalism over the years, professional associations are said to be 'an essential characteristic of a profession' (Millerson, 1964), promoting, among other things, lifelong learning (Karseth & Nerland, 2007), professional norms and ethos (Wilensky, 1964) and a community of practitioners (Watkins, 1999) that is shielded off from external influences (Willmott, 1986). In general, they are seen as 'front runners' (Scott, 2008) of professionalism, promoting the interests of the profession both externally and internally.

Especially in their contemporary context, where many centrifugal forces put pressure on the coherence, quality and congruence of their profession, the role of these front runners is pivotal. Apart from medical education, there is no institution that is shared by medical professionals, who nowadays work in diverse organizations and who operate ever more closely together with their non-medical colleagues (Leicht & Fennell, 1997). To achieve their aims, professional associations are forced to prevent interference by other actors and values, for this will inevitably dilute the professional characteristics of an autonomous, peer-controlled domain. To oppose centrifugal forces, they will act as a centripetal force around specifically professional values that can make professionals stick together. Or don't they?

1.3. Some paradoxical positions

The insights on professional associations above suggest they will have a pivotal position, promoting professional interests in line with the demands of their members. Being associations they are organized in a way that places members in a prominent position. Officially, the assembly of members is the highest organ within the organization. Still, the view of a medical practitioner about her

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[7] http://www.orde.nl/over-oms/wat-wil-de-oms/missie-en-visie.html, 20 May 2012
[8] http://www.anesthesiologie.nl/p_missie_visie, 20 May 2012

professional association in introducing *Diagnose Behandel Combinaties* in 2005[9] does not seem to resemble its pivotal position in the profession:

> *"I wish it was that simple, that managers bare sole responsibility. Medical professional associations took the initiative themselves […] and, after long deliberations, came up with 30.000 DBC's […]. The representatives of doctors agreed on a system that does not please their constituents […], containing a lot of 'guidance information' for 'market incentives' and full of 'transparency' for shopping patients."*[10]

When we dig deeper in the outings of professional associations themselves, there seem to be indications of similar positions less closely related to the specifically professional interests they are said to represent. Take for instance a press release issued by the *Koninklijke Nederlandse Maatschappij ter bevordering der Geneeskunst* (KNMG) after the fall of the Rutte-cabinet in April 2012:

> *"Rising costs of Dutch health care as well as rising demands for care – partly based in obsolescence – ask for far-going measures with an eye on the future. The necessary steps to make growth reduction, integral defrayment of care and developments like e-health possible are in danger of lacking behind […]. Therefore KNMG is taking the initiative to come to a reform agenda for health care in cooperation with field parties and politicians."*[11]

1.4. Studying professional associations

Both the strong pressures contemporary developments pose, as well as the hints towards changing positions of professional associations make a study into the way these organizations deal with these pressures very interesting. Professional associations are presented, both by observers and by themselves, as organizations promoting the interests of their members. As academic authors have observed themselves however, theoretical assumptions about their behavior have been backed up by very little empirical evidence (Greenwood et al., 2002; Holleman et al., 2006; Friedman & Phillips, 2004). Because "little research effort has been directed to the study of the professional associations" (Willmott, 1986:555), there is not much evidence that either supports or confronts theoretical propositions and claims. As has been observed over half a century ago, "what the association professes as its aims may coincide with what it actually does – but again it may not" (Merton, 1958:50).

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[9] *Diagnosebehandelcombinaties* or DBC's are a way of financing health care provision in which the entire path of medical services (diagnosis- treatment – after care) is combined into prescribed 'packages'. See for instance http://www.nza.nl/zorgonderwerpen/dossiers/dbc-dossier/

[10] *NRC Handelsblad,* 3 May 2008

[11] http://knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/Val-kabinet-Rutte-onzekerheid-voor-de-zorg.htm, 26 April 2012

1.5. Question and focus

Taking up this subject, the central question of this study can be formulated as:

How do medical professional associations respond to contemporary pressures in health care, and what factors explain these responses?

The study can be divided in two main lines. The first, mainly descriptive line will analyze actual responses of professional associations to three 'streams' of developments that can be expected to put pressure on professional work. These 'streams' deal with pressures coming from increased links between professionals and organizational constraints, recent emphasis on market dynamics within the health care sector, and changing clients that professionals have to deal with in their work. Analysis will focus on describing responses of professional associations on a continuum, ranging from passively going along to actively resisting these developments. The second line in this study will look for factors that can help to explain these responses. To find possible factors, I will focus on the role professional associations take up in their domains and the way they relate to their profession as well as other stakeholders in health care.

I have formulated seven subquestions to help in answering this central question. Here, these questions are presented and briefly discussed. The overview of the relation between the main question and the subquestions is presented in figure 1 below.

1. *How do medical professional associations relate to (the interests of) their profession?*

To find an answer to this question, chapter three presents theoretical expectations to this relation and a theoretical framework that is able to inform the empirical analysis. In interviews and a supportive document analysis, I will find out in what way these theoretical expectations are met, or whether relations between professional association and profession can be characterized in another way.

2. *How do medical professional associations relate to (the interests of) other stakeholders in health care?*

In the same way as with subquestion 1, the theoretical framework on the position of professional associations is used to answer this question. Based in interviews with both professional associations and other actors I will look at this relation empirically. Both subquestion 1 and 2 will be useful in analysing factors explaining behaviour of professional associations in responding to pressures in health care.

3. *What role do medical professional associations have?*

The 'role' of professional associations is studied based on an overview of three streams of literature on professionalism, and three corresponding perspectives on how professional associations can be interpreted. These perspectives are then used to propose three possible roles for these associations in

their professional domain. I have used the interviews with board members and directors of professional associations to find out what role(s) are most prominent in their behaviour.

4. *What pressures do organization, market and client developments in health care pose for medical professional associations?*

To describe the most important developments in health care for professional associations, chapter two presents a literature and document study into these developments. This study focuses specifically on three streams of organizational, market and client developments.

5. *How do these pressures affect medical professional associations?*

The effects of these developments on professional work might not be the same as their effects on medical professional associations. Therefore, this subquestion focuses specifically on the second aspect. Chapter two pays specific attention to filtering out (possible) pressures of the three streams of developments for professional associations. Interviews will be used to see whether these pressures are recognized, and whether there are other pressures that are important as well.

6. *How do medical professional associations respond to these pressures?*

Chapter three presents a continuum of theoretical categories of theoretical responses of professional institutions towards pressures. This continuum provides a framework which is used in the empirical part of this study, presented in chapter 5. Based on interviews with respondents from within professional associations and other actors in health care, I will analyse how the (strategic) behaviour of these organizations relates to the theoretical categories of responses.

7. *What factors explain these responses?*

Based on the answers of the subquestions above, this question will find an explanation of the responses of professional associations as described by answering subquestion 6. I will check for connections between relations and role of professional associations and their responses to pressures in their environment. Other factors that come up in empirical data collection are included in the analysis as well.

The focus of this study is visualized in figure 1.

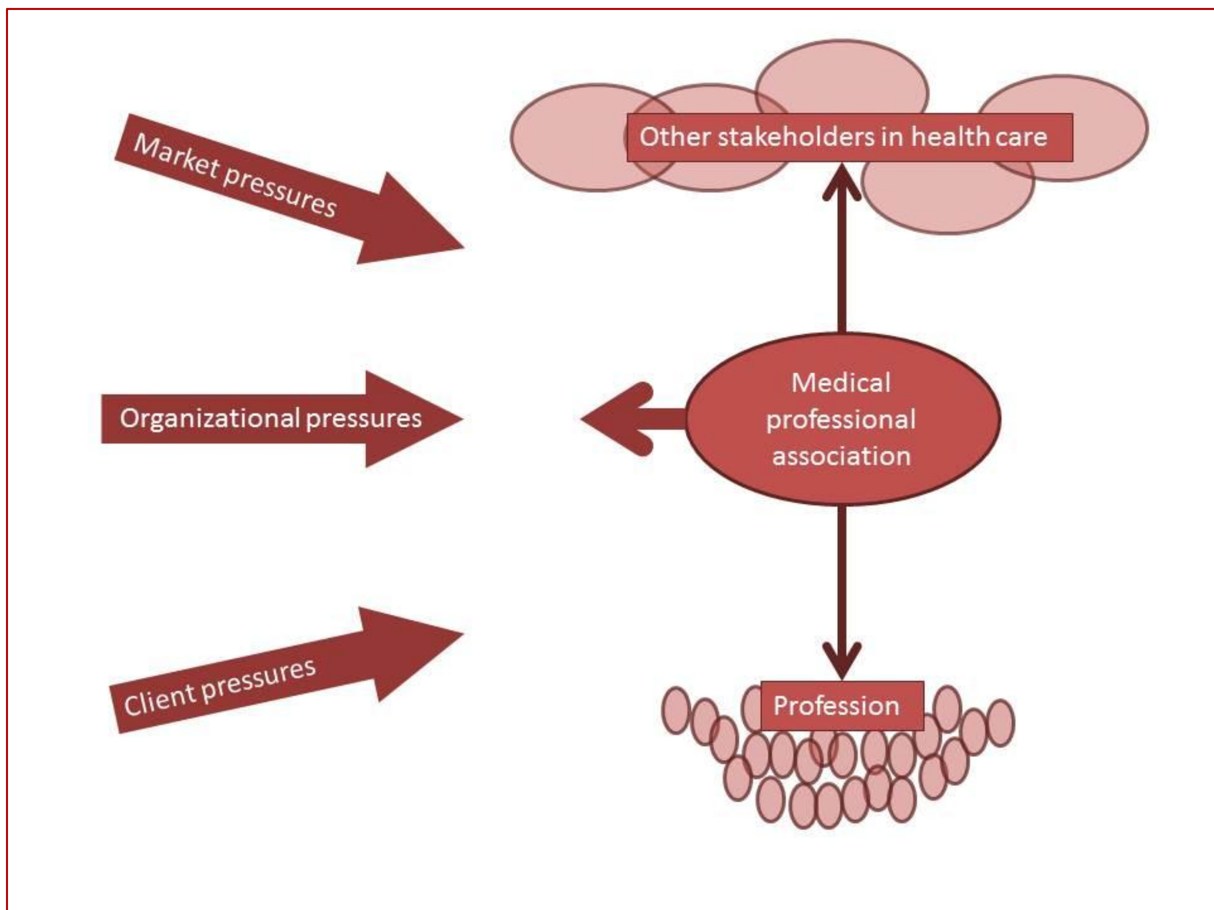

Figure 1: Focus of this study

1.6. Relevance

The relevance of finding an answer to these questions is threefold. First, *practically*, it can help professional associations to evaluate their present strategies in dealing with (perceived) pressures. As studies into strategic options to cope with changing positions (see for instance Baggerman et al., 2011) and the interviews that were conducted for this study suggest, professional associations are struggling to make sense of (the changes in) their domain and are searching for ways to cope with them. This study can contribute to their efforts by giving insights into the underlying processes of strategic responses.

Second, *empirically*, this study can give insights in aims that contemporary associations set for themselves and ways in which they are trying to achieve them. Because little empirical studies have focused on professional associations within the medical domain (see above), the results presented in this report are also relevant for insights into the role, strategies and challenges of medical professional association within the health care sector.

Third, *analytically*, it can be seen as a contribution to the present academic debate on whether professionals (and their domains) are 'under pressure' by other actors (Gleeson & Knights, 2006) or whether these tensions are being bridged by professional institutions themselves, establishing 'new',

dynamic and relational forms of professionalism. Although the debate has focused on dichotomies between professionals and managers, or occupational and organizational logics for a long time, attention has shifted towards dynamic and relational approaches more recently (Noordegraaf, 2011b). Hybrid and organizational forms of professionalism are increasingly recognized as empirical phenomena (Noordegraaf, 2007; Evetts, 2009; 2010). This study will focus on professional associations as one specific institution in the professional domain and see how their responses towards pressures on professionals are connected to this debate.

1.7. Outline of the report[12]

In **chapter two** I will deal with recent developments in the Dutch health care sector and the way they present pressures for medical professionals and their associations. It thereby describes the context of this study. I will focus on pressures from recent developments like an emphasis on (regulated) market dynamics, organizational pressures on efficiency and value for money, and more demanding and informed patients.

Chapter three presents the theoretical focus of this study. By using relevant insights from academic theories from different streams of research, I will present three specific subjects. These insights help to make sense of the empirical reality under study. The first is the way professional associations are interpreted, and on what issues they predominantly focus. Secondly, I will look at their position as representative organizations, in between their constituents and external interlocutors. Thirdly, I will focus on possible strategic responses towards external influences. This will accumulate in expectations for the empirical part of this study.

The research set-up and methodological choices are presented in **chapter four**. It presents the rationale for conducting qualitative research, and the way this research was carried out. Also, it evaluates this methodology in terms of the scope of the results of this study.

In **chapter five** the actual empirical results are presented. These results are based on 23 semi-structured interviews and a supportive document study. This chapter will focus on several relevant aspects of this study, both descriptive and explanatory. **Chapter six** presents the answers to the subquestions of this study based on the description of empirical results in chapter five. It also relates these findings to theoretical expectations that were made in chapter three.

Chapter seven presents the **conclusion** of this study by answering the main question as presented in chapter one. It thereby combines all the elements that were presented in the different chapters. In **chapter eight** I will place the findings of this study in perspective, by looking at their relevance and implications for both the medical and other sectors and contexts, and to see how they relate to the empirical, analytical and practical aims of this study.

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[12] Some might wonder why this report has been written in English. It is a consequence of its purpose as master thesis for the research master in public administration and organizational science at Utrecht University. As this master programme is in English, it was one of the demands for this thesis report.

The **appendices** present the literature that was used, topic lists that guided the interviews, a coding tree that was used to analyze the data, an overview of medical professional associations in the Netherlands and the original, Dutch fragments of interviews that have been used throughout the report.

2. Three developments in health care: pressures for professionals?

As was pointed out in the introduction, the health care sector is often described as a very complex public service sector (Plsek & Greenhalgh, 2001). This is no surprise when we take into account the impressive amounts of money that go through the sector and the number of people that either work in the sector or that rely on its services as 'consumers'. In 2004 the total costs of the Dutch health care sector were estimated at € 57.5 billion (Hoek, 2007:6). In 2010, this had risen to over € 61 billion.[13] Also, in 2004, 13.8 % of the Dutch working population was employed in the health care sector (Hoek, 2007). In 2011, the absolute number was estimated to be 1.3 million.[14] In the coming years of growing obsolescence, this demand for labour will rise even further and costs of health care are estimated to rise as well.

In this chapter, I will focus on important developments in Dutch health care. It is therefore closely linked to subquestion 3. In this way, chapter two presents the locus of this study by describing the 'scenery' in which professional associations have to operate. I will start by introducing the dynamic and hybrid character of health care, in which interests of patients, policy makers, doctors and managers are constantly (re)balanced (see Putters, 2009; Bal, 2008). Secondly, I will focus on the way this balance has shifted over past years and decades. Three important developments are presented, that can be expected to influence professional domains. These are pressures stemming from (a) an emphasis on regulated market dynamics in health care, (b) the increasing importance of organizational contexts in which professionals work and (c) effects of changing clients on medical service delivery. Consequently, I will focus on the way these developments can be expected to produce pressures for professional work and for the work of medical professional associations. I will conclude by giving an answer to subquestion 4 based on the analysis presented in this chapter.

2.1. Who is governing the health care sector?

Governing a complex public domain like health care means balancing different and diverse interests. "Given the specialized nature of medical care and the difficulty for lay-persons of assessing the quality of health care delivery, the complexity of managing a social health insurance scheme, together with the need to contain health care costs, a health care […] system demands a plethora of governance arrangements that are, by their very nature, complex" (Helderman 2007:177). These different governance arrangements stem from four distinct theoretical ideal typical governance principles: the state, the market, the community and the profession (Bal, 2008).

As a public service, the state, or government, is concerned with the quality of the services that are delivered in health care. It is in many cases a matter of life and death for its constituents. Governments will thus always have to answer to these constituents for the way health care is organized, and

[13] http://medischcontact.artsennet.nl/Nieuws-26/Tijdschriftartikel/84619/Rem-op-groei-kosten-gezondheidszorg.htm, 20 May 2012
[14] http://www.rijksoverheid.nl/onderwerpen/werken-in-de-zorg, 20 May 2012

whether this is done effectively. Organizing health care is seen as a public task, and the state will demand its influence to be able to steer the way choices are made and work is done. Governance by government is ideal typically based on (bureaucratic) regulations and guidelines. In the Netherlands, government is responsible for the overall system of health care. Its inspectorate, the *Inspectie voor de Gezondheidszorg* (IGZ), keeps an eye on the standards for the quality of care to avoid risks and malpractice in health care institutions.

Because medical services are professional services, professional governance arrangements also play their part. As Helderman observed above, especially in medical specialist health care, professionals are the (only) ones who have sufficient knowledge and experience to judge the way services are delivered. Professional self-governance in terms of quality assurance and knowledge development has historically been an important part of health care governance (Bal, 2008). Ideal typically, professional governance is done by a system of shared knowledge and shared norms and values that are maintained by the profession itself (see for instance Freidson, 1970). Theoretically, professional governance is shaped mainly by professional associations and professional (academic) education (see Oliver, 1997).

In the Netherlands, civil society has traditionally also played an important part in the governance of health care. In the Dutch 'polder model', decisions were made by corporatist decision making and consensus between important societal groups. Health care organizations are important employers, and in this function they participate in negotiations on collective labour agreements (cao's). I already pointed to over 300 representative and interest organizations operating in health care. Among others these include patient organizations, organizations representing health care institutions like hospitals and nursing homes, umbrella organizations for health care insurance companies and professional associations. Because their know-how and their influence over their members can be very helpful, government tries to include these organizations in policy making and implementation in health care.

The introduction of 'regulated market dynamics' in Dutch health care in 2006 has strengthened a fourth governance arrangement: that of the market and the logic of supply and demand. Health care organizations have gained relative freedom to compete with each other over the market of consumers. 'Good' service delivery in this ideal typical governance arrangement is not determined by rules and regulations (government), professional norms (professionalism) or a consensus based on negotiations (civil society). Instead, these standards arise out of interplay between demand for and supply of medical services.

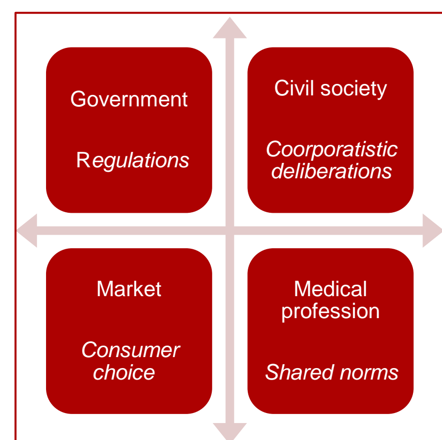

Figure 2: Four ideal typical governance arrangements (Bal, 2008)

These four governance mechanisms (of government, market, professionalism and civil society) can be understood as positions on a quadrant (Bal, 2008; Putters, 2009). This quadrant is divided on two axes. The first horizontal division can be made on the extent to which government can act as

the central steering actor. The two upper arrangements include government as a decision-maker at the negotiating table. In the lower two, decisions are made without direct government interference. The second, vertical one is on the possibilities of private and societal parties to come to self-regulation. The four governance arrangements are summarized in figure 2.

2.1.1. The hybrid and dynamic character of health care

From a governance point of view, one of the most eye-catching characteristics of the sector is its hybrid character (Putters, 2009). No single of the four governance arrangements shortly described above is lastingly dominant. In other words, the way health care is governed is by definition a blend of several arrangements. As the notion of 'regulated market dynamics' indicates for instance, a market governance arrangement is inherently combined with preconditions that stem from government jurisdiction (Bal, 2008). Next to this, representative organizations and medical professions will not disappear from the table. By introducing a 'system change', the four arrangements are repositioned in a new blend. To achieve the public values of accessibility, quality and affordability (VWS, 2003),[15] each of them will still be required in some form. With the input of public regulations, the public character of health care is ensured. It promotes availability and equality for patients. To organize this efficiently, and to be conscious of costs of services that are delivered, market forces play their role. To achieve and assure quality, substantive medical input of medical professions is essential, as Helderman (2007) pointed out. Also, to make sure all parties involved are heard and represented, and sufficient support is organized, negotiations between these parties and groups have to be part of way the governance arrangements are shaped.

Next to this hybrid character of health care, balancing different governance arrangements also leads to a dynamic character of health care governance. "The organization will change [in reaction to] changes in its environment. This makes that hybrid organizations will move towards entrepreneurship in a market, that they sometimes function more as an executive agency of governmental policies and might have to answer to their societal role in other cases" (Putters, 2009:8, translation by me). In health care, we can add that it is also possible that they will follow professional norms to achieve clinical autonomy (Putters, 2009; see Harrison & Ahmad, 2000). As none of these arrangements will become obsolete, emphasis on specific arrangements is constantly changing. As Putters (2009) observes, the task for decision makers in health care is to create a constant awareness of the (specific emphasis on) different arrangements, and to make sure others are sufficiently allowed to play their part. In other words, it is important to keep balancing them.

[15] Or, formulated in a different way, the central 'values' of health care revolve around patient safety (preventing qualitatively inferior care delivery; the equivalent of quality), customer orientation (care that fits the demands of patients; which resembles accessibility) and effectiveness (organized in a way that both meets the standards for quality and costs; which can be compared to affordability) (RVZ, 2009).

2.2. Three contemporary developments

Due to societal, technological, medical, ideological and other developments, health care is constantly changing. For the purpose of this study, I will focus on three contemporary 'streams' of developments. Each can be expected to put pressure on the specific 'blend' of governance arrangements, and on the work of medical professionals in health care (e.g. SCP, 2004; Groenewegen & Hansen, 2007; Pollitt et al, 2010). Together, they cover several pressures that are recognized both in praxis by professionals and their representatives as well as in theory by authors and observers describing 'what is happening out there'. The first 'stream' consists of market pressures, stemming from the developments towards increased market dynamics in Dutch health. The second 'stream' deals with the 'organizational capture' of professionals within their hospitals, nursing homes and other health care institutions. The third and last 'stream' deals with pressures coming from changing and more demanding patients that affect medical work itself. Although there are many more developments that influence the sector, these cover the most important pressures facing professionals in contemporary health care.

2.2.1. Market pressures: Consumerism in health care

In the past decades, as in other public sectors, reforms in health care have been influenced by a discourse of new public management and business-like managerialism (see Hood, 1991). Over the years,

> *"numerous politicians and policy-makers argued that health care should be 'consumer-driven' and 'consumer-oriented'. Care providers should become entrepreneurial; they should cater according to consumer preferences with regard to prices and quality of care."* (Dwarswaard et al., 2011:389)

These calls have been answered to a large extent. Several reforms that led to this emphasis can be seen to have passed 'successive waves' (Noordegraaf & Van der Meulen, 2008). In the light of financial cutbacks in the 1980s, reforms in health care were focused on reducing costs and promoting efficiency. In the 1990s, most important reforms revolved around promoting integrated service delivery. As with most governments in Western-Europe, the 'logic of market consumerism' was increasingly introduced in health care. Some argue that the Netherlands has even gone farthest of all Western European countries (Dwarswaard et al., 2011). In October 2006, after a long period of

deliberations and incremental steps, regulated market dynamics were introduced in Dutch health care by a "complete overhaul of the insurance system" (Dwarswaard et al., 2011:390) through the *Wet markordening gezondheidszorg* (Wmg). This 'overhaul' aimed at emphasizing demand for care instead of supply of care by contributing to "more freedom of choice for care providers, patients and insurance companies" (NIVEL, 2009:8). Also, it was aimed at driving innovation and, through "fierce competition", at benefitting the relation between costs and quality (Sanders, 2006:22) and improving the position of consumers (NIVEL, 2009). In relation to these aims, four preconditions should be met:

- Where possible, market mechanisms are put in place
- Government will (still) be able to regulate tariffs and performance if necessary
- Care providers and health care insurance companies give patients and the insured adequate information based on which they can choose for a specific provider and insurer
- Creating connected supervision on market dynamics (NIVEL, 2009).

2.2.1.1. The need for transparency and accountability

By the introduction of regulated market dynamics, health care providers have also become parties in the market. In both roles (care provider and market party), they have to be accountable for their actions (NIVEL, 2009). The preconditions for the introduction of competition and consumerism resemble this need. Government has to be able to regulate tariffs and performance. Patients have to be given 'adequate information' to make informed choices and supervisors will have to oversee market dynamics in practice.

To achieve all of this, these parties will somehow need to gain this 'adequate information'. Consumers will need information on the performance of both health care institutions and professionals. The same is true for insurance companies that have to contract with care providers on the prices of care delivery. Because government still has a responsibility towards the quality of care and patient safety in a system of regulated market dynamics, performance information is also needed for the Dutch health care inspectorate (IGZ) to supervise (professional) care provision (NIVEL, 2009; RVZ, 2009). In sum, to make the new system of market dynamics work, specific information on medical service delivery is needed. Professionals can no longer escape to be transparent in their professional conduct. In the new constellation,

> *"the discussion whether transparency should be enacted or not is […] a rearguard fight. Patients have the right to know results of care delivery to come to deliberate choices on that basis. The same goes for their representatives, health care insurance companies."*[16]

2.2.2. Organizational pressures: Encapsulated professionals

During the times of the first academic analyses on professionalism and their organization, in the beginning of the twentieth century, professionals were still mostly working autonomously as

[16] http://www.springerlink.com/content/961854t8ml1l8574/, 21 May 2012

independent practitioners (Carr-Saunders, 1928; see also Wilensky, 1964). When they did work inside an organization, it was mostly supporting and subject to professional norms of a profession. As the twentieth century advanced, organizational contexts of professionals became more important (Brock, 2006). Both governmental regulations as well as increased market dynamics (see above) have stimulated organizations “to adopt more corporate and managerial modes of operation in search of increased efficiency” (Powell et al., 1999:2). In doing so, public and non-profit organizations have become more business-like, entrepreneurial and market-oriented (Pollitt and Bouckaert, 2004). Although professionals have been dominant in public organizations like hospitals for a long time, this development has led to a change. Professionals are no longer the (only) ones responsible for service delivery and management in these organizations. Even more so, under this managerial logic, their autonomy and say over their work is seen to be diminishing (Van den Brink et al., 2005). “Professionals must be monitored and managed, professional services must be rationed, and professional behaviour must be evaluated” (Noordegraaf, 2011a:468).

Through a focus on efficiency and accountability, individual professional practice is seen to be ‘under pressure’ by this managerial logic. It creates a so-called ‘organizational capture’ (Brock, 2006), in which professionals have to account their actions towards managers and other actors. The effects of this ‘encapsulation’ are twofold. Firstly, professionals will ‘feel’ increasingly part of their organization instead of their profession. As they become familiar to the organizational logic and its associated discourse and activities, it will increase identification with their organization. Simultaneously, the togetherness of the profession itself decreases (Wallace, 1995). Because organizations in which professionals work differ (Leicht & Fennell, 1997), the common denominator of a professional group decreases. Secondly, professionals are increasingly accountable towards the organization. Work of professionals does no longer stand on its own, but is delivered within an organizational context (Buntinx & Van Gennep, 2007:7). Quality of service delivery, and with it quality of professional work, is measured more and more in (managerial) terms of productivity, efficiency and value for money (Svensson, 2006).

2.2.3. Client pressures: Demanding costumers, complex patients

The third stream of pressures is most apparent in the actual medical process. Two broad societal developments ‘change’ the clients of medical services. As with all service delivery, quality of services is inherently linked to the clients receiving these services (see Van der Aa & Elfring, 2003) When clients change, services themselves change. In health care, we can observe this both in increasingly demanding and informed patients, questioning the skills and knowledge of professionals, and in the increased complexity of health care due to demographic changes.

The first development is the rise of demanding citizens and clients (see Tonkens 2008; Nationale Denktank, 2010). Several broader societal trends have changed the layout of society and the way professionals are perceived by others (SCP, 2004a; Brint, 1994). Information is more readily accessible through the rise of mass media, internet and social media. Social links in society are becoming more diffuse and dynamic as we all individualize. Citizens are increasingly independent and

are posing higher demands for practitioners. All these developments result in rising expectations towards medical professionals: clients know more, demand more and are less dependent on others in their judgement (Nationale Denktank, 2010). “Patients, surfing on the Internet, do not see themselves as patients, but as critical consumers testing the knowledge of doctors” (Hardey, 1999:820). Several authors point out that doctors will have to adjust to these ‘new’ patients (see Trappenburg, 2006). The work of professional doctors is no longer taken for granted. Doctors “can no longer only invoke their professional authority. They have to make understandable decisions and have to explain their choices” (Van Dijk, 2003 in SCP, 2004b; translation by me). As the relation between doctor and patients becomes more symmetric, doctors have to act accordingly.

Next to an increase in assertiveness of clients, the complexity of medical cases in health care is also increasing. “A growing number of patients suffer from chronic and overlapping health problems (multi-morbidity) and this is illustrated by the increased problems related to cost, the workforce and the quality of work” (Plochg et al., 2009:1). As the Dutch population is aging, obsolescence changes the medical process. ‘Easy’ medical cases are becoming rare, as patients often suffer from underlying diseases. The increased complexity does not only seem to affect professional medical service delivery, but also the organization of professional work in health care. These ‘new’ patients demand other forms of care. “Having multiple chronic, complex and overlapping health problems is associated with poor outcomes in terms of quality of life, psychological distress, longer hospital stays, more postoperative complications, higher mortality and higher costs of care” (Plochg et al., 2009:3). These characteristics of present-day and future care put strain on its contemporary organization. Medical specialisms for instance, who have become ever more specialized in recent decades, might fail in combining different forms of care that fit the needs for multi-problem patients with underlying diseases.

2.2.4. Coping with critical audiences

Although these three streams of developments are different in nature, they all pose specific pressures for professional work. They also represent a common theme in the kind of pressures they present for professionals. Each in its own way, these developments present professionals with increasingly ‘critical audiences’. Professional work is no longer taken for granted. In the case of developments towards consumerism and market dynamics, health care insurance companies and governmental inspectorates need ‘adequate information’ to check professional work. Due to the organizational capture of professionals, managers will impose their discourse of efficiency and value for money on professionals. As clients are more knowledgeable and demanding, they also take a more critical stance towards medical doctors and other health care practitioners. These critical audiences all demand the same: more information on what ‘tricks professionals are playing’. And, if they can, they would like to influence their behavior as well.

2.2.4.1. A world of performance measurement and -management

Due to these developments and the rise of ‘critical audiences’, “the world of public management has become, first and foremost, a world of measurement” (Noordegraaf & Abma, 2003: 853). Although this

statement is probably slightly exaggerated, a trend towards this 'new world' can definitely be recognized in public sectors like health care. The roots of this development can be traced in developments described above: an increased emphasis on cost reduction and value for money, a reinforced focus on market requirements, the rise of more demanding and knowledgeable clients and medical failures that have received a high level of public attention (Numerato et al., 2011). Performance measurement is therefore based on two grounds. "Governments and policymakers searched for more effective and efficient healthcare services, coupled with demands regarding healthcare accountability and transparency" (Numerato et al., 2011:2).

The use of performance indicators, as a form of performance measurement and -management in health care, is seen as "promising" for several reasons (Berg et al., 2005:59; see also Talbot, 2005). First of all, it gives room for management of individual institutions and (/or) professional groups to shape the way in which a desired level of performance is met. Bureaucratic and detailed rules and regulations are no longer necessary to achieve safe and effective care. Secondly, they can be used instrumentally by professionals themselves to provide insights into results of their work. In this way, performance indicators can help them to spot problems, redesign work processes and see whether their improvements have the desired effect (Berg et al., 2005). Thirdly, indicators, as simple, quantitative data on complex, professional services, help consumers, as well as health care insurers, to come to an informed judgment about care providers. "Payers may closely monitor their money's worth" (Berg et al., 2005:60). Yearly public hospital rankings like the ones of *Algemeen Dagblad* (AD) and *Elsevier* are indeed based on performance indicators as used by IGZ.[17] Finally, use of performance measurement can also be seen as a method of 'turning on the heat', by pointing out inadequate care delivery and to increase a sense of urgency for change. These (perceived) advantages of the use of performance information in health care have created an "excited wave of performance indicator programs" in Dutch health care since the beginning of the twentieth century (Berg et al., 2005:60; see Politt et al., 2010).

There are however also important risks associated with the use of performance measurement (Noordegraaf & Abma, 2003; Talbot, 2005). The Netherlands are seen internationally as one of the countries in which the use of performance measurement has been most controversial over the years (Talbot, 2005; see also Pollitt et al., 2010). Critique has focused on some specific points. First, the idea that performance indicators can rightfully 'describe' the complexity of medical service delivery is criticized. They are seen to be either incomplete or useless because of their over-complexity. Is direct output, for instance, enough to indicate eventual outcomes? A common argument deals with the relation between quantitative measurements versus a reality that is difficult to quantify (Talbot, 2005). Whether a medical indicator indeed "reflects the quality of care is endlessly debatable" (Berg et al., 2005:60). Another set of arguments deals with the way in which indicators are, or can be used. "Many

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[17] http://www.ad.nl/ad/nl/1401/home/integration/nmc/frameset/nieuws/ziekenhuistop100.dhtml, 24 March 2012; http://www.elsevier.nl/web/Nieuws/Wetenschap/319714/Elsevieronderzoek-De-beste-ziekenhuizen-van-2011.htm, 19 October 2011

are concerned about the risks of publicly 'shaming' professionals or institutions – especially when their 'poor performance' [as measured by indicators] may not even be attributable to them" (Berg et al., 2005:60). Also in professional service delivery itself, some take a critical stance towards performance indicators. They see the result of using performance measurements as an undesired "scientific-bureaucratic medicine whereby medical practice becomes rationalized and standardized through 'cook-book' guidelines" (Harrison, 2004 in Waring & Curie, 2009:760).

Benefits of performance measurement	Risks of performance measurement
Gives room to health care institutions and professional groups to shape their own work; reduces rules and regulations	Risk of misrepresenting complex service delivery by quantitative indicators
Can be used by professionals to give themselves insights into their work (evidence-based norms)	Misuse of performance measurement data for blaming and shaming
Can help non-professional parties to come to an informed judgment of care delivery	Misrepresenting medicine and health care delivery as 'cook-book guidelines'
A means of 'turning on the heat' to prevent inadequate care	

Table 1: Benefits and risks of performance measurement

Based on the above, an emphasis on performance measurement by indicators in health care can thus be interpreted as "a transition in the management of professional work exemplified by the introduction of more dynamic systems of governance, based on the use of evidence-based guidelines to direct professional practice and audit systems to assure compliance" (Waring & Curie, 2009:760). As Pollitt et al. (2010) conclude in their study on the evolution and use of performance information, when performance indicators have been created, they tend to live a life of their own. They are used not only in a clinical sense to check for inadequate care, but, next to this,

> *"the availability of quantitative data becomes associated with target setting […], and individual and/or institutional sanctions (occasionally rewards) become associated with PI [performance indicator] scores. PI scores may also become seen as a source of information upon which patients and/or primary care gatekeepers can base their choices."* (Pollitt et al., 2010:25)

In sum, we can observe an increase in the use of performance indicators for two reasons. The first is directed to internal quality improvement of professional practice by focusing on learning and setting informed norms and standards. Secondly, in contemporary health care, indicators and performance measurement are used for external accountability. "In more and more cases health care institutions and professionals are asked to give information about their own performance to insurance companies, patient organizations, policy makers, governmental inspection agencies and supervisory councils […] that is used by others than practitioners themselves." (RVZ, 2004; see also Groenewegen & Hansen, 2007).

2.3. Conclusion: pressurized professional domains

In this chapter, I have analyzed three contemporary developments in health care and their consequences for medical professionals. External parties, organizational management and clients can

be seen as increasingly ‘critical’ audiences. Expanding consumerism, tighter links between doctors and their organizational context, and more demanding clients change the setting in which professionals do their job. Times in which professionals could work without any external interference were of course long gone. The streams of developments presented above do seem to pressurize their autonomy even further. Professionals now *have* to deal with these forces.

One of the questions I started out with in this chapter was to see in what way these pressures would influence the work of professional associations as specific institutions within the professional domain. As was observed in the introduction, both observers and professional associations set important aims for them(selves). As ‘an essential characteristic of a profession’ (Millerson, 1964), they aim at promoting, among other things, lifelong learning (Karseth & Nerland, 2007), professional norms and ethos (Wilensky, 1964) and a community of practitioners (Watkins, 1999) that is shielded off from external influences (Willmott, 1986). Groenewegen et al. (2007:15-16) already pointed at difficulties they seem to have in reaching these aims:

> *“Professionals are employed increasingly in permanent employment and part time, within larger organizations. […] Mutual trust seems to be decreasing in a more competitive context. Besides their professional associations, [they] also focus increasingly on the organization in which they work.”*

When external, critical audiences gain influence over the medical domain, it is harder for professional associations to achieve their aims as ‘front runners’ of their members (see the introduction above). Their member base is less autonomous and less coherent. The developments described in this chapter do not help, that much is certain. The second part of uncovering the questions of this study lies in the way professional associations respond to these pressures. This will be the subject of the following chapters. In chapter 3, I will start by introducing theoretical insights on what professional associations are, and in what ways theories on professionalism can help us to make sense of the ways in which they might respond to the pressures in contemporary health care.

3. Theoretical framework: Roles, relations and responses of professional associations

So, what are medical professional associations, and what do they do? As this is a study from the field of governance, I will focus on how these organizations can be observed from this perspective. This means analyzing their organizational characteristics and how they behave in their public function, in relation with their societal and administrative context.[18] This chapter aims at theoretically describing professional associations, focusing on what they do and how they do it. First, I will deal with theoretical insights on what professional associations 'are', and how they can be interpreted, using literature on professionalism. This results in three theoretical 'roles' for professional associations. Secondly, I will focus at theoretical insights on how professional associations relate to both their profession (as their members) and other stakeholders in health care (as their interlocutors), and the way they have to balance these two distinct environments. Thirdly, I will present a framework to analyze the responses of medical professional associations towards external pressures. I will conclude by raising expectations to responses that are most likely based on the insights in this chapter. The insights on roles and relations of professional associations will also be used to raise expectations about factors explaining these responses.

3.1. Roles: professional associations and professionalism

To be able to describe Dutch medical professional associations in an informed way, I will introduce three perspectives on professionalism to see how they make sense of professional associations. They all give important insights into how professional associations have emerged as social phenomena, what they 'are' and what role they can play in professional domains.

3.1.1. Professionalism: a contested concept

Professionalism is amongst the most contested concepts in the social sciences (see Birkett & Evans, 2005). From the beginning of the twentieth century, authors have paid attention to certain occupations that could be separated theoretically from other occupations in one way or another (see Carr-Saunders, 1928). Partly because of the many authors contributing to the field, through the years, the literature on professions and professionals has become "fragmented and disordered" (Birkett & Evans, 2005:101). As the twentieth century furthered, many theoretical arguments were employed to make a case for a specific distinction. Here, I will present three perspectives on professionalism that have influenced the debate during the past century (Willmott, 1986). First of all, the *functionalist* perspective that highlighted specific 'natural traits' of professions, and their function for society based on these characteristics. Secondly, I will focus on a *political* perspective, which analyzes professions as forces that actively pursue market closure and autonomy in their self-interest. From this perspective, the demarcation lines of professionalism are subject to political struggles over autonomy and resources.

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18 http://www.uu.nl/faculty/leg/nl/organisatie/departementen/departementbestuursenorganisatiewetenschap/Pages/default.aspx?refer=/usbo, 4 April 2012

Third, a less well defined, but prominent perspective in contemporary debate is introduced, which raises attention for the socially constructed nature of the concept of professionalism, and the ways in which it is used in normative and *symbolical* ways. In this perspective, professionalism is not stable, but “can be contested and changing without being a simple matter of political clout” (Scott, 2008:221).

3.1.2. Functional perspective: who *are* professionals?

The earliest accounts of professionalism (Carr-Saunders, 1928; see Brint, 1994) saw professionals as functionally distinct from other occupations. In other words, from this view, some occupations, like medicine and law, have inherent characteristics that make them fit to carry the label of professions. This perspective does not focus on the specific context in which professions ‘arise’. Instead, to see who is a professional, one has to analyze the substance of the work, the way the work is organized and the way these professionals go about in doing their job. As Willmott (1986:557) observes, from a functional perspective, “the distinctive attributes of the professional, such as the possession of esoteric knowledge, independence, altruism and self-discipline are emphasized, and are largely unquestioned”.

The first characteristic of professions as seen from this perspective is the knowledge base of the occupation, and the character of the work (see Evetts, 2006; Wilensky, 1964). To ‘become’ a professional, one has to go through extensive training and education. This training makes sure that he or she will be able to apply general, abstract scientific knowledge in specific cases. This characterization of the content of the work professionals do is directly related to the relatively large autonomy professionals enjoy (see below). Through this education and training, they know what skills to use and how to use them (Noordegraaf, 2007). This sets them (clearly) apart from other occupations. Part of this knowledge is tacit, gained through experience in professional practice (see Flyvbjerg, 2001:9-20).

A second element of this ideal typical professional, as seen from the functional perspective, is that he or she acts according to a ‘service ethos’ (Wilensky, 1964). The education and training act not only as carriers of knowledge and skills, but also as carriers of socialization by which professionals learn how to “behave and appear professionally” (Noordegraaf, 2007:766). This ethos is an essential part of professionalism. A ‘real’ professional knows how to act as a professional, both based on professional knowledge and professional virtues such as altruism and a public interest.

From a functionalist perspective, the knowledge base and service ethos combine to a third element of ideal typical professionalism. Because professionals will know what to do best (in their domain of expertise), and can be trusted to do so, it flows naturally from here they will have a large degree of autonomy in their work (Freidson, 2001). As they are seen as (functionally) crucial for the delivery of these tasks to society, they are themselves the ones best legitimized to organize and control these tasks (Brint, 1994). To ‘be’ a professional means being part of the autonomous professional domain (Noordegraaf, 2007). In this way, the domain is almost naturally sheltered from external influences (Larson, 1977).

The functional perspective thus views professions as qualitatively different from other occupations. By focusing on their functions in society, it flows 'logical' from here that these professions are organized in an autonomous way and have the freedom to educate and regulate themselves through professional institutions.

3.1.3. Functional associations

Based on these traits of a profession, professional associations are seen as an essential institution of a profession, related to the knowledge base, ethical norms and an orientation towards the public good (Millerson, 1964). In this perspective, professional associations are interpreted in terms of the functions they have for the work of their members and thereby for society at large by "performing a social good" (Friedman & Phillips, 2004:188). In an article published by Robert Merton in 1958, this is exactly how they are interpreted. A professional association can be defined from this view based on these functional characteristics as

> *"an organization of practitioners who judge one another as professionally competent and who have banded together to perform social functions which they cannot perform in their separate capacity as individuals."* (Merton, 1958:50)

In doing so, the association serves to benefit professional service delivery (Merton, 1958). It is characterized based on the specific functions it has to this end. Among other things, professional associations make sure the professionals have frequent contact, remain a close community and motivate each other to keep up their professional role. They stimulate life-long learning amongst their members and help solve disputes between professionals and the organizations they work in.

Furthermore, for the profession as a whole, the professional association makes sure standards of service delivery are set at a high level and helps to enforce them. By preventing professionals from 'resting easily on their oars', it functions to enable the profession to anticipate on future developments (Merton, 1958). It promotes research, education and rigorous application of professional norms. In sum, they act in the benefit of the quality of service delivery of the professionals they represent.

Several authors have tried to disentangle the different functions professional associations are seen to have theoretically. Some focus on one specific function, like the promotion of academic research (Holleman et al., 2006). Others give an overview of the many activities associations (might) employ (Noordegraaf, 2011a:470). An overview of the literature on professional associations results in four areas of activities that substantiate their functional 'role'. These areas share a common focus on the quality of professional service delivery. The first area is quality assurance (Merton, 1958; Friedman & Phillips, 2004; Watkins, 1999). To ensure quality of professional work, associations employ activities to oversee and control conduct of their members. Professional associations set quality standards for service delivery and formulate professional codes of conduct. To make sure these standards are met they organize checks and controls by peers. To be able to enforce these standards a system of

disciplinary law is set up to sanction and discipline their members (Noordegraaf, 2011a; Merton, 1958; Greenwood et al., 2002).

Secondly, professional associations are involved in training and educating their members in order to increase their competence (Kloss, 1999). Noordegraaf (2011a) and Watkins (1999) point to the way associations influence curricula and training programs in universities. Also after graduation they promote life-long learning amongst their members during their working lives (Karseth & Nerland, 2007). By publishing journals and organizing conferences, professionals are kept up to date on recent developments in research and praxis in their domains (Noordegraaf, 2011a).

The third area consists of activities that are aimed at bringing the members of the profession together in order to promote unity and coherence (see Merton, 1958). In this way, professional associations are seen to stimulate a close community of practitioners (see Tonkens, 2008).

Lastly, the functional perspective of professional associations is resembled in conducting and stimulating (academic) research on topics that link closely to the occupation. Authors focus both on associations that are actively sponsoring and stimulating academic research (see Holleman et al., 2006) as well as on associations that are conducting studies into topics of interest for the profession themselves (Kloss, 1999).

Role in professional domain	Functional body
Focus on	Quality of service delivery and societal value
Key activities	**Quality assurance** - Standard setting - Peer control - Disciplinary law
	Education and training - Influencing (academic) curricula - Providing education and training - Promoting life-long learning - Publishing journals - Organizing conferences
	Community building - Bringing members together
	Research and innovation - Promoting research - Conducting research
'Front' of interest	Substance

Table 2: Overview of a functional perspective on professional associations

In sum, the focus of professional associations observed from a functional perspective lies on improving the quality of service delivery and benefiting the way their members contribute to societal value. Research has shown this is exemplified by several specific activities. Medical professional associations will, when we assume they have a primarily functional role, act as guardian of medical quality.

Although the functions described in table 2 are commonly mentioned both in the literature and in practice, others argue that the behavior of professional associations as ‘front runners of professionalism’ might be an end in itself rather than a means for improve quality of professional service delivery and improve societal value. As the social world is “not inevitably a harmony of interests”, the possibility exists that professional associations will, consciously, place the interests of the profession above societal interests of others (Merton, 1958:51). This observation leads to another perspective on professionalism, which focusses on the political dimension and the benefits of strategically claiming professionalism.

3.1.4. Political perspective: who *claim* to be professionals?

During the 1970s, the functional perspective on professionalism came under scrutiny. “The idea that professional workers could or should be trusted to act competently in the interests of members of the public was increasingly questioned, especially by those favoring a market economy approach” (Swann et al., 2010:552, see also Larson, 1977). Inspired by Marxist scholars, status and privilege were being distrusted. Natural traits that had been accepted in the functional perspective were no longer taken for granted. This approach is critical towards the merits of professionalism, claiming professionalism can be conceptualized as “a strategy involving solidarity and closure, which regulates the supply of professional workers to the market” (Willmott, 1986:558).

The critical-political perspective does not focus on questions that try to distinguish practitioners that ‘are’ professionals from others who ‘are not’. As professionalism is seen as a strategy that can be (and that is being) consciously employed by certain occupations to achieve autonomy, status and market closure, the question rather becomes who ‘claims’ to be professional, and to what extent they succeed in doing so. The political perspective on professionalism is therefore by definition relational and dynamic. Succeeding in claiming professionalism means being recognized by ‘powerful others’, like the state, to be the appropriate institution for ‘responsibly’ and ‘reliably’ regulate, control and promote the quality of service delivery (Willmott, 1986).

A consequence of this perspective is that attention is shifted not only to relational elements, but also to the process of professionalization (Wilensky, 1964; Larson, 1977; see also Noordegraaf, 2007). It is not about ‘being’ professional, but about ‘becoming’ a professional by ‘claiming’ professionalism. Therefore, authors have focused on ‘professionalization projects’, which are (intentionally) aimed at establishing professionalism in terms of autonomy and self-regulation. From a political perspective, these elements of professionalism are not conceptualized as beneficial for the public interest, but for the interests of the professional group itself.

3.1.5. Political associations

In line with this perspective on professionalism, professional associations are perceived as political bodies. Where Merton (1958) observed a societal function in the work of these associations, the political perspective assumes that they are specifically aiming at promoting the interests of the profession, or in other words

> *"to gain prestige and status for the profession, bringing esteem to the individual practitioner. If this esteem is reflected in higher remuneration, while giving to the profession at the same time the reputation of rendering service rather than seeking profit, so much the better for the practitioner."* (Gilb, 1966:54)

As these 'functions' are not mentioned or observed directly, they are interpreted in the light of market closure, self-interest and creating a monopoly position (Willmott, 1986). The fact that professional associations will not openly strive for more control and power is, from this perspective, easily explainable. As they will have to convince 'powerful others' about their claim to professionalism, they will present themselves as 'being' professionals in line with the functional characteristics presented above. Still, this is instrumental to their political aims.

Being interpreted as political bodies, professional associations operate within a web of relations, with which they have to compete in order to shield their members from external pressures (see Scott, 2008; Burrage & Thorstendahl, 1990). The main focus of professional associations from a political perspective is to keep up a 'market monopoly' for their members, thereby maintaining autonomy. Their activities are therefore aimed at two main areas that are directed to the supply of as well as the demand for the professional workforce they represent. Their focus is on defending autonomy, status and income of their members.

To control supply of new workers in a professional domain, a professional association is active in controlling membership, thereby controlling who is working in a specific occupation. To do this, it sets membership criteria which regulate who are allowed to perform professional activities (Willmott, 1986; Freidson, 1970). Furthermore, they are active in accreditation (Casile & Davis-Blake, 2002). This allows them to 'filter' new professionals by focusing on their qualifications. These activities enable associations to set up entrance barriers that control membership of a profession. It serves the interests of their members by limiting competition and defending the prestige and quality of professional work. From a purely political perspective, these activities will be placed in a discourse of 'market closure' and strengthening boundaries.

The demand side for professional work is also part of the work of professional associations (Willmott, 1986). To increase the autonomy and freedom of professionals in order to control their own work, professional associations operate as pressure group or lobbying organizations trying to influence policy-makers and new regulations (Akers, 1968; Killbane & Beck, 1990). By enacting trade-union functions they are able to collectively promote the interests of their members towards the state and other stakeholders (Merton, 1958; Burrage, Jarausch & Siegrist, 1990; Watkins et al., 1996). In a similar way, they are front runners of the interests of their members towards competing pressure groups and interest organizations.

A special area of activities that does not directly link to protecting either supply of or demand for professional work is the function of internal mediator between conflicting interests inside the profession (see Bucher & Strauss, 1961). To achieve an influential bargaining position, associations profit from

united rank and file members. They will therefore try to prevent tensions among their members (Greenwood et al., 2002).

Role in professional domain	Political body
Focus on	Defending autonomy, status and income
Key activities	**Controlling membership (supply of professionals)** - Setting membership criteria - Accreditation
	Promoting interests of their members (demand for professionals) - Influencing laws and regulations - Lobbying - Collective bargaining
	Struggle for power with other stakeholders
	Internal mediation
'Front' of interest	Boundaries

Table 3: Overview of a political perspective on professional associations

In sum, when we assume a political perspective on professionalism, we can expect professional associations to take on a political role. This role is best described by a focus on defending the boundaries of the 'professional domain' by controlling who is 'in' and who is 'out' and by promoting and strengthening the autonomy, status and income of professionals. Other than from a functional perspective, the focus is not on quality of service delivery, but on interests of professional practitioners themselves.

3.1.6. Symbolic perspective: who are *seen* as professionals?

The third theoretical perspective on professionalism presented here builds on the second. It stems from the observation that more and more different occupations are aiming at a professional status. It are no longer the 'classical' professions, that can be characterized (or have successfully claimed, according to the perspective) by traits like a specific knowledge base and legitimacy based on professional norms and rules. More recently, occupations like managers and social workers are also striving for the benefits of professionalism (see Etzioni, 1969; Evetts, 2006; Noordegraaf, 2007). They do not 'claim' to be professional in a pure or classical sense, having control and autonomy over their workspace. Instead, they can be seen as 'hybrids' that (have to) connect their professional logic with the logic of the organization they work in.

Although this perspective on professionalism still focusses on the process of professionalization, as well as on the ways in which the concept is socially constructed, the negative connotation that is evident in the political perspective is no longer part of this perspective. It is a view that "permits us to argue that the knowledge claims advanced by professionals can be both somewhat arbitrary and sincerely advanced, that professional jurisdictions can be contested and changing without being a simple matter of political clout, and that in many circumstances the advancement of professional interests is not inconsistent with attention to client welfare." (Scott, 2008:221).

Letting go of the conflict model creates space for a model that focuses on the connections between professionals and their surroundings. Conceptions of (who are seen as) professionals do not change due to clashes in political struggles, but are the result of the complex interaction between actions of the occupation and “the influence of social, cultural and technological changes that are affecting the technical and moral fabric of professional services” (Noordegraaf, 2011b:9). As is observed, professional agency is not intentionally (and directly) directed towards improving status and power, and cannot on itself account for a professional status. On the other hand, professions are not formed (and stable) according to a naturalistic account of their ‘growth’ (Scott, 2008).

What this nuanced account shows is that professions are embedded in their context, and this context will influence their position within society in terms of trust, status and legitimacy (see Svensson, 2006; Evetts, 2006). Professions are neither formed by specific characteristics or by strategic action alone. Instead, professionals are conceptualized as both influencing and influenced by their surroundings. This opens up the possibility of many different ‘forms’ of professionalism, that are all based on specific aspects of the work of different occupations.

3.1.7. Symbolic associations

From this perspective, professional associations are perceived as symbolic bodies that have to ‘convince’ others as well as the professionals themselves that the occupation is indeed professional. As we have seen above, the symbolic perspective does not assume that a profession with specific inherent characteristics exists objectively. Professions and especially their institutions will have to convince others and themselves of their professionalism to ‘become’ professions. As Van der Meulen (2009) shows, managers who are professionalizing will establish ‘professional’ associations as one of the first things they do. These associations are not interpreted as having specific functions for the occupation (or profession) nor for their ability to defend the profession in political struggles over autonomy. In these processes of professionalization, the associations are primarily symbolic. ‘Having’ an association as a profession enhances your credibility, because it links to the common idea of professional self-governance. As Noordegraaf & Schinkel (2010:17) observe, “in many ways, all of this is symbolic. [Professionalism is about relying] upon professional discourses to ‘put on a professional performance’”. In turn, this increases their professional status.

Activities that link to this perspective on professional associations aim at promoting the ‘professionalism’ of an occupation. This is done both externally towards others, but also internally, to promote a professional identity and ‘remake’ their members into an ideal typical professional.

Internally, professional associations function as “arenas through which [their members] interact and collectively represent themselves to themselves” (Greenwood et al., 2002:61). In these interactions, they both formulate and absorb shared understandings of “reasonable conduct and the behavioral dues of membership” (Greenwood et al., 2002:61). In other words, they work to make up and promote a professional identity amongst their members. Practically, they engage in storytelling, formulating

service ideals and vision statements as well as organizing rites of passage that promote group feeling (Noordegraaf, 2011a).

Professional associations also represent their members' acclaimed professionalism towards others. In doing so, they 'represent themselves to others' by "a process of social construction: the act of portrayal [of their professionalism] clarifies membership and, usually, leads to reciprocal behavior from others [towards] the legitimacy of the projected identity and role" (Greenwood et al., 2002:62). By using the same mechanisms as they do internally, they appeal to the public opinion and common discourse towards their work and legitimacy (Watkins, 1999).

Role in professional domain	Symbolic
Focus on	Promoting professionalism
Key activities	**Externally representing the profession** - Appeal to the public opinion - Representing their 'professionalism'
	Internally promoting professionalism - Identity formation - Socialization - Promoting 'professional' conduct
'Front' of interest	Profile

Table 4: Overview of a symbolic perspective on professional associations

In sum, viewed from a symbolic perspective, professional associations have primarily a symbolic role. Instead of a focus on service delivery, or on defending autonomy, status and income, they can be expected to aim at the profile of a profession towards external audiences as well as internally. They will focus on promoting professionalism, showing their professional ideals. The difference between the symbolic perspective and the other two lies in the fact that, from a symbolic role, professional associations do not actually have to focus on service delivery or autonomy and income. It is primarily about *showing* you are 'professional'.

3.1.8. Three roles for professional associations

These three perspectives are summarized in table 5 below. Each perspective provides us with a theoretical role for these organizations or, in other words, a specific focus in the way these organizations can be interpreted. What is most important is to see on what aspects they place their focus. Do they see themselves primarily as guardians of service delivery, or do they focus on the interests of their member themselves in terms of autonomy, status and income. A third possibility, based on the analysis above, is that they will worry most about convincing others of their professionalism, without focusing too much on how their members deliver their services, or on claiming autonomy in work processes. What is interesting to see is which roles are emphasized, and what makes associations focus on one (of more) specific role(s).

	Functional perspective	**Political perspective**	**Symbolic perspective**
Role in professional domain	Functional body	Political body	Symbolic body
Focus on	Quality of service delivery and societal value	Defending autonomy, status and income	Convincing others of their professionalism
Key activities	Quality assurance Education and training Community building Research and innovation	Controlling membership Promoting interests of their members Struggle for power with other stakeholders Internal mediation	Externally representing the profession Internally promoting professionalism
'Front' of interest	Substance	Boundaries	Profile

Table 5: Three perspectives on professional associations

It might be possible to interpret the same activities or policies from different perspectives. A simple example to illustrate is posing quota for educating new doctors, as most scientific associations do. This might be said to be related to a functional role, as it helps to prevent an overflow of doctors, and thereby a loss in quality. Simultaneously, it might be seen as political, controlling the supply of doctors and thereby their value. Thirdly, from a symbolic perspective, the activity in itself might help to 'show' you can be seen as professional by employing some form of self-governance. This means that for this study it is important to analyze not only what activities professional associations focus on, but also the discourse they use to interpret them. In other words, the way they (and other actors) make sense of specific activities is essential in describing their role within their profession.

3.1.9. Raising expectations

This paragraph has presented three theoretical perspectives, which all propose a specific role for professional associations within their professional domain. Here, I will argue that the second, political role is most likely to be expected in the contemporary context of Dutch health care.

The functional perspective assumes a sufficient level of societal trust in professionals to be able to 'receive' autonomy in their job. This trust is based on their skills, and the way they can be expected to use these skills: namely in a way that is beneficial to clients of service delivery. The extent to which a professional association will be able to focus on functional behavior is subsequently also dependent on this level of societal trust in professionalism. Professionals (specifically in health care) are under scrutiny by increasingly critical audiences, as chapter two has observed. Calls for accountability, transparency and value-for-money can be interpreted from declining levels of public trust in professional service delivery.

This leads to the expectation that professional associations will focus first and foremost on defending the boundaries of the professional domain. Without these efforts, they might end up being 'off side': no longer in a position to be part of the playing field that defines and delivers medical services. Under

pressure, their (limited) time and energy can be expected to defend medical professional interests like autonomy and their position within health care.

The symbolic perspective presents some difficulties when filtering out theoretical expectations. It is easily related to a political role: promoting professionalism can be seen as a tactic to strengthen the bargaining position of their members. This would mean that professional associations might indeed employ a symbolic discourse. On the other hand their current context, as described in chapter two, makes that this strategy is hard to accomplish. A symbolic perspective assumes professional associations aim at demonstrating professionalism. It is exactly this professionalism that is increasingly distrusted. This observation points in the direction of the expectation that professional associations will not interpret their work in a symbolic discourse, for it can be seen as 'ineffective'.

3.2. Relations of professional associations: in between members and interlocutors

This paragraph will turn to the way professional associations relate both to their profession and external stakeholders they have to deal with. Like all associations, professional associations have a very specific member base (in their case professionals). They can be seen to aim at representing the interests of these members (functionally, politically or symbolically). In this light, they are being interpreted as a specific type of representative organization (see for instance Bennett, 1999). Although there are important differences within this category of organizations, all different 'types' aim at promoting the (collective) interests of their members (Bennett, 1999). "A professional association is one type of [representative] association whose stakeholders are individuals (as opposed to organizations) with education and training in a particular occupation or profession" (Kloss, 1999:71). In this way, they are *intermediary* in nature (see Bennett, 1999; 2000). They operate in between the demands of their members on the one hand and the constraints and opportunities of their external environment of interlocutors on the other.

This means that every representative organization, like a professional association, has to operate in two environments. On the one hand they serve to represent their members. This first *membership environment* provides an impetus to organize in a way that makes sure their members are represented equally and in a right manner. Furthermore, in their activities, they will try to increase their relative member base (in relation to the total profession) in order to represent as many members of the occupation as possible. On the other hand, to represent their members effectively, they will have to organize themselves in a way that enables them to gain influence in relation to other (external) actors. This *influence environment*, consists of "the collective actors in relation to which they represent" their members (Streeck & Kenworthy, 2005:15). These two environments in which every intermediary association by definition has to operate both produce their own 'logic' (Schmitter & Streeck, 1999).

3.2.1. A logic of membership

The first of these logics is the *logic of membership*. This logic is based on the interaction between the organization and its members or constituents (Streeck & Kenworthy, 2005). As intermediary organizations are seen as representatives of their members, the logic of membership stimulates

associations to be conscious of the demands of their constituents[19] and to act in a way that is based on their interests. Streeck & Kenworthy (2005) present several aspects of this incentive for associations. In following the logic of membership, associations can be expected to act in a way that is focused on specific aspects like the ones presented in table 6. Because of this logic, there is a constant impetus for (professional) associations to relate their behavior to (perceived) interests of their members.

A logic of membership
Gaining information about and formulating the specific (collective) demands and interests of their constituents
Increasing cohesion and coherence among their members
Promoting the interests of their members in such a way that makes it attractive for their constituents to comply with them
Induce new members by improving collective benefits

Table 6: Some aspects of a logic of membership

3.2.2. A logic of influence

The second logic that can be recognized in the way representative organizations like professional associations operate is the *logic of influence*. This logic is provided to them by their influence environment. This environment includes the actors that associations have to deal with in their efforts to represent their constituents. It provides an impetus to enhance the effectiveness of the activities in relation to their interlocutors, and thereby to increase the influence on their surroundings (Schmitter & Streeck, 1999). This relation between association and its interlocutors is governed by a logic of influence through a focus on aspects like those presented in table 7 (see Streeck & Kenworthy, 2005). It means representative organizations will always take into account the effects their behavior will have on their relations with important other stakeholders. Without relations with these interlocutors, professional associations have no change to be effective in representing their members.

A logic of influence
Gaining information about and adapting to the specific constraints and opportunities of the arenas they are working in
Finding a balance in its bargaining positions between demands they have and offers they can make to their interlocutors
Increasing their influence on the decisions that are made in the arenas they are working in
Building lasting and trustworthy relations with their interlocutors

Table 7: Some aspects of a logic of influence

The aims that stem from a logic of influence are directed towards gaining an optimal position 'at the negotiating table', as opposed to achieve optimal representation of their members' interests. What is important to observe here is that these logics are often seen as competing (Streeck & Kenworthy,

[19] I have used 'constituents' here, because it is more accurate in the case of professional associations. Because not all members of an occupation are by definition member of a professional association, this in itself can create pressures on the association, as we will see below.

2005). Focusing on a better position in relation to external interlocutors often means moderating and compromising specific demands of their members to be able to be an effective discussion partner in the environment of influence. And the other way around, when a representative organization focusses on optimal representation and relations with their members, it might lose ground amongst external interlocutors.

3.2.3. Raising expectations

These insights on two logics professional associations have to deal with in their work can raise the expectation that they will not be able to focus on the interests of their members alone. As representative organizations, they have to take their influence environment of relations with external stakeholders into account. This can contribute to a focus away from a political role, as this includes strong advocacy. This focus revolves around protecting the interests of professional interests, as we have seen above. In the terminology presented in this paragraph, it is very much in line with a logic of membership. It starts from their interests, and 'uses' its position as representative to promote these interests.

In sum, dealing with external stakeholders is expected to influence the behavior of professional associations. Without a focus on this environment, professional associations are not able to achieve their aims. Therefore, we can expect professional associations will be partly drawn away from the interests of their members because of an impetus to maintain good relations with external interlocutors.

3.3. Responses of professional associations: from internalization to opposition

The most important question for this study based on the developments outlined in chapter two is how professionals, and in particular professional associations, respond to the pressures of several developments in contemporary health care. Grounds for a (hypothetical) answer to this question lie in the view on whether professionalism is inherently conflicting with other logics of managerial or organizational pressures. The emphasis above on market dynamics, cost-efficiency and transparency shows that "[medical] professionals have [increasingly] become part of large-scale organizational systems with cost control, targets, indicators, quality models and market mechanisms, prices and competition" (Noordegraaf, 2007:763). Other than the classical, 'pure' professional model, in which professionals were able to control their own jurisdiction including norms, values, quality guidelines and working conditions, this new situation forces professional groups (and their institutions) to 'deal with it'. From the perspective of new public management, pure professional control is seen to be at odds with the emphasis described above. Professional control is distrusted, based on the own economic focus, for being "self-serving producer monopolies" (Flynn, 1999 in Noordegraaf, 2007:769). Under these pressures, "professionals can no longer evade organizational and financial considerations – considerations that focus on costs, efficiency, value for money, consumers' demands and so forth" (Noordegraaf, 2007:772). They will have to deal with these developments – the question is how they will do so.

3.3.1. Professionalism and other logics: inherent conflict?

One theoretical perspective that has formulated a (hypothetical) answer to this question argues that "professionals are seen as the victims of organizational control, which they will resist in order to defend occupational spaces, standards and values" (Noordegraaf, 2011b:2). It does not make sense to argue that breaches in their autonomy could be combined with being a professional, as autonomy is seen as one of the defining characteristics of professionalism. From this point of view, organizational and other external logics do seem to be inherently conflicting with a professional logic. In the conflict that arises when these logics clash, as they have done in health care more intensely over the years (see chapter two), Ackroyd et al. (2007) have found for instance that in sectors where professional dominance has been strong (like health care), reforms to strengthen the organizational logic have been less successful because of stronger professional forces opposing these changes. As professionals see their domain under pressure, they see no other choice for themselves than to resist them. This perspective assumes professionals will act like Charles Darwin predicted: like the survival of the fittest, with different species confronting each other under the premise 'eat, or be eaten'.

As the evolution of species suggests however, new environments do not only result in species going extinct. They also boost species to evolve, adapting themselves to their new surroundings. Next to the combative discourse of conflicting logics, newer relational perspectives have come up with very different expectations to how professionals and their associations will deal with external pressures. Other than separate, intrinsically contradictory worlds, "in contemporary societies, professional and managerial roles have become more blurred than the stereotypes suggest" (Noordegraaf, 2007:772). An emphasis on an organizational logic does not merely limit professional logics, but instead stimulates interaction and 'cross-fertilization' between the two. The newly evolved 'real' professionalism is not only about professional practice alone. It is equally so about being able to connect this practice to the (new) organizational context described above. Professionals in this meaning of the concept..

> *"know how to operate in organized, interdisciplinary settings that cannot be organized easily; they know that cases, clients, costs and capacities are interrelated. In other words, they will learn how to behave in neo-bureaucratic settings, with hybrid organizational forms"* (Noordegraaf, 2007:775)

As with the perspective that focusses on conflict, this relational perspective has also been recognized in present-day empirical reality. In public sectors, professionals are taking up managerial roles. Medical managers that work on the intersection of actual professional practices and the organization of these practices in their organizational context are a prominent example (Causer & Exworthy, 1999). Especially in health care, were much of the relevant information that is used to organize (allocate resources, funding, staffing) is medical, "organizing and managing must be seen as professional issues" (Noordegraaf, 2011b:10). Because of the specialized knowledge required to formulate performance indicators, professionals become integral in creating and monitoring these performance measurement instruments. Because of this cooperation, "managerial expectations around service

quality are more closely aligned with the performance expectations of doctors" than we might expect (Flynn, 2004 in Waring & Curie, 2009:760). The evidence-based medicine movement, which aims at finding and formulating best practices in medicine, can even be seen as a form of performance measurement that has its roots in the medical profession itself (see Broom et al., 2009). In sum, looking at professional domains under pressure from this perspective opens up other professional responses that might be more likely than a defensive response that is solely aimed at resistance.

3.3.2. A continuum of responses

These different positions within the academic debate have implications for expectations towards empirical responses of professional institutions – like, in this case, their associations – to developments that might result in interferences by other logics in professional domains. When we assume professionals *have* to remain fully autonomous, we can expect they are likely to resist these developments. On the other hand, if we assume connections can be made, and might even be beneficial, this leads us to other expectations about the responses of professional associations to external pressures.

Numerato et al. (2011) have conducted a study that presents an overview of the results of a large number of articles presenting research concerning questions on professional reactions to external interferences. Based on this review, they "have captured a variety of professionals' reactions to management" and related pressures that can be seen to interfere with a professional logic (2011:4). In analyzing this 'variety', they were able to categorize over 6000 specific research outcomes into five categories of responses. They did so by focusing on how professional associations (and other professional institutions) reasoned, framed and gave meaning to a growing influence of other logics. Also, they looked at activities and policies professional institutions employed in reaction to these developments (Numerato et al., 2011). Their five categories are presented below in table 8.[20] Their analysis has resulted in a continuum, ranging from passive responses that (consciously or unconsciously) yield to other logics to active responses that openly resist any external interference.

[20] These five categories are also informed by Oliver's (1991) framework of "strategic responses to institutional processes", which follows a similar logic from passive to active response types.

Category of responses	Sorts of actions and meaning attributed to external developments
Acquiesce	Professional associations **indoctrinate** doctors into the managerial mode of reasoning by **connecting medical practice**.
Co-optation	Professional associations **recognize** the utility of external guidelines and performance measures. They **accept** their content and acumilate them to increase their benefits for professional practice and smoothen their use.
Negotiation	In being **adaptive** and seeking to limit external involvement, professional associations try to **renegotiate** the boundaries of external influence. Although they might give in at some points, they try to **maintain** professional dominance as much as possible.
Strategic adaptation	Professional associations **retain** external facets of values and interests of other logics, although this appearance makes it possible for their underlying professional conduct to **remain unaffected**.
Opposition	Professional associations actively **criticize** external logics and promote **resisting, ignoring or defying** influences by others in the professional domain.

Table 8: Categories of responses of professional associations to external logics (based on Numerato et al., 2011)

3.3.3. Raising expectations

In paragraphs 3.1.9 and 3.2.3, I have formulated expectations towards the role of professional associations, and the influence of two distinct environments in which they (have to) operate. Based on these expectations, we can expect that professional associations will respond to external pressures by responses that fall in categories of strategic adaptation or negotiation. Because they will probably take on a political role, their responses fall within the bottom half of table 8, actively striving for professional interests like autonomy. They still have to deal with their influence environment however. To do this, active opposition can be expected to be (relatively) ineffective, as it will negatively affect their position within this environment. Following this line of argument, strategic adaptation and negotiation seem the most likely responses of professional associations within the context described in chapter two.

As the continuum of Numerato et al. (2011) is fluid, based on categories without hard dividing lines, the difference between negotiation and strategic adaption might be hard to establish. Negotiation can be interpreted as somewhat more adaptive in nature, taking the new situation as a given and making the best of it by coming to new arrangements with their interlocutors. Strategic adaptation is relatively less adaptive, holding on to professional norms and values, albeit 'under disguise'. A possible way professional associations might act is by adapting in a way that creates a mere façade of cooperation, opening other opportunities for opposition to interests of external stakeholders.

The expectations for the empirical part of this study have been summarized in table 9 below.

Subtopic	Subquestion	Section	Expectation
Role and focus	3	3.1	Political role due to contemporary pressures of critical audiences. Focus on defending professional interests and staying in control of the professional domain.
Relations to profession and external stakeholders	1/2	3.2	Professional associations have to balance their relation with members to represent their interests and their relation with external stakeholders to represent these interests effectively. This will contribute to a focus away from a political role, as they will have to take the influence environment into account.
Influence of pressures	4/5	2	Market, organizational and client developments put pressure on professional domain. Critical audiences require professional institutions to deal with this new situation.
Responses to pressures	6	3.3	Professional associations will respond by negotiation or strategic adaption to external pressures. Their political role demands them to defend professional interests. The logic of their influence environment prevents them from openly opposing pressures.

Table 9: Overview of expectations

4. Research strategy

This study focuses on describing and explaining the responses of professional associations to a changing Dutch health care sector. This chapter will present the research strategy that is used to answer the questions that were presented in paragraph 1.5 above. I will start by outlining the general perspective that is the starting point for this strategy (4.1). The perspective will help as a 'logical model of proof' that connects the specific methods and techniques which are introduced below to the research question(s) that direct this study (Nachmias & Nachmias, 1992). Secondly, I will discuss the research methodology that I have used in this study, and the specific choices I have made in this studies' design (4.2). Thirdly, I will present the empirical data collection methods that were used, and the way the data was analyzed and used to come up with results and answers to the research questions (4.3 and 4.4). The final paragraph 4.5 evaluates the strategy and techniques that are used, focusing on its strengths and weaknesses.

4.1. Research perspective

Professional associations within the Dutch health care sector are embedded in a changing and complex environment. The sector is constantly receiving a high level of political and societal attention. This is not surprising, as the interests are high, both in the high costs of health care as well as in the way it deals with peoples' most precious possession: their health. There are important interests at stake, and the associations are in the middle of it: in between the practitioners and other parties in the health care sector. This will be resembled in diverse perceptions of what is going on in their environment. Different actors might not agree on a single, objective representation of the reality they are in. They can all employ deviating accounts of what is going on and 'who they are' (see Morgan & Smirchic, 1980). Professional associations might see themselves as promoters of 'the social good', while others may view them as political bodies acting in the self-interest of the professional group. In other words, what happens in reality can be given meaning in different ways. I belief it is important to incorporate (such) several perspectives in this study. The three perspectives on professionalism above, for instance, can help to get a better grasp on the activities on professional associations. Their activities and responses can be interpreted as a way to increase autonomy, to benefit knowledge on health care or to symbolically convince others of the superior knowledge of the profession. To be able to describe 'what is going on' and to understand why this is happening in that way, it is important to incorporate different perspectives like these in this study.

This assumption has some important implications for the way I set out to achieve my aims. First, this study has to recognize multiple interpretations that exist, and that there does not necessarily has to be one underlying, objective reality (see Van Thiel, 2007:41-42). What is 'true' depends to a large extent on the way actors involved act, think and give meaning to their actions and (inter)relations. To achieve this, a holistic approach is needed that is able to incorporate multiple perspectives. Another implication of the assumption outlined above is that the specific context is a very important element of the analysis. As Morgan and Smircich (1980:498) observe, "any method that closes the subject of study within the confines of narrow empirical snapshots of isolated phenomena at fixed points in time, does

not do complete justice to the nature of the subject". Aspect A (for instance, the responses of professional associations) can be influenced by a range of different factors that cannot all be expected on forehand. To find an answer to my questions, these factors are important to take into account. By using a holistic approach, the context becomes crucial to make sense of the social phenomena under study (see Flyvbjerg, 2001). In my case, to understand the responses of professional associations, I will take an open view to be able to incorporate 'unexpected' insights, and use theoretical insights from the literature to gain a focus. Emphasis will be placed on "understanding and describing the empirical reality, taking into account the context in which phenomena occur and/or actors are in" (Van Thiel, 2007:155). As there is an "already interpreted reality", I will have to make my own "interpretation of how participants understand their daily life" as a researcher (Boeije, 2011:13). Theoretical insights are used to focus the empirical part of the research (see Tummers & Karsten, 2011). Understanding will thus build on the combination of empirical insights and theoretical concepts that can help explain and make sense of these insights. In this way, it is "required to re-interpret the information while preserving the participants' meaning" (Boeije, 2011:14).

A consequence of this approach is that it can be harder to generalize results of this study on professional associations' behavior to other contexts or sectors. After all, their responses are a result of the complex interrelation of contextual factors. These are by definition tied to their specific context. Still, there is some room for gaining insights that are relevant to other contexts as well. As an exploratory study, I will pay attention to factors that help explain responses of professional associations. Insight into these factors can help future research formulate expectations based on the extent to which these factors are resembled in other context or sectors.

4.2. A qualitative approach: gaining deeper insights

To achieve this, I have taken a qualitative research approach (see Boeije, 2011). More so than a quantitative approach, it is fit to "do justice to the complex reality", because reducing this reality to numerical data and analyses easily loses much of the information that provides needed insights (Van Thiel, 2007:155). Boeije (2011:11) presents three 'key elements' that represent the core of qualitative research: (1) it deals with looking for meaning and interpretation of phenomena, (2) is uses flexible research methods enabling contact between researcher and researched, and (3) it provides qualitative findings. It is however hard to present general rules for how to 'correctly' conduct a qualitative study. Not only are there many different forms of qualitative research, all with their own specific premises and 'logics of proof' (Boeije, 2011), the process of conducting a qualitative study is often, and also almost naturally, iterative and flexible in nature (Van Thiel, 2007). It is hard to fully plan a qualitative study on forehand.

This flexibility can be seen as one of the downsides of qualitative research: reliability can be questioned relatively easily (Van Thiel, 2007:165). One can ask how other researchers know that the right data was collected in such an iterative process, and that it was done in the right way. It is therefore harder to check validity and reliability of qualitative research compared to quantitative research. To control for this downside, and to be able to adequately account for what I have done, I

will document the choices that I have made in the “flexible and open-ended” process (Boeije, 2011:13) of this study in the past few months here. Although the (theoretical) steps of setting up the study, collecting and analyzing data, and writing down the results are distinct, they do overlap and have affected one another during the actual process. Here, I will present the consequent steps, and the way they have interrelated.

4.3. Data collection

After having formulated the research aims and questions the first step has been to find and gain access to the right data sources. One of the first insights has been that there is no single professional association exclusively representing the medical profession (see chapter five). To answer the research question, it was therefore necessary to include different associations, in relation to each other, in this study. I have not chosen to focus on one specific association as a case for a case study, because in first interviews and documents, each association seemed to have a specific and special position within the health care sector as well as within the profession it represents. Focusing on just one association would do no justice to the differences and relations between them.[21] The consequence of this is that, by selecting data sources, an informed sample was aimed for that represents this interrelated ‘system of professional associations’ as well as their position within the health care sector.

4.3.1. Interviews

Semi-structured interviews have been used as the primary data collection method. In total, 23 interviews have been conducted. These interviews all lasted between 40 minutes and one hour, and have been conducted on location in the period from March to June 2012. To structure the conversations, I have used a topic list that is derived from the theoretical insights on the subjects of the several subquestions of this study. Two distinct topic lists were drafted, one for respondents from professional associations themselves and one for other actors.[22] Apart from these topics, I have asked all respondents to other issues that they thought were important for the subject of this study, and points they would like to add themselves.

Respondents were contacted by an introductory telephone call in which I introduced myself as a student conducting research for my master thesis. I proposed to send a short document with further information on my subject, my question for conducting an interview and the reason for approaching their organization. The choice for the exact respondent within the organization was (unless stated differently below) left to the organization.

Respondents that were interviewed for this study can be divided into three categories. An overview of respondents from these categories is presented in the tables below. The first category consists of **respondents working in or for medical professional associations**, being associations of medical

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[21] See appendix IV and paragraph 5.1 for a more detailed description of the professional associations in Dutch health care.

[22] See appendices II and III for the topic lists.

doctors. In all these associations, boards consist of (at least some) medical practitioners active in the field. Most of them have supportive organizations in the form of an associational bureau, led by a director. To exclude the possibility of a biased perspective of one of these sides both (medical) board members as well as directors and employees of bureaus have been interviewed. Next to umbrella associations as KNMG and OMS, I have included scientific associations (*wetenschappelijke verenigingen)* that range from relatively large (NIV, NVA, NVK) to relatively small (NOV, NVALT), both in member base as well as in size of associational bureaus.

Respondent	Association	Speciality (if so)	Function
1	KNMG	Medical doctors	Head of the policy and advisory department
2	VVMS	Newly established association for medical specialists	Chairman
3	OMS	Medical specialists	Secretary of the divisions 'vrij beroep' en 'dienstverband
4	Verenso	Geriatrics	Director
5	Verenso	Geriatrics	Communication advisor
6	Verenso	Geriatrics	Staff member
7	NIV	Internal medicine	Director
8	NVOG	Gynaecology	Director
9	NVK	Paediatrics	Director
10	NVALT	Lung medicine	Board member
11	NOV	Orthopaedics	Director
12	NVA	Anaesthesiology	Vice-chairman
13	AJN[23]	Youth physicians	Chairman

The second group consists of **respondents working in professional associations of other non-medical professions within health care**. These include physician assistants (NVDA), and nurse practitioners (V&VN, NU'91). These professional associations are professionalizing their organization in the light of recent developments in health care, which increases their responsibilities. The two respondents of V&VN are active in specific sections within the umbrella organization of V&VN. V&VN itself did not wish to participate in this study, giving as a reason the almost daily requests for participation in different studies. These interviews were included to provide reflection on the insights from the interviews in the first category above

Respondent	Association	Speciality (if so)	Function(s)
14	NVDA	Physician assistants	Director and chairman
15	V&VN P&P	Nursing personnel; physician assistants	Chairman
16	V&VN IC	Nursing personnel; intensive care nurse practitioners	Board member
17	NU'91	Nursing personnel	Chairman

[23] This professional association operates for a medical profession that does not work in hospital care, but instead in youth care institutions.

The third category consists of **other actors working in the health care sector**. Representing important other perspectives, they include hospital management, governmental inspection, health care insurance companies, patient organizations and health care research institutes. The umbrella association of hospital management, NVZ, was contacted, but did not wish to participate in this study, giving as a reason the reorganization they were going through. Therefore, Actiz was contacted.

Respondent	Actor	Organization	Position
18	Hospital management	Hospital	Hospital manager
19	Governmental inspection	Inspectie voor de Gezondheidszorg	Coordinating specialist senior inspector
20	Employer organization	Actiz	Two senior staff members
21	Health care insurance	Zorgverzekeraars Nederland	Director
22	Patient organization	VSOP	Senior staff member
23	Health care research institute	NIVEL	Research programme leader

4.3.2. Documents

The second data source that was used has been (available) relevant strategic and policy documents of professional associations in the Dutch health care sector. To retrieve these documents, an overview was made of professional associations active in health care (see appendix IV). In an internet search, websites of these associations were searched for relevant (and public) documents. Also, when not directly available, a Google search was conducted.[24] This search has led to relevant strategic or policy documents of 10 associations. These all cover the strategic choices and policy for periods ranging from one year to ten years. Analysis of these documents is used as supportive information on (strategic) responses of professional associations as well as on describing (the role of) these associations.

4.4. Data analysis

In preparation of the analysis, interviews have been transcribed verbatim using the audio tapes that were recorded during the interviews. Both interview transcripts as well as relevant documents that were retrieved were uploaded into the software program NVIVO. Here they were coded, using the topic list as a starting point for the code tree. Next to these topics, codes were established for other relevant fragments. This first step of open coding (Boeije, 2011) led to a coding tree as presented in appendix III below. This first reading (and coding) of the qualitative data led to some global answers to the research questions. I have summarized the main line of these first results in a short text for each of the subquestions. As a second step, coded fragments for different codes were retrieved and grouped together. Using selective coding, I looked for “connections between the categories in order to make sense of what is happening I the field” (Boeije, 2011:114). In this phase, I looked for themes that recurred in different data sources and the relations between these themes. After the dissemination of

[24] As syntax, the abbreviation of the association was used, accompanied by consequently the Dutch terms ‘*strategisch plan*’ and ‘*beleidsplan*’.

data into separate coded fragments, I have reassembled the data in a way that links to the research questions and topic of this study. Attention was also paid to defiant insights. Individual citations from data sources have been used to illustrate results that arose from this selective coding phase.

4.5. Reflection on research design and methodology

This study can best be regarded as an exploratory study (see Stebbins, 2001). The relation between profession, professional association and their surroundings has remained relatively unquestioned (see paragraph 1.4). Not much is known about the exact position of professional associations in relation to their profession and in health care. These questions have become increasingly relevant as important changes in society and health care, as well as development in academic thinking on professionalism, have places classic conceptions of professional associations as 'front runners' of their members in a new perspective.

The exploratory character is resembled both in the methods that were used and the questions that have directed this study. The questions as presented in paragraph 1.5 are directed at finding and presenting the (interrelation between) factors that explain the specific empirical responses of professional associations to external pressures in health care. This study did not focus on one specific factor or variable, but started out holistically, from an open view, informed by different theoretical perspectives (see chapter 3). The qualitative methods that were used reflect this character. They are not fit to describe an entire population, but to gain new insights by listening to and observing several viewpoints. For this, both the interviews and (supporting the interview data) strategic documents have been useful data collection methods.

Due to this exploratory perspective, is has sometimes been hard to relate data and interpretation. To prevent a disproportionate personal bias, I have used relatively rigorous qualitative data analysis techniques like fully transcribing interviews and coding data using computer software. Still, in analyzing empirical data to come up with answers to my research question, as in every qualitative (interpretative) study, it takes some effort by me as a researcher. Again to prevent a personal bias, I have paid attention to defiant insights that might go against an analysis. This attention of defiant cases was also included in the choice for respondents, which include several viewpoints (see paragraph 4.3.1). Related to these possible weaknesses is the suggestion to complement the insights of this study, which open up new possibilities for research, with quantitative (or mixed-method) research into the organization and behavior of one specific professional association (see paragraph 8.1.1). This is especially relevant as this study has shown a large diversity in professional associations representing the medical profession (see paragraph 5.1). This diversity calls for a closer investigation of their differences and possible consequences of such a division. Within the confines of a master thesis, this study has looked primarily in an exploratory way to the subject. Paragraph 8.1.1 will go more specifically into the implications of this study for academic research and theories.

One last point of reflection is on the objectivity of interview respondents. As Baker & Johnson (1998) describe, research interviews can be interpreted as part of 'professional practice'. In other words,

professionals might use interviews to get their message across about the uniqueness and indispensability of their profession. Paragraph 5.3.1 gives an example of a situation in which this might have occurred. In reflection however, this hypothetical professional attitude was not recognized in the interviews within professional associations. First of all, as associational bureaus have grown in recent years, directors are no longer professionals themselves. This made they were able to talk with a certain distance of their own profession. Secondly, as the outcomes of this study show, the assumptions that would make professionals 'use' research interviews to promote their profession are not reflected in the work and discourse (of boards) of professional associations. Interviews as professional practice would imply a focus on their (functional) necessity. In interviews however, respondents were very open about their political activities.

5. Empirical results

This chapter will present the results of the empirical part of this study. In the previous chapters, the locus (chapter two) and the focus (chapter three) of this research have been introduced. Here I will focus on the roles, relations and responses of professional associations within the context of three streams of developments within the health care sector. The empirical findings presented in this chapter are based on the qualitative data of the interviews that were conducted, the analysis of strategic and policy documents of medical professional associations and insights that resulted from these data sources (see also chapter four above).

I start by empirically describing medical professional associations. The first part of the description is directed to their relations, both with their members (profession) and with external parties (other actors in health care). The second element is based on the role they are seen to have in this position. Thirdly, I focus on the way in which contemporary developments influence (the work of) professional associations. This will build to a description of how these organizations respond to contemporary pressures on professional work and the factors that explain these responses.

After each element of this chapter I will shortly summarize the core of the results and conclude on its relevance. Chapter six starts with the empirical results presented below to formulate specific answers to the questions of this study, linking these results to the theoretical insights and expectations presented in chapter three.

5.1. A multitude of professional associations

One of the first insights of this study, which even came before actual data collection, is the multitude of 'professional associations' representing, in some way or another, the profession of medical specialists. As we have seen in the chapters above, most theories that focus on professional associations assume (implicitly) that a profession and its professional association are a natural combination. In the medical domain, this is not the case. Representation of medical doctors is 'layered'. The basis for this development lies in increasing specialization within the medical domain over the past sixty years or so.

> *"For a long time KNMG has been an independent umbrella association. Besides it professional associations for general practitioners, medical specialists and other occupations originated. Because they all became emancipated, independent professions, who also had to defend their own interests." (*Respondent 1)[25]

> *"KNMG is for all medical doctors, so very broad. That is so broad that it is logical that during history all these specific organizations arose alongside it, for the medical specialisms"* (Respondent 5)

[25] See also note 4. As this study was conducted within a Dutch context, quotations and fragments from interviews are originally in Dutch. For the purpose of this report, they were translated in English by the author (unless stated differently. For matters of accuracy, the original Dutch fragments are presented in appendix V at the end of this report.

Within the profession of medical specialists, this development of the establishment of several professional associations has led to a layered representation on three levels. On the highest level, the KNMG represents the entire medical profession. Next to medical specialists, they represent other medical professions like general practitioners and assurance doctors as well. As one of the federation partners, the *Orde van Medisch Specialisten* (OMS) is the professional association specifically representing the medical specialist profession. On this second level, it overarches the entire group, and is

> *"in principle the representative organ ['gezicht naar buiten toe'] for medical specialists, […] that is most convenient, you've got one representative organ for all specialists."* (Respondent 7)

On the lowest level, there is a group of 29 'scientific associations' (*wetenschappelijke verenigingen*), representing medical specialisms like internal medicine, cardiology and anesthesiology.[26] Most of these associations were founded a long time ago (around the end of the nineteenth century) as their specific specialisms started to emerge. There are no official relations between them and either OMS or KNMG.

> *"And besides that scientific associations were founded, already a long time ago, to very specifically […] stimulate, support and develop their own profession."* (Respondent 1)

Figure 3 presents an overview of medical professional associations within health care. In this figure, the associations representing medical specialist (in some way) are highlighted. A complete overview of all medical professional associations representing medical professional associations is presented in appendix IV.

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[26] Some respondents talk about 26 or 33 specialisms. The number of 29 scientific associations represents the official number of medical specialisms in the Netherlands, as registered by the *Medisch Specialisten Registratie Commissie* (MSCR) of the *Centraal College Medisch Specialismen* (CCMS). See appendix IV for a total overview of medical professional associations in the Netherlands.

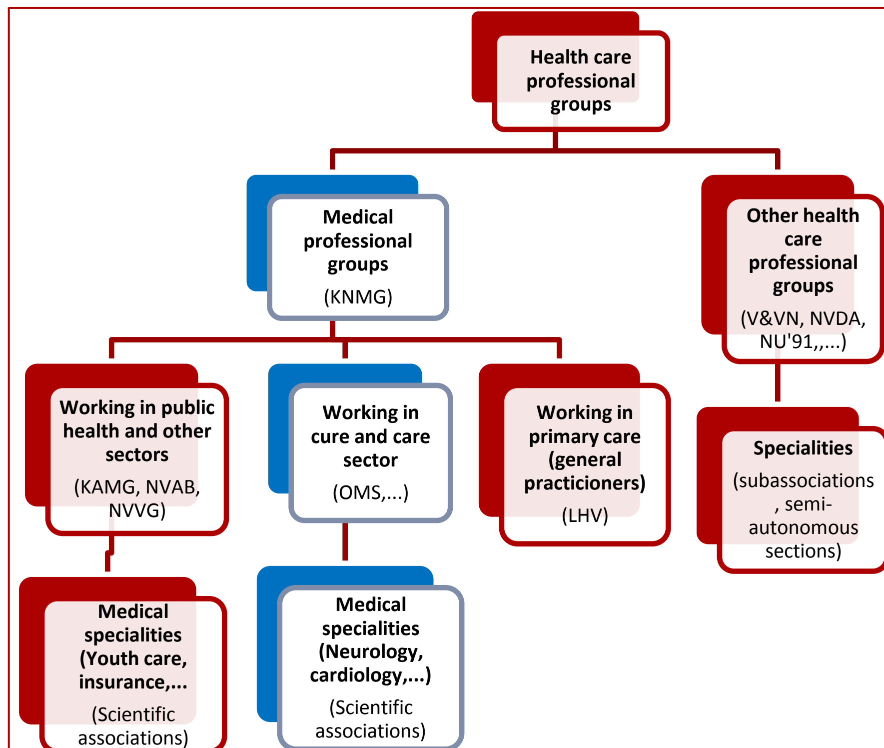

Figure 3: Overview of professional associations in health care

5.1.1. Internal politics and the need for a common voice

The OMS is one of the federation partners of the KNMG. In this way, its chairman is also part of the board of the umbrella organization. There are however no formal relations between the scientific associations on the one hand and the OMS and KNMG on the other. Every doctor will decide for himself whether he will be a member of the OMS and/or his scientific association. As a result, scientific associations on average have a much higher member density than the OMS.

> *"The* Orde van Medisch Specialisten *is an association with individual members, just like us. We [a scientific association] do not have any formal-juridical relations with the* Orde *(yet). […] Less than half of the internists are member of the* Orde." (Respondent 7)

> *"Formally, we do not take part in that. We are a free association. Of all pediatricians, about 10 percent is also a member of the* Orde.*"* (Respondent 9)

This presents both OMS and scientific associations with a complex situation. Although the OMS claims to represent the entire medical specialist profession, their member base is relatively low with only 36% of all medical specialists (Baggerman et al., 2011:27). This is not only the lowest rate of all seven federation partners of the KNMG, but also far lower than the scientific associations representing the same professionals.

Relations between scientific associations and OMS can be described as twofold. On the one hand, smaller and more specialized scientific associations observe they need "a common voice" to be able to get their message across. The OMS is presently seen as a good option to achieve this.

> *"We will never have the illusion that we [scientific associations] sit around the negotiating table everywhere; with health care insurance companies, with the Ministry of Health, Welfare and Sport. We do on specific policy issues, but never representing the interests of all medical specialists. No scientific association will do that, because we are with 27.*[27] *So one single party, the* Orde*, should do that.*" (Respondent 7)

On the other hand, they are cautious of misrepresentation by the OMS. Firstly, some argue the base of the OMS amongst medical specialists is relatively low. In the eyes of respondents, this might create an association disconnected from the professionals it is said to represent. Secondly because the specific interests of one specialism do not necessarily align with the interests of other groups, resulting in internal politics and conflicts of interests between scientific associations. Some even question whether the advantages (a stronger external voice) still outweigh the disadvantages of internal struggles and possible conflicting interests.

> *"The* Orde *establishes the general picture. In general, they [scientific associations] all want better conditions, but to achieve this some specializations might give in on some points. This creates internal politics between the scientific associations. Nobody wants to be abridged or loose autonomy."* (Respondent 18)

> *"Yes, that created discontent within many scientific associations. It is also one of the reasons that all these scientific associations are growing as they do now, to represent their own partial interests. So the position of the* Orde *is very much under pressure at this moment. As a representative organ. Because the* Orde *externally is no longer recognized by large parts of our constituents."* (Respondent 7)

As this remark by respondent 7 suggests, the absence of formal relations between medical professional associations is seen by respondents as something that 'itches'. Professionals have the possibility to be a member of both OMS and scientific associations. This means both can claim legitimacy in representing medical specialists. But as specialisms have grown in importance in recent years the interests of 'medical specialists' as a professional group have become fragmented. As a result, the data suggest there are different organizations, representing the same professionals, but with diverging and increasingly conflicting interests.

> "*The* Orde *is no association of scientific associations, but an association of individual medical specialists. [This] creates tension, it is not right, as far as governance is concerned. A case for you I think. You've got the wrong representation."* (Respondent 11)

5.1.2. Cooperation and struggles

Professional associations do share a substantive common ground in their work, as they are much alike in the way they are organized and the aims they pursue. Internal conflicts do not prohibit cooperation

[27] See footnote 27 on the exact number of scientific associations. The exact number is 29.

in the eyes of respondents. This cooperation can be both substantive, when specific interests coincide, as well as practical. By cooperating at a supporting level, professional associations are able to combine each other's strengths.[28] The KNMG for instance has a large standing organization and can help smaller associations in advising on their communication and internal organization. As scientific associations have good contacts with large shares of doctors in their specialism, these contacts can be valuable for other associations as well.

On the other hand, as specialisms are becoming more important and the medical profession is fragmentizing, there are also aspects that seem less suitable for cooperation. Associations can have conflicting interests. These conflicts arise in several ways. Sometimes, interests for the profession as a whole can conflict with partial interests of specialisms. Tensions like these are especially recognized in the relations between OMS and scientific associations. The same can be true when groups within specialisms do not feel represented by a scientific association itself. A special conflict of interest arises when professional groups feel they are competing for clients. Especially in times of increased market dynamics, respondents also recognize these conflicts over 'consumers'.

> *"Yes, that is what you try to do. You try to make connections [to other professional associations]. But there's the chance that when a problem relates to two 'types' of doctors you step into the domain of someone else. In such a case, it does not solve a problem, but results in a struggle over domains."*[29] (Respondent 6)

> *"On the one side education and health care are public services. And on the other you are being urged to look at it as a system of supply and demand [*'markt'*]. […] Shoot each other, and compete on the market, as it were. […] They are actually two fundamentally different systems, that are used both. […] If you extend this to associations, than we have to compete with surgeons. But on the other hand, there are many things we do the same. If we talk about things like registering complications, conflict control, or certifying sub specialisms. Actually, we are doing a lot of things the same. And on the other hand, we have to fight each other. 'This is my patient, and this one is mine'. And that's a bit odd."* (Respondent 11)

In sum, in describing the relations between medical professional associations, there is a constant tension between the wish to cooperate and the obstacles that conflicting partial interests pose for this cooperation. As a result, respondents argue cooperation is most effective on the level between staff of associational bureaus. In a same way as these bureaus can connect more easily to other actors in the field (see below), they can relatively easy overlook the differences and focus on common problems.

> *"We're only a small organization. Still, we are relatively large, but we are a small group of people. So, if I need somebody on a very specific topic, like how I make a good news email. It*

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[28] This is one of the reasons all but a few medical professional associations, among which OMS and KNMG, have chosen to relocate to a shared building, aptly named the *Domus Medica* in Utrecht several years ago.

[29] Respondent 6 observes this is not a problem in their situation, as problems of their professional group do not easily overlap with other medical specialisms.

may be someone is available for that at the Orde. *We might use him or her in a certain way. It goes the same way with the* KNMG*, for instance when I need HRM advice, than I can call the HRM-guy of the* KNMG." *(Respondent 9)*

5.1.3. Conclusion

This section on the different medical professional associations in Dutch health care has shown the layered representation of medical specialists by several 'professional associations'. The KNMG, OMS and 29 scientific associations claim to represent the same professionals. Fueled by increased specialization, interests between different segments in the professional group of medical specialists diverge and (possibly) conflict. This has also created tensions in the relations between the different representative organizations that are all grounded in the same individual member base. Although these tensions sometimes limit cooperation, especially on the level of associational bureaus, relations are warm and there is intense cooperation on organizational subjects.

5.2. Relations of professional associations

In this section, I will deal with the relations of professional associations. I start out with the relation between the association and its profession. Secondly, I will deal with the relation of associations with other actors, policymakers and interest organizations in health care.

5.2.1. Professional associations and their profession

In their mission statements, professional associations set themselves the task of representing the interests of their profession as well as to increase quality of service delivery of the ones they represent. This duality in their aims creates some tensions in the relation between a professional association and its profession. In describing their relation towards the profession, almost all associations point out they see themselves as 'front runners'. Respondents do not start out by collecting opinions and issues among their members. Instead, professional associations formulate their own vision towards the goals they hope to achieve. As this comes first, relations with members revolve around getting them to go along with the proposed views and strategies of the association itself. This takes much conscious policy making and activities to keep members informed and connected as it is not a natural state of affairs. In other words, professional associations constantly have to balance their role as trailblazer and the distance they can go without being too far ahead of the troops.

*"[When you do not pay attention], you end up with a child with hydrocephalus ['*kind met een waterhoofd'*]. A consequence is that associations will develop a vision and policy on their own, too far removed from their members. Than you get an association that is huge, and does no longer connect to its members. And that's a danger for associations. Stay close to your members. Act in a way that fits their demands. Do not become too big. Stay an association that serves its members and responds to needs in the field."* (Respondent 6)

"I: And how do doctors react [to progressive policy]?

R: *As many groups react: 'don't be silly, things are going well as they are, my waiting room is full, isn't it?' And after three years of 'bashing' you've got 30 to 40 percent on your side in new developments. It's almost the classical front runner, with a middle piece and some dull dogs. This is how it always works. But we do move, both literally and as a matter of speaking. We are no facilitating company, like 'you call, we walk'. No, it's pumping, pushing, bashing and developing."* (Respondent 11)

"*Yes […], we do try to get them involved, via the Internet, panels or meetings at location. We also ask their opinion on certain concepts there. We are working on it. But on the other hand: it is complicated when you are an organization like us. You cannot always react only to your constituents. They are on average quite conservative, so not very progressive. And sometimes you have to go ahead a little. So we do not ask 'what does everybody think', and then act it in that way."* (Respondent 1)

This last quote suggests that the perspective on the relation between association and profession is built on an implicit judgment about the medical profession. Respondents do also make this explicit. They see their rank and file doctors mostly in fairly conservative terms, as the following excerpt resembles. Although professional associations like to innovate, in their view, medical doctors often do not see the use of such novelties.

"Doctors will always be doctors. Usually they are not so capable in communicating on management level. They are just doctors, aiming at the best for their patients. In their education they learn to heal. They are not sufficiently prepared for management tasks; their education is about 'being a doctor', analyzing health problems and to provide an optimal or effective treatment. That's a very concrete practice, not a practice of negotiating. Doctors always tell their managers: 'if I do not get something, my patients will die and you will be to blame'. And that's very inconvenient." (Respondent 6)

This presumed conservativeness of professionals can make it even harder for professional associations to interest their member to become active within the association or to get them enthusiastic about new policy plans. Respondents argue that the extent that professional associations achieve this differs between activities. The OMS has to deal with relatively active and demanding members due to the material interests they represent. Associations dealing primarily with substantive issues face much calmer and sometimes even indifferent constituents. Both present these associations with a challenge. On the one hand, associations have to convince their members of strategic choices in representing their interests.

"The big difference is that we are not concerned with material interests, like just income. That determines a lot. It means that there is a lot less pressure from our constituents, because it does not deal with 'money'. The Orde *and* LHV *just have to score in the media. We are not bothered by that. It makes our work a lot easier."* (Respondent 4)

On the other hand, they have to actively show that their substantive activities concerning quality of medical service delivery will give professionals something in return for their membership fees. This can be particularly hard when associations are promoting something professionals actually do not like that much.

> *"That can be complicated. Because we do not bring direct, concrete advantages for our members. So you have to be idealistic, and focus on the bigger picture. That's a question that pops up once and again. They pay € 600 to 700, and pose the question 'what do we get in return? Yes, well, a clinical guideline. But what's in it for us? And so I have to pay for something that I actually do not like that much'."* (Respondent 4)

The insights of respondents (both inside and outside of professional associations) on these tensions suggest they have contributed to a growing distance between (the organizations of) professional associations and the professionals they try to represent. This can be related to the professionalization of associational bureaus (see paragraph 5.4.4); their daily work and discourse is further removed from the working life and concerns of rank and file medical doctors.

> *"Scientific associations are [in fact] just a group of people that picks a board from their own ranks with initially scarcely any mandate to conduct a policy on medical quality. Also [not] within their profession."* (Respondent 19)

Still, respondents argue it is also important for representative organizations to remain in contact with their members. As an increasing distance is recognized by respondents, associations are indeed trying to bridge the gap that they see to have grown between themselves and their members.

> *"A challenge is how we can raise and highlight the future role and position of youth health care physicians […], and that this not always corresponds with how our constituents view it. [As a possible solution..] it's actually just informing, informing, making contact. Personal contact, talking to people. Making sure lines are short. I do not know any other way."* (Respondent 13)

5.2.2. Relations with other actors

Being representative organizations of medical professionals, professional associations also have to deal with translating the interests of the medical domain to other domains and actors. Respondents argue that the contacts with external stakeholders are therefore functional in convincing them of the added value of medical doctors within health care. Presenting their relations with other actors in this way is based on the implicit assumption that interests of professional associations and these other actors like insurance companies, governmental bodies and representatives of health care management are naturally conflicting.

> "*And that's actually our most important function [in these contacts]. Making sure the right people in the right places know the expertise of these medical specialists. Because they are working within health care processes every day, and know what it's all about like nobody else.*

And there is still a dismatch there. There are civil servants, making policy based on insights they receive from just somewhere." (Respondent 8)

"And to other partners, we have to explain what our added value is as a physician." (Respondent 13)

On the other hand, interviews show that professional associations have freed themselves from the specific (theoretical) interests of their professionals to a certain extent. Although they do argue that the contacts with external parties are important for the work of professional associations, they are not only functional in promoting professional interests. In other words, professional associations seem to take up a position further removed from their professional constituents, as has been pointed out in the previous paragraph.

"I: Does that also mean something for the way in which you cooperate?

R: Yes, I think we are taking a much more independent position. [...] And more self-conscious, making clear what our position is, what we want to do and who we are. So somewhat less following, more in the lead."

This development in the relation between association and profession is also resembled in their relations with other actors. It gives them more freedom in formulating their own position on a policy issue, and consequently makes it easier to cooperate with other actors. As they are less directly tied to the demands of their members, the urge for political advocacy seems to be decreased.

As both respondents within professional associations and within other parties observe, both sides understand the need to cooperate in a complex public sector like health care. Without substantive professional knowledge and skills, other actors are not able to fully comprehend and judge medical service delivery. Professional associations need other actors to organize it effectively. As government left much of governance within health care to field parties, for them, organizing themselves effectively means maintaining good contacts with other stakeholders. In fact, several respondents argue the contacts between stakeholders and policy makers can be seen as a 'polder model' within health care. One respondent describes it as follows:

"You all have a very clear goal, namely keeping land dry. In health care this common goal is to deliver qualitatively good, affordable and safe care. And if you do not work on that, everyone from its own expertise, dikes, mills, water outlet et cetera. It's incredible what you have to achieve together. And you know that whatever you do, if you do not keep this goal in mind, and if it is not the criterion for your actions, than you will all be flooded. That's literally what happens. 'To polder' is not about making sure everybody has their say until we are bored, but instead about getting a clear picture about common interests, delivering good, affordable quality of care, making sure all interests are taken into account, and keeping this picture always in sight. This phenomenon is what's keeping Dutch health care viable." (Respondent 19)

This focus on cooperation is recognized either implicitly or explicitly by almost all respondents. (Public) interests of health care, instead of the specific interests of medical professionals, are increasingly the primary focus of professional associations. Within this discourse, the emphasis is on finding alliances to overcome mutual problems instead of a 'combative' discourse on struggles over autonomy or power. One of the respondents within a professional association observes about their activities within the 'polder model':

> *"Of course, that's where you look for alliances. Look, we have a number of shared interests with the* Nederlandse Vereniging van Ziekenhuizen *(NVZ), but also a lot of things where we do not align. So you look for alliances, for instance on the issue of e-health. There, you look for mutual support to execute a certain programme. Or you search mutual support for the question of governance of hospitals, and quality assurance, et cetera. But these are real common issues. So you are searching for alliances. […] Still, there are many issues on which you cannot agree. You leave those, until there is a move on which you can hitch in. For instance such a budgetary discussion, minister Schippers also likes it, very up-to-date, there is also financial pressure. Suddenly, there are many actors that are moving in the same direction. Than you will have to, so everybody will hitch in. From a common insight it's important and there is no other way."* (Respondent 1)

The good (personal) contacts between decision makers within all these (different) organizations are strongly related to this cooperative focus. Closely linked to the concept of a 'polder model' is the metaphor of a "diplomatic service" of health care (Respondent 19). People from representative organizations meet each other often, and get to know each other very well. Their common denominator increases as they are educated in the same institutions and have worked at different sides.

> *"Certainly in the last 10 years, you can observe a kind of travelling circus arising of people that meet each other in all kinds of contexts. Sometimes even multiple times a week. And these people, from umbrella organizations, bureaus of these organizations, they meet each other. Sometimes you even get the feeling they are the most direct colleagues you have."* (Respondent 19)

> *"Yes, so if the ministry of health care has an idea, we all get invited and we meet each other again. The familiar club is together again on such an occasion."* (Respondent 21)

As bureaus of professional associations have professionalized (see paragraph 5.4.4), they have increasingly become part of this diplomatic service. To be close to other actors, one professional association is even replacing its office to a more central location in Utrecht (Respondent 13).

> *"If I look at the contacts my director has with several associations, they range from business-like to quite informal when time passes. You do meet representatives of these organizations on congresses and other expert meetings, so you end up in addressing each other by their first names. These networks are actually very smooth."* (Respondent 22)

"The organizations that cooperate have a need for the knowledge that we have [as a professional association]. And so you know how to find each other, that's actually what is happening in my opinion. That is possibly a consequence of the development of bureaus of people who are no doctor, and who are more easily inclined to just go and talk with other people. There used to be more incomprehension between parties." (Respondent 8)

5.2.3. Conclusion

In this paragraph, I have focused on the relations of professional associations within the professional domain and their relations with external stakeholders. The first relation can be described as loosening. Professional associations seem to take on a more independent position, fueled by professionalizing associational bureaus. This more independent position is resembled in their relations with external parties. These contacts are characterized as close, following logically from the representative character of professional associations, and their 'membership' of the diplomatic service of health care and the close and multiple (personal) contacts that come with it.

Within this context, professional associations see themselves primarily as 'front runners' of their profession, getting them to adapt to a changing health care sector. Their activities seem primarily directed at cooperating with other parties to solve public challenges health care is facing and to 'convince' their members to go along with this line of thought. Still, they do observe the need to 'stay in touch' with their profession.

5.3. Roles for professional associations

Having described the relation of medical professional associations to other actors, and thereby their position within the medical domain and in health care, I will now turn to describing their role within their domain. First, I will focus on all three theoretical roles (see chapter three), and see to what extent they can be recognized in the activities of professional associations. At the end of this paragraph, I will focus on developments in these roles in recent years.

5.3.1. Functional role

When asked about the role of their association and their most important activities, almost all respondents primarily start from a functional discourse, focusing on quality of service delivery and promoting the substance of medical work. As this could already be observed in mission statements of professional associations, it is resembled in the way they (wish to) see themselves. In presenting the *raison d'etre* for their organization, almost all give reasons focusing on benefitting patients, health care or medicine.

"Our higher cause is of course to get a more healthy youth in the Netherlands. That is just the trade of youth health care physicians, that's what we're working on continuously. And we're doing that by equipping our members, the youth health care physicians, in a way that they are able to fully carry out their job." (Respondent 13)

"Well, we're there for orthopedics, our field of study." (Respondent 11)

This discourse is substantiated by several activities that professional associations say to focus on. The functional discourse is most clear in the work of scientific associations. Respondents mention that education, quality assurance and medical research are crucial aspects in their work. These activities can be conducted both directly, by the association itself, as well as indirectly, by supporting others. Some respondents even argue that functional activities are the only thing scientific associations do.

"We mostly concern ourselves about quality, education, research and events. It actually comes down to that." (Respondent 11)

"These scientific associations, […] are exclusively concerned with the substance of their work. So the scientific side, the medical side. That is what they do." (Respondent 1)

The functional profile of scientific associations links to their historical starting point. Most scientific associations have started out at the end of the nineteenth century as organizations that were responsible for setting up and supervising medical specialist education in a specific area of medicine.

"We've actually started with the education to become a gynecologist, and we're still responsible for that. Making sure this goes well, that educational standards are strict enough." (Respondent 8)

Over the years however, their focus has broadened. Scientific associations are also overseeing medical conduct of medical doctors themselves. By promoting clinical guidelines, which has increased rapidly since the 1990's, they try to set and maintain medical standards for service delivery. By promoting these guidelines and keeping an eye on the way professionals live up to these standards, they are seen as a safeguard for underachievement and dysfunctioning doctors.

"A second aspect is quality policy. That has gone high-sky in the last 20 years. You have to think about making clinical guidelines. And these guidelines are, in their core, directed to making sure all medical conduct of medical specialists is done in the same way. That nobody will act because he has the idea that it is the best method of treatment, but that there is a guideline saying what the best way is, and what you should do." (Respondent 8)

"In that way these associations function as an M.O.T. ['APK'*] of doctors."* (Respondent 18)

Not only scientific associations present such a functional discourse. The KNMG, being an umbrella organization for all medical doctors, present itself in a functional discourse. In its own words, the KNMG represents the "immaterial interests" of medical doctors (Respondent 1). Quality is seen as an important part of their work. They argue their work focusses mainly on fairly abstract issues. The aim is on 'what is means to be a (good) doctor', without a focus on actual substantive medical issues. Examples are issues around medical ethics, like the role of doctors in euthanasia.

"The KNMG is concerned with quality in a very broad sense. KNMG is a real substantive organization. […] They are concerned with ethics, medical ethics. With 'what is a good medical

record' and what should be in it. So medical-ethical issues like euthanasia and circumcision." (Respondent 4)

This explicitly functional profile is least easily visible in the activities and discourse of the OMS. As we shall see below, their focus has historically been aimed at material interests of the profession itself. Still, in recent years, the association has developed their activities in line with a functional profile. This has resulted in a closer cooperation with scientific associations to pick up common issues in policies revolving around medical service delivery that are equally important among all medical specialists.

"Quality development is certainly something that has been focused on increasingly over the last years. I'm working here for 12 years now. When I started at the OMS*, it was already active on the topic. But certainly over the last years it has seen an enormous acceleration and growth. Examples are the development of clinical guidelines, visitations, a system around evaluation of medical specialists, a model code around dysfunctioning doctors, patient safety, safely reporting incidents et cetera."* (Respondent 3)

5.3.2. Political role

Next to a functional discourse, most respondents also point to a focus of professional associations that is closely related to a political role. Some are more explicit about it than others, but almost all admit it is an important element in their work. This role can be very specifically linked to the discourse of the OMS. Its focus has classically been on political issues, focusing on material interests of the profession of medical specialists. Some even narrow the activities of the OMS down to financial interests alone. These (material) interests are seen as the core of the work of the OMS. Although in recent years the organization seems to have shifted towards a focus on a functional discourse, they are still perceived in the field to focus mainly on maintaining strict boundaries around their professional domain.

"The Orde *is originally an association focusing on the interests of its members. It was purely about money. The last years they wanted to develop in the direction of a policy around quality. Although they have achieved this, you do notice the image of interest organization still surrounding them."* (Respondent 8)

[Pediatricians] argue, well, after all, the Orde *is the organization for people from 'partnerships' ['*maatschappers'*] who like to drive around in a Porsche."* (Respondent 9)

The political discourse however is not unique to the OMS. Respondents also talk about scientific associations, representing specific groups within the profession of medical specialists, as increasingly active in representing the specific interests of their profession. Alongside their functional activities, they have set up commissions that deal with the specific "financial-economic" interests of their members.

*"The other pillar is the interests of our members, so the financial-economic interests of internists. And then it's about de DOT, DBC's, income, the organization of partnerships ['*maatschappen'*], anticipating on legislation, administrating data et cetera."* (Respondent 7)

"It means you are less orientated inward and more outward. And you do notice a very clear shift in focus over the last two years here in the organization. Historically, it used to be 80 percent policy around quality, clinical guidelines and everything that comes with it. And now it's much more image-forming and management." (Respondent 4)

Efforts within this political discourse are directed at other actors in health care, but also towards other specialisms within their own profession. Specialization and fragmentation are seen as an important driving force behind the rise of a political role of scientific associations, focused on defending the interests of their members. Other actors in health care also recognize this development.

"I: How would you describe the work of these associations?

R: Well, they are interest organizations in the first place, and they have always been so. 'How do you guard the societal interests as a medical specialist, of your field of study, especially in relation to other specialties?' More than in relation to government, you seek to fencing off your domain from other groups of medical specialists who are doing roughly the same." (Respondent 19)

5.3.3. Symbolic role

Other than a political and functional role, the symbolic role is less clearly visible in the discourse of respondents on professional associations. It is hard to see what activities or strategies are aimed at being a 'symbol' for a fully professional occupation. This is partly hard because respondents themselves also struggle with this role.[30] In principle, respondents do agree that it is an important aspect of being a professional association. Associations have to carry out the message of their competence and the important task they have for health care as well as for society as a whole. By doing so, they try to improve the status and image of their profession. This means for instance supporting transparency and better contacts with patients; both in the profession as well as for the professional association itself. In sum, a symbolic role of professional associations can be recognized in the way they try to connect to the popular societal image of how doctors *should* behave.

"When a group of doctors is still a young specialism, it does not yet recognize its own strengths. So the image and the status of doctors is something you should constantly work on as a professional association." (Respondent 6)

"I: How important is it for a profession to organize the image-forming towards society effectively?

R: Yes, that is very important. We come from a time, and that's not even that long ago, in which doctors thought of themselves as a different group of people. A kind of caste,

[30] There are two other reasons that might make it harder to observe a symbolic role in the discourse and profile of professional associations. The first is that it is mostly theoretically related to upcoming occupations, who 'act' professional. In the case of medical associations, their professionalism is more widely recognized. Secondly, it might be hard to observe a symbolic role as a researcher, as symbolic activities might be (interpreted) as functional or political at the same time.

the medical caste. […] We have increasingly started behaving ourselves as a socially responsible professional association, so to speak. We have more and more contacts with patients, we've become much more transparent, and we realize our own interests on these matters better. So how you behave externally is very important. I guess, when you would investigate our communication, you would see we have become much more 'societal', aimed at what's important for civilians." (Respondent 1)

The symbolic role is mostly recognized in a discourse on communicating professional ideals and skills. Some even refer to it as "marketing" and "reputation management" (Respondent 11). In the essence, it revolves around externally showing how good you are, without actually improving how good you (really) are, or trying to use it for direct gain, for instance in political negotiations.

> *"Communication and reputation management. If there's something medical specialists do not realize enough, it is the importance of presentation, external communication and marketing."* (Respondent 11)

This task is not that simple, however. There are many more forces contributing to the image of medical specialists in society. The extent to which a professional association is able to influence this image is limited. Next to all these other forces, associations are limited in their recourses. Their means of communication are limited. The real message has to be brought over by professionals themselves. Just by doing their job right, linked to the demands of society, has far more potential than activities of professional associations alone.

> *"Yes, well, the whole world is quite large. And the whole world is not continuously eager for all kinds of emails. So you constantly have to find starting points and to do something that is purposeful."* (Respondent 5)

> *"It is not all that easy. Changing an image about medical specialists is incredibly difficult. Especially when the profession is changing, from a focus on health care institutions to service delivery, irrespective of where patients are. This demands new forms of cooperation, with general practitioners, districted nurses, et cetera. They first have to belief themselves that they are able to work in such a way. They have to send out this image, than I can sell it."* (Respondent 6)

This does not mean it leaves professional associations empty-handed. Partly, symbolic discourse of professional associations is directed towards the profession itself. This is done particularly by improving for the "self-image" of professionals, hoping they will be better able to 'sell' themselves. Also, professional associations seem to have a role in maintaining and strengthening coherence within a profession.

> *"That is the self-image of our doctors. We are saying that is to humble. And that should become leading again."* (Respondent 4)

"Especially important, although it might sound strange, is the image-forming around internists within our own association. In our association, we have to deal with several differentiations. But the principle should be that you are and feel primarily an internist and only after that a differentiation." (Respondent 7)

"We already exist 125 years, so doctors do have some sentimental feeling with that fact. You do not easily let go of our association. It is also a kind of club of friends, whom you meet at congresses. It has a high resemblance with a reunion. 'You have educated me', that keeps us together." (Respondent 8)

5.3.4. Converging roles

As we have seen above, the three theoretical roles for professional associations are visible in the discourse of respondents on professional associations. Until recently, the distinct roles are argued to have been most prominent in specific layers within the 'system' of medical professional associations (see paragraph 5.1). The profile of KNMG, as an umbrella organization, is mainly interpreted as symbolic, promoting and determining what it means to be a good doctor (or professional). OMS is historically seen to deal with material interests of the entire profession of medical specialists, based on their common interests as independently established practitioners. Because of this, it is mostly interpreted as a political body. Based on the substantive medical differences between medical specialisms, respondents relate the activities of scientific associations to a functional discourse.

This 'neat' distinction has somewhat changed over the years. These roles and discourses on different associations have grown closer together. As was observed above, OMS is increasingly interpreted as a functional body, and scientific associations are increasingly focused on as looking after the (material) interests of their specific members. KNMG typifies its own areas of interest as "very broad", ranging from a functional, symbolic and sometimes even political role (Respondent 1).

Respondents point to the ever far-reaching specialization within the medical (specialist) profession as an important development related to this convergence. Through it, the conception of what constitutes a professionals' profession(al group) changes. In doing so, it makes that particular professional associations feel the need to conduct all three roles themselves. Respondents argue for instance that, partly based on the insufficient representation of the OMS of medical specialists described above, scientific associations are taking up political roles, increasingly focusing on remuneration and conditions of 'employment'. Other associations, representing increasingly 'foreign' professional groups, are less trusted with specific interests of specific (sub)groups.

"Actually, we are a scientific association. But we notice that, because of all the developments around us, our attention is drawn to promoting the interests of our members and to profile [professionals] instead of stimulating scientific development." (Respondent 13)

"*No, I do not think that has been a conscious choice. Historically, it was mostly about substance. And then came profiling. And the more you profile yourself, the closer you will get to material interests of course."* (Respondent 4)

Although there are some voices that belief material and substantive interests should be separated to be effectively enacted, most parties agree that this development of combining roles is the only way to be effective in all of them. As an example of the second argument, one respondent mentions the OMS. They are often observed as being mainly interested in the material interests of their members. This image does not help in their work, because it infringes their professional (functional) base for claiming material interests.

> "*I: Is the one possible without the other?*
>
> *R: Yes, of course it is, but then you're no longer a complete association. You have to make demands for the association. It has to exist out of a diversity of competences. And you have to be able to secure this."* (Respondent 6)

When roles for professional associations become mixed between the several 'layers', as has been observed above, this has an effect on the way associations relate to each other. Paragraph 5.1.1 above already suggested associations balance their individual interests and their need for a stronger common voice. The development of professional associations taking on multiple roles can be seen as a way to take matters in their own hands. Scientific associations focusing on their political role do not have to trust on the way OMS will deal with these issues for them.

Still, this convergence also means associations move into each other's domain. Interestingly, this does not seem to have developed in increased conflicts between professional associations. Instead, in taking up new roles, professional associations are very practically weighing benefits and disadvantages of cooperation and conflict. In some cases, to defend the autonomy of a medical specialism, a scientific association will need the support of the OMS. And, the other way around as well, when the OMS wants to strengthen its substantive activities, it observes the need for support from scientific associations. In sum, as convergence might be expected to create stronger tensions between layers of professional associations within the medical domain, it seems to promote cooperation, because they are able to help each other in taking on new roles. Respondents observe cooperation is beneficial for both parties; it covers the OMS by taking away the image of proponent of medical specialists enriching themselves, and it helps to combine the voices of small scientific associations to a common and louder voice.

> *"We are in a process to see whether there are possibilities for further cooperation. There are dossiers that are too big for us. […] If you're talking about the autonomy of medical specialists, that is much larger than pediatrics alone. So, as a scientific association, we will have to cooperate, and you will need some sort of 'vehicle' to do that. Then it's obvious to see whether there are possibilities to start cooperation with the* Orde." (Respondent 9)

> *"So we are already talking with them, in what we call the 'synergy track' ['*synergietraject'*], with all scientific associations and the* Orde*. Because we do have an interest in one party speaking for us on behalf of all medical specialists."* (Respondent 7)

Some even argue that in a few decades different associations will merge into one large organization that is…

> *"broader, more mixed, a better mix between substance and financing, combining different interests."* (Respondent 1)

5.3.5. Conclusion

This paragraph has described the extent to which the three theoretical roles for professional associations in their professional domain can be recognized empirically in the discourse of respondents on the work of Dutch medical professional associations. The fact that there are many medical professional associations is resembled in the way these roles are visible in their focus. The most 'broad' task of symbolically showing and promoting professional service ideals is best visible in the work of the KNMG. OMS, being a representative for all medical specialists, can be best described historically as a predominantly political body. This is logically when we take into account the most prominent common denominator for medical specialist are their working conditions and the way they have to deal with the systems of costs and rewards in health care. As medical specialisms have grown apart, and can be seen as increasingly substantively distinct areas of medicine, it is no wonder the functional role for professional associations is best recognized in their work.

An important development respondents touched upon is a convergence in this 'neat' distinction of roles over the several layers of professional associations. A focus on a functional discourse is no longer reserved for scientific associations alone, as the OMS is increasing its focus on substantive issues. And as medical specialisms have grown in importance, this has also diversified their non-substantive interests, creating the need for scientific associations to a focus on political discourse to defend the boundaries and freedom of their specific subdomain.

Having described both relations and roles of professional associations, I will now turn to the responses of professional associations to contemporary developments in health care. The insights of the previous paragraphs serve as a background for the next part of this chapter, because they have given us an informed overview of what medical professional associations are, and what they do. The way these organizations relate to other actors and their profession, as well as the way they focus on theoretical roles for professional associations can also help to find factors that explain the responses described below. Before I will describe responses of professional associations, I will first deal with the way in which the three streams of developments, as described in chapter two, are recognized and perceived by respondents in health care.

5.4. Developments in health care and pressures for professionals

Respondents of professional associations, as well as other actors in health care, recognize very strongly that the world around them is changing. Although this has been so constantly over the last decades, last years have seen an important turn in the way medical doctors are observed and

approached. Demands have risen, and the medical domain has become increasingly scrutinized by other actors.

> *“The world has changed. The position of doctors is different now. People make higher demands. They want better explanations.”* (Respondent 4)

> *“We’re much more in the spotlights. This morning I have received phone calls from* KRO Reporter *already, who are working on a new television show. And* TROS Radar *is also working on a show. You are under a looking glass. That was totally different three, four years ago. People closely monitor what you do.”* (Respondent 11)

In this paragraph, I will focus on the extent to which the three important streams of market, organizational and client developments in health care, described in chapter two above, are recognized within the medical domain itself and in what ways they pose pressures in the work of professionals and professional associations.

5.4.1. Market pressures

In the eyes of respondents, market dynamics indeed seem to have invaded the medical domain. Respondents strongly recognize the pressures of accountability and transparency that are associated with this development. Also, it seems to become increasingly important to think along with clients, instead of arguing what is good for them. Demands of costumers are increasingly important in medical service delivery, as they are linked to the way health care is financed by insurance companies.

> *“We have to work more and more demand-driven, instead of supply-driven. So we have to stand alongside customers [sic!], thinking along with what they feel is important.”* (Respondent 13)

> *“That is something they [doctors] still find difficult. But it is part of their job, because it helps to show who you are, what you’re capable of and what cannot do.”* (Respondent 11)

> *“Medical specialists are under increasing pressure”, because “quality standards, especially accountability over quality, are forced up more and more.”* (Respondent 9)

5.4.2. Organizational pressures

The second stream of developments that is recognized in the literature consists of organizational pressures, stemming from the increased influence of a logic of efficiency and cost-consciousness. Respondents also recognize these pressures that stem from this development. As they observe, the work of medical professionals is increasingly observed in terms of costs and judged based on efficiency. Quality itself is no longer the only (and most important) criterion. Revenue is not only measured in terms of ‘making people better’, but also in relating this to the costs involved in the service delivery.

"People are much more critical, looking at what it brings in for them, and whether they can get it cheaper somewhere elsewhere, saying 'you are so 'expensive', and 'what do we get in return?' So we have to show our 'revenues' more and more." (Respondent 13)

As professionals are 'encapsulated' by the organizations and institutions they are working in, the managerial concerns of these organizations are resembled in the way respondents talk about their work. Professional associations are very much concerned about issues dealing with cutbacks and money streams within health care. These developments can influence the position of the medical profession within health care institutions. Respondents point to the fact that, as the most expensive employees, medical doctors have to show their worth. Others are afraid cutbacks might also influence the way health care is organized and medical services are delivered in a negative way.

"But also the financial cutbacks. They make that we as a profession, we're the most expensive discipline in youth health care, that when we are not able to show our added value, we run the risk of being cut away due to economizing ['wegbezuinigd'*]."* (Respondent 13)

Next to this direct impact of organizational pressures on medical service delivery, respondents also point to consequences for the work of professional associations themselves. Within the 'polder model' of health care (see paragraph 5.2.2), they are seen as important players. Within this domain of decision- and policy makers, they are the parties that are best capable of representing medical doctors. If a development in which these doctors are more closely incorporated into hospitals would continue further, this position might be endangered. Other actors in health care point to a possible future scenario, in which a "substantive boss" (professional association) will become of minor importance in relation to a "hierarchical boss" within hospitals and other health care organizations (Respondent 20). The fact that doctors are fairly autonomous…

"is an important reason for the existence [of medical professional associations]. But suppose, and it might not even take so long, that all doctors are in paid employment. Then part of their reason to exist falls away. Because, as a health care insurance company, I will talk to their organization. I will not conduct business with individual medical specialists." (Respondent 21)

5.4.3. Client pressures

As it is closest to the actual medical process, pressures from changing clients are perhaps most directly recognized by respondents from professional associations. As with consumers in a market, clients demand new things from doctors. When society changes, medical service delivery changes as well. One respondent working in a professional association states this development and its consequences very clearly:

"Society demands a different treatment by medical specialists. They have to work more transparent and accountable. A lot has changed in dealing with patients as well, just because of the Internet. A patient will come to a doctor well prepared, almost with an iPad in its hands. When a doctor diagnoses a patient, he or she can almost search on the Internet whether a

doctor is right or not. Patients do no longer take the knowledge of doctors about their wellbeing for granted. This asks for a different, more advisory approach of doctors towards their patients." (Respondent 3)

"R: Pressures on health care are rising.

I: How should I imagine these pressures?

R: What you see is that people are growing older, and older people by definition need more complex care. This is something we see, not just on TV, but really an observation. This care with elderly people is often more complex and more expensive. […] A quiet, relaxed day, like we had those before, they do not occur anymore." (Respondent 12)

5.4.4. Critical audiences and the work of professional associations

Until now I have mostly focused on the consequences of these three developments for professional work itself. Respondents recognize their effects: doctors have to be transparent, and have to account for what they do. The managerial logic of cost-consciousness and value for money is becoming stronger in their work, and clients have changed in a way that poses new demands for practitioners.

Next to these effects, respondents also point to some consequences for the work of professional associations themselves. For these organizations, it creates a twofold pressure. First, it increases their workload quite dramatically. As new, critical audiences pose higher demands for professional work, much of this comes down to professional associations. Respondents often point to drafting clinical guidelines. Although they have originated as a tool for self-governance within the medical domain, they have become more important as they are also used (and demanded) by other actors like the *Inspectie voor de Gezondheidszorg* (IGZ) and health care insurance companies. This increases workload for professional associations to coordinate and conduct the formulation of these guidelines, as it has classically been one of their core tasks. Respondents point out that developments like these are an important driving force behind the professionalization (and enlargement) of professional associations and their bureaus.

"[In the 1990's, substantive policy of scientific associations] was something in which doctors had to cooperate, but they did not have to act on the results. It was confidential. Depending on the associations, one could make sure aggravating things were kept out of the report. […] But that has been the beginning of a kind of coherent system around medical quality." (Respondent 19)

"And in this way substantive policy is constantly professionalizing. And then it's not only about clinical guidelines, but also about making the right indicators, so making it measurable. And looking at certain complication registration systems. When you conduct certain acts, how often does it work, and how often does it go wrong, and what can you learn from that. That's something we all deal with." (Respondent 8)

> *"Yes, that is something that makes you crazy. And everybody is posing demands. You constantly have to do all kinds of stuff."* (Respondent 11)

Next to the increased demands for professional associations on their familiar areas of work, developments in health care have also changed the work of professional associations in another way. Critical audiences have also pulled them into new tasks. New external demands for the profession make that the professional association, as its representing body, is increasingly asked to think along with other actors and to sit at the negotiating table in many talks and meetings in the sector. As a consequence, its focus has inevitably changed from its profession to these other actors. The part of the work of professional associations dealing with organizing and supporting the profession itself has decreased in favour of new tasks that are related to the organization of health care as a whole. Relations with other actors are closely related to this development (see paragraph 5.2.2). This development might endanger the relation between the profession and its professional associations. As these organizations loosen (physically and personally) links with their rank and file doctors, they become positioned "*in between two fires*", in between professionals and demands of critical audiences (Respondent 13).

> *"There are more and more associations that argue they need a director who leads their bureau and is a contact person externally, walking around in networks and making connections between the ministry and professionals."* (Respondent 8)

> *"We've got a large associational bureau in Utrecht, […] with nine people who have a fulltime job to represent anesthesiology in its broadest sense in the Netherlands. That is towards members primarily on issues of representing interest and scientific, because you're working on clinical guidelines, indicators, quality assurance et cetera. But also very explicitly with stakeholders. What does the IGZ want of us, what does the government want, what do health care insurance companies want from us? And you try to take care of this as good as you can."* (Respondent 12)

5.5. Responses of professional associations

Professional associations have to deal with this new reality that contemporary developments in health care have created. As we have seen, they have changed professional work profoundly, and also influenced the work of professional associations themselves. This paragraph deals with the responses of professional associations towards these developments. In chapter three (paragraph 3.3) a theoretical framework for interpreting possible responses has been proposed. Here, I will describe the way medical professional associations responded in terms of this continuum.

5.5.1. Changing ideals, pragmatic policies

Respondents do observe the need to act in relation to a changing society and rising costs. Either pragmatically or based on ideals of medical service delivery, in principle, they understand and support the need to change. Respondents argue for instance that the interests of professionals can no longer

be followed ubiquitously; instead, this always has to be balanced against values of cost-effectiveness and interests of consumers.

> *"Everybody would like golden teaspoons, but if they cannot be paid, they are not being paid. You will have to deal with this very pragmatically, and look what your position within this 'game' will be. And eventually we want to be able to keep proposing clinical norms. And then, pragmatically, you will have to move along a little. The days when you [as professionals] could demand these golden teaspoons are over, because costs of health care are rising fast. […] Than you have to do this. Both based on pragmatism, but actually also from a social consciousness."* (Respondent 9)

Others see a role for themselves in calling attention to these changes among their members, and promoting new values that relate more closely to this changing environment. Doctors do not always seem to realize or understand new developments as directly as professional associations. To a certain extent, they just do their job. For professional associations, picking up, translating and acting on new developments is one of its core tasks (Respondent 10).

> *"That is, they do have a task in that policy. That's what I'm trying to get them to see. They often feel victimized, you're right about that. But then I say to them 'you're not taking you're role'. Then I go and talk to them. Like, you squeak, but what have you done yourself? […] So educating people is also a task in that sense. Making them conscious of the role they can have themselves, where their own responsibility lies, how they can think along and come to creative solutions; that's something that everyone should familiarize him- or herself with."* (Respondent 6)

> *"You just cannot hide your head in the sand. You cannot wait and live in an ivory tower, and do not think anything of that."* (Respondent 9)

In principle, respondents from within professional associations argue they have embraced new values that have grown in importance. Some examples in the activities and behavior of professional associations do indeed reflect an incorporation of values that have grown in importance due to increasingly critical audiences. One scientific association, recognizing the benefits of transparency and being accountable, is introducing a new educational programme. This new programme is directed to new competences like communication, cooperation and new forms of being a professional, next to classical medical skills and knowledge (Respondent 11). Another tries to get professionals to prescribe medicine in an efficient way, under the banner of "expensive when necessary, but cheap if possible" (Respondent 7). In formulating and enacting new policies, professional associations argue they still have to be selective. As has been observed above, new developments create high demands for professional associations. Therefore, they 'choose' which issues will receive attention and active advocacy within their profession.

> *"You always try to be proactive, to be ahead instead of all backward. But so much is happening, and so much comes your way, that you have to pass out on some dossiers.*

Instead of taking on everything, because if you do that, you'll end up in a situation in which you will fall behind." (Respondent 7)

Another specific recent event that can be seen in this light is the establishment of the *Vereniging Vrijgevestigde Medisch Specialisten* (VVMS). Its establishment is interpreted as a protest against the way in which the focus of professional associations has shifted to general (and more abstract) 'public values' and the way in which cooperation has been intensified with other non-professional stakeholders. Members of this new organization are seen as a "conservative group" (Respondent 1), aiming for a party that once again focusses on the (traditional) interests of the professional group itself.

"I: *Now there is a new association, the* VVMS*. How do you see this development?*

R: *Well, their motive is that the* Orde *is to weak, making too much compromises with health care insurance companies and government. Also on the issue of freezing incomes. Limited growth, et cetera, they do not like that at all. They feel it should continue as it has done. So it's a conservative group, who argue the* Orde *is not firm enough."* (Respondent 1)

As we have seen, respondents from professional associations argue they approve many of the new demands contemporary developments pose for them. When asked about specific reactions, it seems they do not (want to) 'fight back' to these developments. The principles of transparency, accountability, cost-efficiency and consumer orientation are becoming part of the discourse from with professional associations operate.

Still, there are pressures coming from their member base to ease changes for the profession as well. As part of their role in connecting the professional domain with its surroundings, respondents do point to efforts that aim to make sure demands for accountability, transparency and effectiveness present professionals with workable outcomes. In other words, they try to make sure doctors will still be able to do their work without getting caught in too many constraints. As an example, one specific association tries to reduce relevant information of clinical guidelines to short documents of only 1 or 2 A4. Another tries to convince other actors to combine their guidelines for medical service delivery into a single format, so that professionals will not have to deal with a multitude of diverse demands. Lastly, on a more abstract level, another association is setting specific preconditions to which, from their perspective, market dynamics should be confined.

"We do have to think about how we make things workable for doctors. So we're working on a project to see whether we can present them better via our website, using summarizing tables, flowcharts and such tools. [Now, information consists of] sometimes over 200 to 300 pages. We have argued: we have to improve this, so that it will be better accessible. Making sure there are good summaries, maybe even an app or something like that." (Respondent 9)

"What we can do, and that's something we are doing, is pleading, not for twenty clinical indicators per health care insurance company, but making sure they do this collectively. […]

Just pick what you want to know, make a tool for that. But do not importune them [doctors] from twenty directions. There we can play a role of course." (Respondent 8)

5.5.2. Remnants from the past?

Most respondents tell a story of professional associations who are influenced by contemporary developments, and are open to base their work partly on 'external' values. Still, their efforts are partly directed by their relation with their profession, which makes professional associations cautious to infringe professional work.

Respondents from other stakeholders come up with a partially different story towards the way professional associations respond to contemporary developments in health care. In their remarks, classical views on the political character of professional associations color their views. The way of responding that is described by professional associations themselves is not in all cases recognized by respondents of other actors. Some argue that, because of their close links with professional interests and ideals, professional associations are not capable of thinking with a view on the future, and the important challenges health care is facing.

"I feel that many professions, let's say, do not think progressively about their occupation. […] If you look at which way we're heading in terms of a society that is changing color, from green to grey and multicolored, then you should see that your own role and positioning within that palette is also changing. If you're not able to connect, but keep looking from your own position, than you will place yourself out of the game." (Respondent 20)

Still, there are respondents from other stakeholders who acknowledge the strong pressures for professional associations to look "with professional care-eyes" to health care, but come to a different conclusion about their responses. They argue that their position within the field of policy and decision-makers gives them a better overview of the challenges health care is facing. Because of this different position vis-à-vis their members, professional associations…

"have some more sight on how do I achieve things, and then we're talking about national agreements, that's when they know how to do business with us. [… For professionals themselves it's] distant and unknown, and these health care insurance companies, what does it all matter. As soon as they enter a board of a professional association, they will realize that, if you want to deal matters on a national level, you will have to deliberate, and they you've become an interlocutor." (Respondent 21)

5.5.3. Conclusion

Professional associations understand the need to change in the light of contemporary developments. In principle, they understand and endorse the need to incorporate values proponed by other actors into their policy decisions and activities. Respondents argue they would not be able to legitimate

choices that are solely based on the interests of their members alone. Professional associations have to take other interests and values, linked to public values in health care into account.

These new, but (partly) internalized starting points do not mean interests of their members are forgotten at all. Although the starting point for many professional associations is shifting to a position among other policymakers and external stakeholders, the professional interests of their members are still visible. However, these interests are mainly acted upon to prevent unworkable situations for their members. Because professional associations have internalized other values, their responses to pressures on professional work are not aimed at using them to increase autonomy irrespective of non-professional interests of other stakeholders, but at coping with them as best as possible.

In the next chapter, I will use the insights of the empirical data, presented above, to answer the subquestions that were formulated in paragraph 1.5. In this way it links the empirical results to the theoretical insights and expectations presented in chapter three.

6. Answering research questions

This chapter will relate the empirical results of this study, which have been presented in chapter five above, to the seven subquestions presented in paragraph 1.5. These questions were formulated to help focus the study and provide insights into specific aspects that relate to the main question.

6.1. Subquestion 1: Relation to their profession

A clear answer to the first part of this subquestion is that professional associations see themselves primarily as front runners or 'voortrekkers' in relation of their profession. On policy issues, they are the professional institution thinking out new strategic directions, and looking ahead at what developments might influence their profession in the future. Respondents do not recognize a relation in which professionals themselves decide the (strategic) direction of their association. Closely related to their self-image as 'front runners' is the image that lives within professional associations (and their boards) of the professionals they represent. Medical specialists are labelled as 'conservative' and 'only interested in their own job', forgetting to look at the (changing) world around them.

Professional associations do try to connect more closely to their member base, as the dangers of being too far in front are also recognized. Still, it seems hard for them to get members sufficiently interested and involved in their work. When they are, their demands in the area of autonomy and remuneration are hard to fulfil. In many cases, professional associations find it hard to show their value to professionals.

Substantive and political issues seem to constitute the relationship between profession and professional association most strongly. In relating to the profession, associations (with the exception of the KNMG) are less concerned with promoting professionalism and service ideals.[31] Professional associations are 'front runners' on these issues. This relates to *how* they relate to their profession as front runners. It means they do not start from a position within their environment of membership. Conscious effort is needed to get members involved and interested. It is especially hard to get these members interested in substantive issues, and convince them of the value of policies that deal with (a loss of) autonomy and remuneration. In the case of functional activities, it is mostly abstract and hard to bring down to individual advantages. In the case of political activities, negotiations and lobbying take a long time without many tangible results.

To sum up, professional associations are not naturally strongly connected to their environment of membership. This is related to their position as 'front runners' on (strategic) policy issues. It means they have to put specific efforts in getting members involved and interested.

[31] This is possibly related to the 'layered' character of medical professional associations as described in paragraph 5.1. Within these layers, the KNMG is least related to a specific specialism or organizational context.

6.2. Subquestion 2: Relation to external stakeholders

The way in which professional associations are organized is increasingly fit to achieve connections with other actors. Associational bureaus have professionalized and in some cases, boards are headed by non-medical people. In some other cases, medical board members themselves feel 'front runners' amongst their colleagues. While connections between profession and professional associations are hard to establish (see paragraph 6.1), connections with external stakeholders seem relatively natural. Especially at the level of directors and their bureaus, the circuit in which policy- and decision makers in health care meet is close and well-known. As these actors from different (representative) organizations meet regularly, personal relations are good. Both sides understand the need to cooperate in a complex sector like health care. In a way that some compare to a 'diplomatic service' or a 'polder model', parties that might be seen as competitors or worse cooperate closely to achieve specific and shared public values.

This does not mean their interests always match. Instead, in these contacts, professional associations are still trying to translate the interests of professionals from the medical domain to this 'environment of influence'. Both pragmatically and ideally however, they recognize the need to cooperate instead of conflicts and narrowing their focus to their self-interests. One of the most important differences between these relations and the relations with their profession is that these relations come natural, as they are 'part of the job' in the work of professional associations. In the case of their members, they constantly have to pay attention to these connections, resulting in a constant struggle to remain legitimate and get doctors involved.

In sum, the representative character of medical professional associations is very apparent in their relations with members and external interlocutors. Although this is often hard, they try to relate to the needs of their members. On the other hand however they relate to external interlocutors as these organizations are part of the natural 'habitat' of professional associations in the polder of health care. Their relations are not only necessary to remain a credible interlocutor. Through these contacts, professional associations are also drawn in this environment with its focus on common policy making and the logic that comes with it.

Expectation	Result
Professional associations have to balance their relation with members to represent their interests and their relation with external stakeholders to represent these interests effectively. This will contribute to a focus away from a political role, as they will have to take the influence environment into account.	Limited connection to environment of membership as professional associations see themselves as front runners in relation to 'conservative' members. There is a strong connection with external stakeholders in the environment of influence. These connections are related to a cooperative, specifically non-defensive stance on both substantive as well as policy issues.

6.3. Subquestion 3: Role of medical professional associations

Medical professional associations within Dutch health care are historically quite diverse. The medical profession is fragmented, and this is resembled in the way medical professional associations are organized. There is no single association representing the profession as a whole on all three possible theoretical roles. Historically, different professional associations were seen to have very specific roles. KNMG, for instance, is seen as a symbolic body, externally representing the medical group as a profession. OMS is classically interpreted a political body, looking after the interests of medical specialists. Scientific associations are seen to focus on functional issues, dealing with education, quality assurance and peer control.

The roles of especially the associations representing the medical specialist group have converged in recent years. Political and functional discourses are embraced by all parties. This convergence is related to two other developments. The first is increased specialization within the medical profession. This has led to diversified interests among specific segments of the medical specialist group. Each specialism needs a political body to look after these specific interests. Secondly, due to developments described in chapter two, a solely political role is no longer accepted by external stakeholders. Without a functional focus, there is no legitimate or convincing base to claim autonomy or income.

The symbolic role is not specifically recognized in the discourse of professional associations. One explanation might be that this role is strongly linked to upcoming occupations, which still have to convince others of their professionalism. As the medical profession is one of the most classic examples, there is no need to take up a symbolic role. Also, it is exactly professionalism that has come under scrutiny by critical audiences. On the other hand, some respondents argue that although representing the profession is not specifically addressed, it is always part of what associations do. In this way, it is hard to observe specifically (see also chapter 4).

Answering this subquestion, contemporary medical professional associations are mostly interpreted from a combination of a functional and political discourse. They pursue two main aims: increasing the standing, autonomy and income of professionals themselves on the one hand, and increasing the quality of service delivery on the other. These roles are seen to strengthen each other.

Expectation	Result
Political role due to contemporary pressures of critical audiences. Focus on defending professional interests and staying in control of the professional domain.	Both functional and political role due to developments that led to convergence in these roles among different 'layers' of professional associations. Members demand political focus, external stakeholders demand functional focus.

6.4. Subquestions 4 & 5: Effect of external pressures on professional associations

As I have already observed in chapter two above, three developments in health care and society have changed professional work in important ways. Respondents do indeed recognize the pressures that stem from these contemporary developments in health care. They do not only change professional

work itself however, but also change the work of professional associations. As several 'audiences' (organizational contexts, inspection agencies, health care insurance companies, media et cetera) have taken a more critical stance, demands for these associations have risen. First of all, the classical tasks of professional associations have become more salient to external stakeholders. Setting norms and standards for service delivery, as examples of internal tasks of professional associations within a classical profession, have become more important to other actors as well. Furthermore, in a system of market dynamics, this information is needed for other purposes, for instance in negotiations with health care insurers. Other stakeholders in health care turn for professional associations to organize and guide these substantive tasks.

Next to tasks like these, which have always been in some way related to professional associations, they have to take on new tasks as well. Their input is for instance required in policy making on the financial structure of health care to reduce costs. These new possibilities to spread professional interests create opportunities for professional associations. Simultaneously, the logic of these new 'arenas of influence' poses new pressures for the way they are organized. It urges them to connect to the way external actors think, and gain knowledge on non-medical aspects of health care.

Expectation	Result
Market, organizational and client developments put pressure on professional domain. Critical audiences require professional institutions to deal with this new situation.	Pressures of increasingly critical audiences are recognized within professional associations. They make that the workload for existing tasks grows. Also, professional associations are 'drawn' into new areas of work, which are governed by non-professional logics.

6.5. Subquestion 6: Responses of medical professional associations

The responses of professional associations towards contemporary developments in health care are based on their recognition of the way they have drastically changed the medical domain. New values like transparency, accountability and cost-consciousness are seen to have gained prominence in medical service delivery. Present times demand that these aspects are taken into account more strongly than they have been historically. Respondents argue this means something has to change in the way professionals operate. In their view, societal, political and economic developments force them to. Not only the interests of professionals themselves, but also wider, public values[32] should be central in the work of professional associations.

This recognition of the incentive to change is an important base for the way professional associations respond to these pressures. Instead of focussing on the demands of professionals alone, they have a wider focus that includes solving the challenges health care as a whole is facing today. Confronted with more conservative members, their main challenge is to induce professionals to go along with this new line of reasoning. In some cases, when reforms are supported, professional associations internalize the need for change among their profession. In this case, they are even more than a

[32] See footnote 15 above.

translator between external actors and profession; they have become part of the forces wishing to reform a professional domain. These responses relate closely to the theoretical category of acquiescence.

In other cases, next to their acceptance of the principle argument to change, professional associations try to make sure reforms do not end up in unworkable outcomes. A term that is closely related to this position is ‘coping’. As respondents observe, the need to draft indicators to cater for the external needs of accountability is not questioned or opposed; instead, professional associations strive to ‘make the best out of it’ by streamlining the way these indicators are formulated and reduce red tape in the work of professionals. These responses fall in the theoretical categories of co-optation and negotiation, depending on the extent to which professional associations are involved in the (policy) process.

Expectation	Result
Professional associations will respond by negotiation or strategic adaption to external pressures. Their political role demands them to defend professional interests. The logic of their influence environment prevents them from openly opposing pressures.	Responses range from acquiescence to negotiation. The principle argument for reform to cope with new challenges of health care is realized and incorporated within policies and strategies of professional associations. In many cases, there efforts are directed to ‘coping’ with changes, smoothing their effects on professional work.

6.6. Subquestion 7: Factors explaining these responses

Many classical theories on professionalism have not questioned the link between professions and professional associations. They were seen to be natural extensions of professions, positioned at the heart of their profession and therefore naturally working with ‘the’ interests of their constituents in their mind. As empirical results presented above have shown, this assumption does not fully resemble empirical reality in Dutch health care. Professional associations are ‘front runners’, but not in the way academic authors have thought them to be. They are not objective messengers, externally promoting the opinion and interests of an entire profession. Instead, they are ‘front runners’ in a different sense: they are running in front of their profession in terms of what their interests should be.

Several factors (help to) explain this position. First of all, professional associations are increasingly influenced by the frames and logics of other actors within health care. As respondents argue, professional associations operate within the ‘diplomatic service’ of health care. Also, related to the professionalization of associational bureaus, fuelled by higher demands from external parties, professional associations more closely resemble other actors operating on a similar, representative, level. This has created a ‘policy bias’: less advocacy, more institutionalization within their non-professional ‘environment of influence’.

Also, professional associations struggle to effectively interest professionals for their work. As with many other associations in Dutch society, links between active and board members on one side, and

rank and file members on the other, are hard to establish (e.g. Putnam, 2000; Kuperus, 2007). This results in the absence of countervailing powers (members), which might put pressure on boards and bureaus of professional associations to keep an eye on the interests of the ones they actually represent. This produces a vicious cycle, in which these interests are focussed on even less, leaving medical professionals feeling even less well represented.

Although associations themselves often see the need to change, and try to convince professionals of the same, some aspects of their behaviour are still aimed at making sure these reforms do not put too much pressure on professional work. Reasoning from inside the profession, professional associations are also struggling to gain legitimacy and sufficient input from their members. To achieve this, they have to show they are able to 'deliver' in terms of (material and non-material) interests of professionals: autonomy, status, and income. This position can also be related to the two roles professional associations are taking up. From a functional perspective, in a changing society, it is indeed plausible professionals act in a way that links to the contemporary needs of patients. This means making their actions accountable, being conscious about their costs and taking account of consumer demands. From their political role, they are still inclined to act according to the interests of their members, making sure professionals can enjoy a smooth working process, getting paid a fair share and remain autonomous over their own work.

Table 10 below summarizes factors that this study has found to be of influence on the way medical professional associations respond to external pressures on the professional domain.

Factors explaining responses of professional associations
Flexible to external interests is related to:
- Position close to external stakeholders in the 'diplomatic service' of health care
- Self-identification of front runner; focus on policy discussions; seeing challenges more clearly 'from above'
- Professionalized and expanded associational bureaus
- Absence of (real) counterbalancing power of members due to difficulties in interesting members of the importance of the work of professional associations
Limited acquiescence with external interests is related to:
- Position within professional domain shows them where new policies break down in practical implementation in professional work
- (Historical) connection with professional work in associational boards and in aims/identity professional associations

Table 10: Summary of factors explaining responses of professional associations

7. Conclusion

The first chapter of this report has introduced the main question this study set out to address. Academic authors and professional associations have set them(selves) important aims as essential institutions for their profession: they are seen as front runners of professionalism, a banner around which professionals will rally. Some contemporary signs indicate however that this assumption might be overstretched. Especially because limited academic or practical attention has been paid to the subject, this study has set out to answer the following question:

How do medical professional associations respond to contemporary pressures in health care, and what factors explain these responses?

Both organizational, market and client pressures present contemporary medical professional associations with a common challenge: how to deal with ever more critical audiences, posing new demands to be transparent, accountable, have an eye to patients' wishes and be cost-conscious. The medical domain is no longer naturally and predominantly the domain of doctors. Governmental inspection, health care insurance companies, patient organizations, policy makers and hospital management, let alone patients themselves, all demand insights and influence into their work and the way professional institutions organize it.

This study has shown that professional associations are positioned not at the centre of a profession, but at its borders. Contemporary demands from (external) critical audiences change their focus: from internal issues within the profession to primarily external subjects related to the way health care is organized. Both by getting involved in new (external) policy debates, and by increased scrutiny of medical service delivery professional associations and their bureaus are drawn into a logic of policy discussions in health care. Simultaneously, this drifts them away from the interests of their own members. The logic of being a representative organization, dealing both with an environment of external interlocutors and with an internal environment of members and their interests, is clearly recognizable. Increasingly, the external environment is the most natural environment for professional associations. This makes it harder for them to connect to members and their interests.

This position is recognized in the responses of professional associations towards the pressures described above. Associations realize the need to reform and help achieve demands for transparency, accountability and cost-consciousness. This relates to a functional discourse, focusing on improving medical service delivery, and to their relations with other policy- and decision makers in what respondents have called the 'diplomatic service' of health care. Although professional associations agree with the principle argument to reform, there are elements in their responses that still resemble a political discourse as representatives of specific professional interests of autonomy and self-governance. In coping with reforms, their efforts are directed at making sure new policies result in workable outcomes for their members. This can be observed in translating new external demands to the work of professionals, keeping them out of the line of fire as much as possible.

In sum, contemporary medical professional associations are front runners, but in a different way than academic authors believe them to be. Based on the results of this study, medical professional associations are not positioned at the centre of their profession. Instead, they are front runners in connecting their profession to external policy debates. In this way they try to relate to a changing health care in a changing society. They are not operating as conservative forces making sure no harm is done to professional autonomy. Professional associations try to remake professionals to be able to face the challenges they will meet in the future.

8. Implications

This last chapter will focus on the value of the outcomes of this study in terms of both societal and academic debates on professionalism and professional associations. These insights help to evaluate whether this study has achieved the aims that were set in the beginning. Firstly, I will go into the implications of the results presented in the previous chapters. In doing so, this section will focus on both academic and practical debates. Secondly, I will deal with the (practical) use of the results of this study to other sectors and professions. The third paragraph focusses on (a possible) future of medical professional associations.

8.1. Implications for research and praxis

The outcomes of this study present some new findings that add to our knowledge of contemporary professional associations. This section focuses on what these insights mean for both praxis and academic research and theories on (the position of) professional associations within professional domains in public sectors, and what new questions they raise.

8.1.1. Implications for academic research and theories

This study has aimed to fill a gap in research and knowledge on the behaviour of professional associations, as paragraph 1.4 has pointed out. Although they are often seen as 'essential' parts of an ideal-typical profession, only a few studies have been directed to their specific role, position and behaviour (see Greenwood et al., 2002; Willmott, 1986). This limited academic interest is resembled in the available academic knowledge. In most cases, professional associations have functioned as a 'case' within research that focussed on specific theory testing or building (e.g. Greenwood et al., 2002). Also within the context of theories on professionalism, the position of professional associations is often assumed to be 'essential'. This position is only limitedly scrutinized however. Abbott (1988) and Freidson (2001) are prominent examples of theory building in this respect. The important question of finding out whether these theories hold in changing, contemporary context has not been posed in the case of professional associations (see Evetts, 2003). Especially in these 'ambiguous' times (Noordegraaf, 2007), a specific focus on these institutions can contribute to our knowledge of (changing) professional domains. This study has taken up this subject by focussing on the consequences of contemporary developments on the organization of professional work, and on the development of professional institutions themselves.

Empirically, the results of this study can be extended and deepened by more specific and focused research. It can be useful to deepen these (exploratory) insights by focusing on one specific association in an in-depth case study. In this way, it is better possible to focus on specific ways in which an association tries to balance their internal and external environment of members on the one side and interlocutors on the other. Exploring several of these cases and focusing on these differences might be useful, as this study showed there are differences in historical development of these associations. This research has mainly focused on recurrent themes among different 'types' of professional associations. The diversity of medical professional associations suggests each will have

to deal with specific challenges. Also, in this study, the insights of members of professional associations have been omitted to a certain extent. A more specific case study is able to combine several data collection methods, both quantitative and qualitative. Thereby, it can act to evaluate the exploratory results of this study in a specific context. In this way, it would contribute to the results of this study and to our understanding of specific ways in which professional associations cope with their position in between professional and external stakeholders and their difficulties in binding members.

This study has also raised some new insights on theoretical questions. One of the aims of this study has been to contribute to the academic debate on whether professional domains are ‘under pressure’ by other actors (Gleeson & Knights, 2006) or whether these theoretical tensions are being bridged by professional institutions, establishing ‘new’, dynamic and relational forms of professionalism (Noordegraaf, 2007; Evetts, 2009; see also paragraph 3.3.1).

This study has shown that professional associations are important driving forces in connecting the medical domain with other values and logics. More so than professionals themselves, they oversee larger challenges in public sectors, and try to find ways to balance professional interests with overarching interests of other actors. The defensive, political aspects of their work are directed at coping with contemporary developments like transparency, accountability and cost-consciousness, not to question them. In themselves, these pressures are not questioned and sometimes even welcomed. This suggests that, although professional domains are ‘under pressure’, these pressures do not result in a fight over autonomy due to dichotomous and incompatible forces. Instead, in this new, (arguably) more demanding environment, professional institutions accept this new reality and try to ‘remake’ their professionals to be able to cope with and be effective under these new demands (see Noordegraaf, 2011a). This does not mean they promote a defensive stance, trying to gear up their members for a harder fight over autonomy. It means they reconfigure what it means to be a ‘good’ professional, in cooperation with other stakeholders, promoting this ‘new’ professionalism among their members. This study suggests that professional associations are taking a pivotal role in transforming medical practitioners. In this way, the results presented in this report can be seen as support for perspectives on professionalism that focus on new forms of professionalism that develop when professional domains encounter changing environments, in which their position is no longer taken for granted.

Still, these insights also raise questions themselves, especially in terms of the stance of professionals vis-à-vis contemporary pressures. Although this study has shed light on the position of professional associations, it also found that these institutions view their constituents as relatively ‘conservative’ and less inclined to change. The establishment of new associations, more directly seen to relate to classical professional interests of autonomy and self-governance (see paragraph 5.5.1) can be seen as an illustration of this. A consequence might be that, although professional associations are inclined to change, professionals themselves are not. This insight points to a possible paradoxical situation: the behavior of professional associations can be understood by theories that focus on new connections and developing relational forms of professionalism (e.g. Noordegraaf, 2011a). On the other hand, behavior of professionals themselves links more closely to classical theories that focus on dichotomies

between professional and other logics (e.g. Van den Brink et al., 2005). More research is needed to explore the implications of this, and to focus on possible consequences of these differences.

8.1.2. Implications for praxis and associational governance

The insights of this study can also help professional associations to make sense of their environment and its consequences for their policies and strategic direction. The most important challenge for professional associations today is to be able to both get to know what the interests of their members are, and to translate them effectively to external interlocutors. Some specific points can be derived from this insight. First of all, these results show it is important for professional associations to keep in touch with the professionals they represent. This study demonstrates that the relation between association and profession cannot be taken for granted. Even more so, as professional associations are increasingly part of a close network of external stakeholders, this task has consequently become both more important and more difficult. As some associations have started, a way out is to consciously organize these connections. When normal channels of participation and information do not work out, new, more effective configurations have to be created. A good example is a kind of 'parliament' or council of members that have committed to their representative task and can represent their less well-informed colleagues.

A second aspect that can help associations stems from their intermediary function. As this study shows, this position is a reality associations have to deal with. A focus on (promoting the interests of) their profession alone is no longer tenable. Within a context of higher demands and critical audiences, it has specific advantages to be able to make a translation between the profession and its surroundings. In the eyes of their members, professional associations might still be seen as organizations that have to focus on advocating professional interests (see paragraph 8.1.1, as future research on this subject is important). This study suggests that it is important for professional associations to be open about their intermediary position, and communicate explicitly about the benefits for health care as well as for medical practitioners. Balancing these two 'logics' means taking an independent position that makes it possible to gain space to be effective both ways.

8.2. Medical and other professional associations

This study has focused specifically on *medical* professional associations. The medical profession is indeed often seen as one of (or even) the most classic profession (Wilensky, 1964; Freidson, 2001; Trappenburg, 2011). Longstanding professional associations exist for other professions like lawyers as well. In recent years, many other occupations have also created their own associations (see for instance, Van der Meulen, 2009). It might be that the findings of this study have something to say about the associations of other occupations and professions as well.

On the one hand, the in-between position of medical professional associations is something that can be expected to affect all professional associations. This 'type' of organization always has to deal with their own member base, as well as with an external environment of stakeholders and interlocutors. Because of this, professional associations will have to find ways to keep connected with their

constituents when they take up new activities, professionalize and gain a stronger position within 'diplomatic services' in their sectors.

On the other hand, the specific (health care) context is also very important, as the analysis in this study shows. Health care poses specific pressures that have changed the environment for medical professional associations. The mix of governance arrangements in health care (see chapter 2) is an important part of this specific puzzle, as are developments in medical service delivery and medical professions. Next to this, chapter five has shown the medical profession is special in its layered and fragmented representative structure. This is also an important part of the analyses presented in this study.

In sum, although some principle mechanisms can be expected to be the same for every professional association, it is important to take into account the specific context to know how these mechanisms will play out. In health care, pressures on professional work, combined with extensive and well-developed networks between stakeholders are important in explaining the responses of professional associations and the roles they have taken on. Specific contexts in other sectors might influence associations to respond differently. This study has shown however that the intermediary character of professional associations, as front runners in a direction towards cooperation and tackling common challenges, is something to learn from in other contexts as well.

8.3. Medical professional associations in the future

Part of this study has been to describe recent developments in the organization and behavior of medical professional associations. As we have seen, a shift from a focus on the professional domain itself to a focus on health care as a whole can be observed in recent years. Not only the profession and medical service delivery, but external stakeholders and other aspects of the health care sector are becoming increasingly important parts of the work of professional associations. They have grown in size to be able to cope with growing external demands for their knowledge and input.

Some pessimistic voices about the future of professional associations can be heard. As they struggle to connect to and represent their members, their 'use' might decrease. Their position within health care is closely related to their ability to represent medical professionals. This is put to use by contributing to policy and decision making having a mandate from these professionals. An expectation can be made that, as this relation is decreased, both by a decreasing member base and a less natural relation of profession and association, other actors might be less inclined to invite professional associations to negotiating tables. In other words, their value as an interlocutor might decrease. Another development that is linked to such an expectation is the increased organizational capture of professionals that also limits the importance of professional associations in the work of professionals.

From a more positive view, we might also expect that professional associations will become an even more important part of the health care sector. Respondents, both inside and outside associations, are positive about the role they have to play in the future. Some argue contemporary medical professional

associations will integrate and cooperate more closely. This might result in them becoming an even stronger interlocutor to make sure policy debates take into account professional values. Others argue that there will be no place left for associations that are solely focused on material interests. As the challenges for health care grow, they argue it will take the combined efforts of all stakeholders to make sure the public values of affordability, accessibility and quality are maintained. The challenge for medical professional associations will lie in convincing stakeholders of the value of well-trained and professionally capable medical doctors, and in convincing professionals to be open to other interests and challenges. When they achieve this, they might end up holding the key (position) to a health care sector that is capable of enduring challenges of the future.

Literature

Aa, W. van der & T. Elfring (2003). *Management van dienstverlenende bedrijven*. Den Haag: Academic Service

Abbott, A. (1988). *The System of Professions. An Essay on the Division of Expert Labor.* Chicago/London: The University of Chicago Press

Ackroyd, S., I. Kirckpatrick & R. Walker (2007). 'Public Management Reform in the UK and Its Consequences for Professional Organization: a Comparative Analysis', in: *Public Administration*, vol. 85:1, pp. 9-26

Akers, R.L. (1968). 'The Professional Association and the Legal Regulation of Practice', in: *Law & Society Review*, vol. 2:3, pp. 263-282

Baggerman, S., O. Dutilh, G. Groeneveld, A. Maas-van 't Hof, A. Rabarison & S. Scheeringa (2011). *Voor de goede Orde. Een onderzoek naar het dynamische krachtenveld van de zorg en de rol die de Orde van Medisch Specialisten hierin kan vervullen*. Den Haag: NSOB

Baker, C. & G. Johnson (1998). 'Interview Talk as Professional Practice', in: *Language and Education*, vol. 12:4, pp. 229-242

Bal, R.L. (2008). *De nieuwe zichtbaarheid. Sturing in tijden van marktwerking. Oratie aan de Erasmus Universiteit Rotterdam, 29 februari 2008*. Rotterdam: EUR

Bennett, R. (1999). 'Explaining the Membership of Sectoral Business Associations', in: *Environment and Planning*, vol. 31, pp. 877-898

Berg, M., Y. Meijerink, M. Gras, A. Goossensen, W. Schellekens, J. Haeck, M. Kallewaard & H. Kingma (2005). 'Feasibility First: Developing Public Performance Indicators on Patient Safety and Clinical Effectiveness for Dutch Hospitals', in: *Health Policy*, vol. 75, pp. 59-73

Birkett, W.P. & E. Evans (2005). 'Theorizing Professionalization: A Model for Organizing and Understanding Histories of the Professionalization Activities of Occupational Associations of Accountants', in: *Accounting History*, vol. 10:1, pp. 99-127

Boeije, H. (2010). *Analysis in Qualitative Research*. London: Sage

Brink, G. van den, T. Jansen & D. Pressers (2005). *Beroepszeer. Waarom Nederland niet goed werkt.* Amsterdam: Boom

Brint, S. (1994). *In an Age of Experts. The Changing Role of Professionals in Politics and Public Life.* Princeton: Princeton University Press

Brock, D. (2006). ‘The Changing Professional Organization: A Review of Competing Archetypes’, in: *International Journal of Management Reviews*, vol. 8:3, pp. 157-174

Broom, A., J. Adams & P. Tovey (2009). ‘Evidence-based Healthcare in Practice: A Study of Clinician Resistance, Professional De-skilling and Inter-Specialty Differentiation in Oncology’, in: *Social Science & Medicine,* vol. 68:1, pp. 192-200

Bucher, R. & A. Strauss (1961). ‘Professions in Process’, in: *American Journal of Sociology*, vol. 66:4, pp. 325-334

Buntinx, W.H.E. & A. Th. G. van Gennep (2007). *Professionaliteit van hulpverleners aan mensen met verstandelijke beperkingen*. Apeldoorn: Garant

Burrage, M., K. Jarausch & H. Siegrist (1990). ‘An Actor-Based Framework for the Study of the Professions’, in: Burrage, M. & R. Thorstendahl (eds). *Professions in Theory and History. Rethinking the Study of the Professions.* London: Sage, pp. 203-225

Burrage, M. & R. Thorstendahl (1990). *Professions in Theory and History. Rethinking the Study of the Professions*. London: Sage

Carr-Saunders, A.M. (1928). *Professions. Their organization and Place in Society*. *Herbert Spencer Lecture*. Oxford: Clarendon Press

Casile, M. & A. Davis-Blake (2002). ‘When Accreditation Standards Change. Factors Affecting Differential Responsiveness of Public and Private Organizations’, in: *Academy of Management Journal*, vol. 45:1, pp. 180-195

Causer, G. & M. Exworthy (1999). ‘Professionals as Managers Across the Public Sector’, in: M. Exworthy & S. Halford (eds). *Professionals and the New Managerialism in the Public Sector*, pp. 83-101

Dwarswaard, J., M. Hilhorst & M. Trappenburg (2011). ‘The Doctor and the Market. About the Influence of Market Reforms on the Professonal Medical Ethics of Surgeons and General Practitioners in The Netherlands’, in: *Health Care Analysis*, vol. 19:4, pp. 388-402

Etzioni, A. (1969). *The Semi-Professions and Their Organization.* New York: The Free Press

Evetts, J. (2003). ‘The Sociological Analysis of Professionalism: Occupational Change in the Modern World’, in: *International Sociology,* vol. 18:2, pp. 395-415

Evetts, J. (2006). ‘Introduction: Trust and Professionalism: Challenges and Occupational Changes’, in: *Current Sociology*, vol. 54:4, pp. 515-531

Evetts, J. (2009). 'New Professionalism and New Public Management. Changes, Continuities and Consequences', in: *Comparative Sociology*, vol. 8:2, pp. 247-266

Evetts, J. (2010). 'Organizational Professionalism. Changes, challenges and opportunities', *DPU Conference Paper,* 20 October 2010

Flyvbjerg, B. (2001). *Making Social Science Matter. Why Social Inquiry Fails and How it Can Succeed Again*. Cambridge: Cambridge University Press

Freidson, E. (1970). *Profession of Medicine. A Study in the Sociology of Applied Knowledge*. New York: Harper & Row

Freidson, E. (2001). *Professionalism. The Third Logic*. Cambridge: Polity Press

Friedman, A. & M. Phillips (2004). 'Continuing Professional Development: Developing A Vision', in: *Journal of Education and Work,* vol. 17:3, pp. 361-376

Gilb, C.L. (1966). *Hidden Hierarchies; The Professions and Government*. New York: Harper and Row

Gleeson, D. & D. Knights (2006). 'Challenging Dualism: Public Professionalism in 'Troubled' Times', in: *Sociology*, vol. 40:2, pp. 277-295

Greenwood, R., R. Suddaby & C.R. Hinings (2002). 'Theorizing Change: The Role of Professional Associations in the Transformation of Institutionalized Fields', in: *Academy of Management Journal*, vol. 45:1, pp. 58-80

Groenewegen, P.P. & J. Hansen (2007). *Professies en de toekomst. Veranderende verhoudingen in de gezondheidszorg*. Utrecht: Springer Uitgeverij

Hardey, M. (1999). 'Doctor in the House. The Internet as a Source of Lay Health Knowledge and the Challenge to Expertise', in: *Sociology of Health & Illness,* vol. 21:6, pp. 820-835

Harrison, S. & W. Ahmad (2000). 'Medical Autonomy and the UK State 1975 to 2005', in: *Sociology*, vol. 34:1, pp. 129-146

Helderman, J.K. (2007). *Bringing the Market Back In? Institutional Complementarity and Hierarchy in Dutch Housing and Health Care*. PhD dissertation. Rotterdam: EUR

Hoek, H. (2007). *Governance & Gezondheidszorg. Private, publieke en professionele invloeden op zorgaanbieders in Nederland.* Rotterdam: EUR

Holleman, G., A. Eliens, M. van Vliet & T. van Achterberg (2006). 'Promotion of Evidence-Based Practice by Professional Nursing Associations: Literature Review', in: *Journal of Advanced Nursing*, vol. 53:6, pp. 702-709

Hood, C. (1991). ‘A Public Management for All Seasons?’, in: *Public Administration*, vol. 19:1, pp. 3-19

Karseth, B. & M. Nerland (2007). ‘Building Professionalism in a Knowledge Society. Examining Discourses of Knowledge in Four Professional Associations’, in: *Journal of Education and Work*, vol. 20:4, pp. 335-355

Killbane, S.C. & J.H. Beck (1990). ‘Professional Associations and the Free Rider Problem: the Case of Optometry’, in: *Public Choice*, vol. 65, pp. 181-187

Kloss, L. (1999). ‘The Suitability and Application of Scenario Planning for National Professional Associations’, in: *Nonprofit Management and Leadership*, vol. 10:1, pp. 71-83

Kuperus, M. (2007). *De vereniging op survival. Overlevingsstrategieën voor hedendaagse verenigingen.* Utrecht: MOVISIE

Larson, M.L. (1977). *The Rise of Professionalism. A Sociological Analysis*. Berkeley: University of California Press

Leicht, K.T. & M.L. Fennell (1997). ‘The Changing Organizational Context of Professional Work’, in: *Annual Review of Sociology*, vol. 23:1, pp. 215-231

Merton, R.K. (1958). ‘The Functions of the Professional Association’, in: *The American Journal of Nursing*, vol. 58:1, pp. 50-54

Meulen, M.J. van der (2009). *Achter de schermen. Vakontwikkeling en professionalisering van publieke managers in de zorg en bij de politie.* Delft: Eburon

Meyer, J.W. & W.R. Scott (eds). *Organizational Environments. Ritual and Rationality*. London: Sage

Millerson, G. (1964). *The Qualifying Associations. A Study of Professionalization*. London: Routledge and Kegan Paul

Morgan, G. & L. Smircich (1980). ‘The Case for Qualitative Research’, in: *Academy of Management Review*, vol. 5:4, pp. 491-500

Nachmias, C. & D. Nachmias (1992). *Research Methods in the Social Sciences*. London: Arnold

Nationale Denktank (2010). *Zelf Vertrouwen. Adviezen aan publieke organisaties om de vertrouwensrelatie met burgers te verbeteren.* Amsterdam: Stichting Nationale Denktank

NIVEL (2009). *Evaluatie Wet Marktordening Gezondheidszorg.* Den Haag: ZonMw

Noordegraaf, M. & T. Abma (2003). ‘Management by Measurement? Public Management Practices amidst Ambiquity’, in: *Public Administration*, vol. 81:4, pp. 853-871

Noordegraaf, M. (2007). ‘From ‘Pure’ to ‘Hybrid’ Professionalism. Present-day Professionalism in Ambiguous Public Domains’, in: *Administration & Society*, vol. 39:6, pp. 761-785

Noordegraaf, M. & M. van der Meulen (2008). ‘Professional Power Play: Organizing Management in Health Care’, in: *Public Administration*, vol. 86:4, pp. 1055-1069

Noordegraaf, M. & W. Schinkel (2010). ‘Professional Capital Contested: A Bourdieusian Analysis of Conflicts between Professionals and Managers’, in: *Comparative Sociology*, vol. 10:1, pp. 1-29

Noordegraaf, M. (2011a). ‘Remaking Professionals? How Associations and Professional Education Connect Professionalism and Organizations’, in: *Current Sociology*, vol. 59:4, pp. 465-488

Noordegraaf, M. (2011b). ‘Risky Business. How Professionals and Professional Fields (Must) Deal with Organizational Issues’, in: *Organization Studies*, vol. 32:10, pp. 1349-1371

Numerato, D., D. Salvatore & G. Fattore (2011). ‘The Impact of Management on Medical Professionalism: A Review’, in: *Sociology of Health & Illness*, vol. 34:4, pp. 626-644

Oliver, C. (1991). ‘Strategic Responses to Institutional Processes’, in: *Academy of Management Review*, vol. 16, pp. 145-179

Oliver, A. (1997). ‘On the Nexus of Organizations and Professions: Networking through Trust’, in: *Sociological Inquiry,* vol. 67:2, pp. 227-245

Plsek, P.E. & T. Greenhalgh (2001). ‘The Challenge of Complexity in Health Care’, in: *British Medical Journal,* vol. 323:7313, pp. 625-628

Plochg, T, N.S. Klazinga & B. Starfield (2009). ‘Transforming Medical Professionalism to Fit Changing Health Needs’, in: *BMC Medicine,* vol. 7:64, pp. 1-7

Pollitt, C. & G. Bouckaert (2004). *Public Management Reform. A Comparative Analysis*. Oxford: Oxford University Press

Pollitt, C., S. Harrison, G. Dowswell, S. Jerak-Zuiderent & R. Bal (2010). ‘Performance Regimes in Health Care: Institutions, Critical Junctures and the Logic of Escalation in England and the Netherlands’, in: *Evaluation,* vol. 16:1, pp. 13-29

Powell, M.J., D.M. Brock & C.R. Hinings (1999). ‘The Changing Professional Organization’, in: D.M. Brock, C.R. Hinings & M.J. Powell (eds). *Restructuring the Professional Organization*. London: Routledge, pp. 1-19

Putnam, R.D. (2000). *Bowling Alone. The Collapse and Revival of American Community*. New York: Simon & Schuster

Putters, K. (2009). *Besturen met duivelselastiek. Oratie aan de Erasmus Universiteit Rotterdam*. Rotterdam: EUR

Raad voor de Volksgezondheid en Zorg (2004). *De Staat van het Stelsel: Achtergrondstudies*. Zoetermeer: RVZ

Raad voor de Volksgezondheid en Zorg (2009). *Governance en kwaliteit van zorg*. Den Haag: RVZ

Sanders, F. (2006). 'Zorgprofessionals en de markt', in: *Bestuurskunde*, vol. 2006:2, pp. 15-24.

Schmitter, Ph. C. & W. Streeck (1999). *The Organization of Business Interests*. Cologne: Max Planck Institute (discussion paper 99/1)

Scott, W.R. (2008). 'Lords of the Dance. Professionals as Institutional Agents', in: *Organization Studies*, vol. 29:2, pp. 219-238

Sociaal en Cultureel Planbureau (2004a). *Sociaal en Cultureel Rapport 2004*. Den Haag: SCP

Sociaal en Cultureel Planbureau (2004b). *Vertrouwen in de rechtspraak*. Den Haag: SCP

Stebbins, R.A. (2001). *Exploratory Research in the Social Sciences.* Thousand Oaks: Sage

Streeck, W. & L. Kenworthy (2005). 'Theories and Practices of Neo-Corporatism', in: T. Janoski et al. (eds). *A Handbook of Political Sociology: States, Civil Societies and Globalization*. New York: Cambridge University Press, pp. 441-460

Svensson, L.G. (2006). 'New Professionalism, Trust and Competence: Some Conceptual Remarks and Empirical Data', in: *Current Sociology*, vol. 54:4, pp. 579-593

Swann, M, D. McIntyre, T. Pell, L. Hargreaves & M. Cunningham (2010). 'Teachers' Conceptions of Teacher Professionalism in 2003 and 2006', in: *British Educational Research Journal*, vol. 36:4, pp. 549-571

Talbot, C. (2005). 'Performance Management', in: E. Ferlie, L.E. Lynn & C. Pollitt (eds) *The Oxford Handbook of Public Management*, pp. 491-520

Thiel, S. van (2007). *Bestuurskundig onderzoek. Een methodologische inleiding*. Bussum: Coutinho

Tonkens, E. (2008). *Herwaardering van professionals; maar hoe? Verslag van de zesde Rob-lezing,* downloaden from http://www.rob-rfv.nl/GetFile.aspx?id=688, 10 May 2011

Tonkiss, F. (2004). 'Analyzing Text and Speech: Content and Discourse Analyses, in: C. Seale (ed). *Researching Society and Culture.* London, Sage, pp. 367-382

Trappenburg, M. (2007). 'De huisarts vanuit patiëntenperspectief', in: *Huisarts en Wetenschap*, vol. 50, pp. 91-94

Trappenburg, M. (2011). 'Managers en Professionals', in: M. Noordegraaf, K. Geuijen & A. Meijer (eds). *Handboek Publiek Management.* Den Haag: Boom Lemma, pp. 165-190

Tummers, L. & N. Karsten (2011). 'Reflecting on the Role of Literature in Qualitative Public Administration Research: Learning from Grounded Theory', in: *Administration & Society*, vol. 20:10, pp. 1 -23

Volksgezondheid, Welzijn en Sport, Ministerie van (2003). *Beleidsagenda 2004. Keuzes voor een houdbare en beter presterende zorg.* Den Haag: Ministerie van VWS

Wallace, J. (1995). 'Organizational and Professional Commitment in Professional and Nonprofessional Organizations', in: *Administrative Science Quarterly*, vol. 40:2, pp. 228-255

Waring, J. & G. Curie (2009). 'Managing Expert Knowledge: Organizational Challenges and Managerial Futures for the UK Medical Profession', in: *Organization Studies*, vol. 30:7, pp. 755-778

Watkins, J., L. Drury & S. Bray (1996). *The Future of UK Professional Associations.* Bristol: Bristol University

Watkins, J. (1999). 'UK Professional Associations and Continuing Professional Development: a New Direction', in: *International Journal of Lifelong Education*, vol. 18:1, pp. 61-75

Wilensky, H.L. (1964). 'The Professionalization of Everyone?', in: *The American Journal of Sociology*, vol. 70:2, pp. 137-158

Willmott, H. (1986). 'Organizing the Profession. A Theoretical and Historical Examination of the Development of the Major Accountancy Bodies in the UK', in: *Accounting, Organizations and Society*, vol. 11:6, pp. 555-580

Appendix I: Topic list for respondents of professional associations[33]

Introductie en biografisch

- Introductie mijzelf en onderzoek
- Reden voor benaderen voor interview
- Opname en anonimiteit
- Positie en verantwoordelijkheden
- Opleiding en carrière
- Keuze voor werken bij beroepsvereniging
- Persoonlijke doelen in het werk

Verenigings-/ en organisatieprofiel

- Visie en centrale waarden
- Leden en beroepsgroep
- Belangrijkste activiteiten
- Organisatievorm en verenigingsstructuur
- Relaties met andere actoren
- Relatie met beroepsgroep
- Relaties met andere beroepsverenigingen

Rolprofiel

- Herkenning functionele rol en activiteiten(focus)
- Herkenning politieke rol en activiteiten(focus)
- Herkenning symbolische rol en activiteiten(focus)
- Verschuivingen en ontwikkelingen in rol

Omgevingsprofiel

- Perceptie belangrijkste ontwikkelingen
- Druk vanuit organisatie voor professionals
    - Effect op professioneel werk
    - Effect op werk van beroepsvereniging
- Druk vanuit systeem van gereguleerde marktwerking
    - Effect op professioneel werk
    - Effect op werk van beroepsvereniging
- Druk vanuit veranderende cliënten
    - Effect op professioneel werk
    - Effect op werk van beroepsvereniging
- Veranderingen ten opzichte van ‘vroeger’

Strategisch profiel

- Inspelen op ontwikkelingen
    - Keuzeproces en strategievorming
    - Factoren die keuze bepalen
    - Rol achterban
- Samenwerking met andere partijen
- Belang van veranderen in veranderende omgeving
- Reactie op ontwikkelingen

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[33] Topic lists were drafted in Dutch, as all interviews have been conducted in Dutch as well.

Afsluiting

- Overige punten van belang voor onderzoek
- Overige punten over vereniging
- Procesafspraken
- Bedanken

Appendix II: Topic list for respondents of other actors in health care

Introductie en biografisch

- Introductie mijzelf en onderzoek
- Reden voor benaderen voor interview
- Opname en anonimiteit
- Positie en verantwoordelijkheden
- Opleiding en carrière
- Keuze voor werken bij organisatie
- Persoonlijke doelen in het werk

Relatie met beroepsverenigingen

- Contacten met beroepsverenigingen
  - Welke verenigingen
  - Welke contacten
- Relaties met beroepsverenigingen
  - Vorm van samenwerking
  - Functie en belang
  - Sfeer en verloop
- Ontwikkelingen in samenwerking

Verenigings-/ en organisatieprofiel

- Visie en centrale waarden
- Leden en beroepsgroep
- Belangrijkste activiteiten
- Organisatievorm en verenigingsstructuur
- Relaties met andere actoren
- Relatie met beroepsgroep
- Relaties met andere beroepsverenigingen

Rolprofiel

- Herkenning functionele rol en activiteiten(focus)
- Herkenning politieke rol en activiteiten(focus)
- Herkenning symbolische rol en activiteiten(focus)
- Verschuivingen en ontwikkelingen in rol

Omgevingsprofiel

- Perceptie belangrijkste ontwikkelingen
- Druk vanuit organisatie voor professionals
  - Effect op professioneel werk
  - Effect op werk van beroepsvereniging
- Druk vanuit systeem van gereguleerde marktwerking
  - Effect op professioneel werk
  - Effect op werk van beroepsvereniging
- Druk vanuit veranderende cliënten
  - Effect op professioneel werk
  - Effect op werk van beroepsvereniging
- Veranderingen ten opzichte van ‘vroeger’

Strategisch profiel

- Inspelen op ontwikkelingen

    - Keuzeproces en strategievorming
    - Factoren die keuze bepalen
    - Rol achterban
- Samenwerking met andere partijen
- Belang van veranderen in veranderende omgeving
- Reactie op ontwikkelingen

Afsluiting

- Overige punten van belang voor onderzoek
- Overige punten over organisatie
- Procesafspraken
- Bedanken

Appendix III: Coding tree from NVIVO

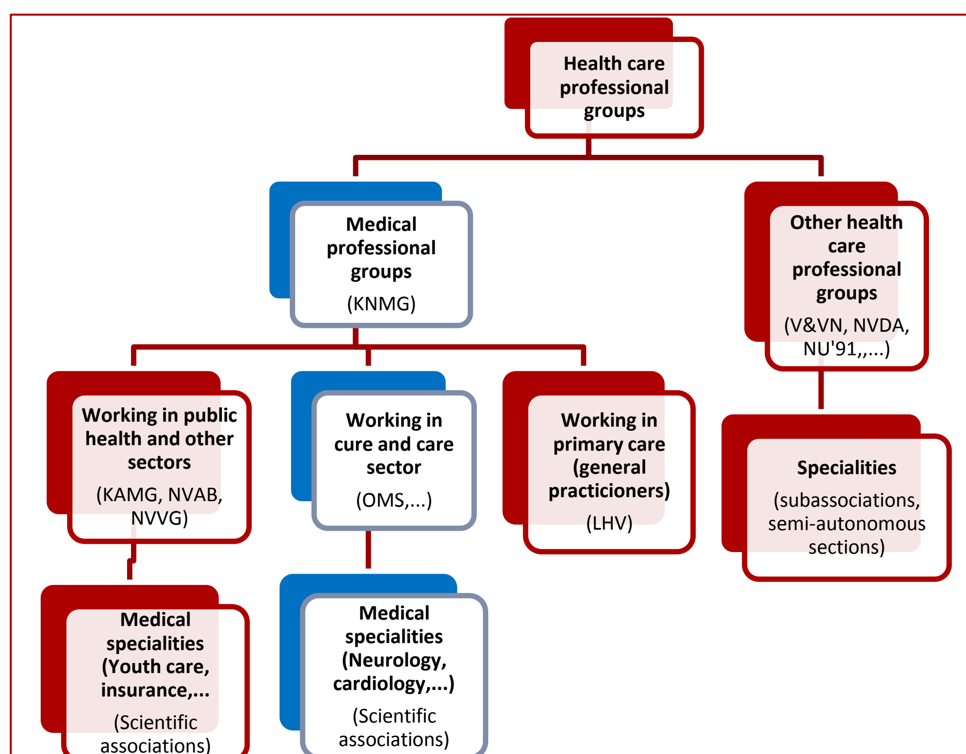
- **Professional association profile**
    - Role of professional association
        - Functional role
        - Political role
        - Symbolic role
        - Changes and development in role
        - Convergence in roles
    - Activities and *modus operandi*
    - Development of professional association
    - Position within health care sector
    - Relation to its profession
        - Image of the profession
        - Frontrunner or rear-guard
    - Relation to other profession(al associations)
    - Relation to other stakeholders
    - Organizational structure
        - Membership structure
        - Structure and staffing of associational bureau
        - Sub-associations and commissions

- **Developments and pressures**
    - Client pressures
    - Organizational pressures
    - Market pressures
    - Other relevant development
        - Developments within the profession

- **Responses of professional associations**
    - Acquiescence
    - Co-optation
    - Negotiation
    - Strategic adaptation
    - Manipulation

    - Connecting to other logics
    - Defending to other logics

Appendix IV: Medical professional associations in Dutch health care



Professional association	Profession	Established in..	Member base[34]	Website
Umbrella organization				
Koninklijke Nederlandse Maatschappij ter bevordering der Geneeskunst (KNMG)	Medical profession as a whole	1849	Federation of seven associations, representing 53.000 doctors	www.knmg.nl
Federation partners				
Orde van Medisch Specialisten (OMS)	Medical specialists	1996	11.000	www.orde.nl
Koepel Artsen Maatschappij en Gezondheid (KAMG)	Artsen Maatschappij en Gezondheid (M&G)	2001	Federation of nine associations	www.kamg.nl
Landelijke vereniging Artsen in Dienstverband (LAD)	Artsen in dienstverband	1948	13.000	www.lad.artsennet.nl
Landelijke Huisartsen Vereniging (LHV)	General practitioners	1946	11.000	www.lhv.artsennet.nl
Nederlandse vereniging voor Arbeids- en Bedrijfsgeneeskunde (NVAB)	Company doctors	1953	2.000	www.nvab.artsennet.nl
Nederlandse Vereniging van Verzekeringsgeneeskunde	Insurance doctors	1969	600	www.nvvg.nl

[34] The member base was either found on the websites of professional associations themselves, or asked directly by email in June and July 2012.

(NVVG)				
Vereniging Specialisten Ouderengeneeskunde (Verenso)	*Specialisten ouderengeneeskunde*	+/- 1972	1500	www.verenso.nl
Scientific associations[35]				
Nederlandse Vereniging van Allergologie (NVvA)	Allergology	1948	259	www.nvva-allergologie.nl
Nederlandse Vereniging voor Anesthesiologie (NVA)	Anaesthesiology	1948	2200	www.anesthesiologie.nl
Nederlandse Vereniging voor Cardiologie (NVVC)	Cardiology	1934	1500	www.nvvc.nl
Nederlandse Vereniging voor Dermatologie en Venereologie (NVDV)	Dermatology and venereology	1896	624	www.huidarts.info
Nederlandse Vereniging voor Heelkunde (NVvH)	Surgery	1902	2000	www.heelkunde.nl
Nederlandse Internisten Vereniging (NIV)	Internal medicine	1931	3000	www.internisten.nl
Nederlandse Vereniging voor Keel-, Neus- en Oorheelkunde en heelkunde van het hoofd-halsgebied (KNO)	Otorhinolaryngology	1893	596	www.kno.nl
Nederlandse Vereniging voor Kindergeneeskunde (NVK)	Paediatrics	1888	2150	www.nvk.nl
Nederlandse Vereniging voor Klinische Geriatrie (NVKG)	Clinical geriatrics	1999	319	www.nvkg.nl
Vereniging Artsen Laboratoriumdiagnostiek (VAL)	Laboratory medicine	1992	18	www.labarts.nl
Vereniging Klinische Genetica Nederland (VKGN)	Clinical genetics	1988	280	www.vkgn.org
Nederlandse Vereniging van Artsen voor Longziekten en Tuberculose (NVALT)	Lung diseases and tuberculosis	1908	660	www.nvalt.nl
Nederlandse Vereniging voor Maag-Darm-Leverartsen (NVMDL)	Gastroenterology	1913	400	www.mdl.nl
Nederlandse Vereniging voor Medische Microbiologie (NVMM)	Medical microbiotics	1992	686	www.nvmm.nl
Nederlandse Vereniging voor Neurochirurgie (NVvN)	Neurosurgery	1953	110	www.nvvn.org
Nederlandse Vereniging voor Neurologie (NVN)	Neurology	1974	1300	www.neurologie.nl
Nederlandse Vereniging voor Nucleaire Geneeskunde (NVNG)	Nuclear medicine	1968	330	www.nvng.nl
Nederlandse Vereniging	Obstetrics and	1887	1000	www.nvog.nl

[35] These 29 associations represent the official medical specialisms in the Netherlands, as registered by the *Medisch Specialisten Registratie Commissie* (MSCR) of the *Centraal College Medisch Specialismen* (CCMS).

voor Obstetrie en Gynaecologie (NVOG)	gynaecology			
Nederlands Oogheelkundig Gezelschap (NOG)	Ophthalmology	1892	1114	www.oogheelkunde.org
Nederlandse Orthopaedische Vereniging (NOV)	Orthopaedics	1898	1250	www.orthopeden.org
Nederlandse Vereniging voor Pathologie (NVVP)	Pathology	1920	640	www.pathology.nl
Nederlandse Vereniging voor Plastische Chirurgie (NVPC)	Plastic surgery	1950	260	www.nvpc.nl
Nederlandse Vereniging voor Psychiatrie (NVvP)	Psychiatry	1871	2200	www.nvvp.net
Nederlandse Vereniging voor Radiologie (NVvR)	Radiology	1901	950	www.radiologen.nl
Nederlandse Vereniging voor Radiotherapie en Oncologie (NVRO)	Radiotherapy and oncology	1978	522	www.nvro.nl
Nederlandse Vereniging voor Reumatologie (NVR)	Rheumatology	1945	-	www.nvr.nl
Nederlandse Vereniging van Revalidatieartsen (VRA)	Physiatrists	1955	750	www.revalidatiegeneeskunde.nl
Nederlandse Vereniging voor Thoraxchirurgie (NVT)	Thorax surgery	1948	113	www.nvtnet.nl
Nederlandse Vereniging voor Urologie (NVU)	Urology	1908	650	www.nvu.nl

Appendix V: Original Dutch fragments and quotations

As the interviews for this study have been conducted in Dutch, the fragments of these interviews (as well as some fragments from other sources in this report) had to be translated. In this appendix, the original fragments that correspond to the fragments presented above in the report are presented.

Paragraph 1.1

> "*We staan voor tijden waarin er veel van ons wordt verwacht: goede toegankelijke zorg, hoge kwaliteit, transparantie over wat we doen en samenwerking. Dit gaat niet vanzelf. Om dit te realiseren zal het de komende tijd nog wel eens piepen en knarsen.*"[36]

> "*[Dienstverlening in de gezondheidszorg] is nu eenmaal ingewikkeld geworden. Daarvoor zijn andere coördinatiemechanismen nodig, waar management er een van is. Toegegeven, de inzet van een […] manager levert niet altijd geweldige resultaten op, maar dat ligt lang niet altijd aan de manager. Helaas is de professional niet los vertrouwd, en is inmenging van anderen, waaronder managers, noodzakelijk om verbetering en vernieuwing af te dwingen.*"[37]

> "*[Medisch specialisten] vonden zichzelf de beste, wisten heel goed hoe alles zat, en lieten zich niet de wet voorschrijven. Maar de overheid wil de zorg efficiënter en goedkoper. […] Nu zijn de rapen gaar. De overheid grijpt in, met quota voor operatieve ingrepen en de eis van transparantie.*"[38]

> "*Het is eigen aan een professional: de vakman met een relatief autonome positie. Die afgeschermde positie staat nu echter onder druk. Ook professionals moeten laten zien wat ze presteren en waar ze falen.*"[39]

Paragraph 1.2

> "*De OMS ondersteunt als representatieve partij de (aankomend) medisch specialist zodanig dat zij als experts de medisch-specialistische zorg in al haar facetten kunnen waarmaken*"[40]

> "*De NVA is een vereniging van en voor anesthesiologen. Zij behartigt de belangen van haar leden en draagt bij aan een positief imago van de anesthesiologie en de anesthesiologen in ons land.*"[41]

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[36] http://www.rijksoverheid.nl/regering/het-kabinet/bewindspersonen/edith-schippers/toespraken/2011/09/27/samen-de-zorg-toekomstbestendig-maken.html, 9 July 2011
[37] http://www.innovatieforganiseren.nl/innovatie-en-management/weg-met-de-professionals-leve-de-managers/, 18 June 2012
[38] *Tubantia,* 12 February 2011
[39] http://www.tssmagazine.nl/media/2008/04/TSS_2008_april_pleidooi_voor_de_manager.pdf, 11 June 2012
[40] http://www.orde.nl/over-oms/wat-wil-de-oms/missie-en-visie.html, 20 May 2012

Paragraph 1.3

"*Was het maar zo simpel dat alleen managers verantwoordelijk zijn. De specialistenorganisaties namen zelf het initiatief […] en na lang overleg kwamen daar 30.000 DBC's uit […]. De vertegenwoordigers van de artsen [gingen] akkoord met een systeem waar de achterband niet blij mee is […,] met veel 'stuurinformatie' voor 'marktprikkels' en boordevol 'transparantie' voor de shoppende patiënt.*"[42]

"De stijgende kosten van de gezondheidszorg in Nederland en de toenemende vraag naar zorg – mede door de vergrijzing – vragen om ingrijpende maatregelen met het oog op de toekomst. De noodzakelijke stappen om groeimatiging, integrale bekostiging van zorg en ontwikkelingen zoals E-health mogelijk te maken, dreigen achterwege te blijven […]. Daarom neemt het KNMG het initiatief om samen met veldpartijen en de politiek tot een hervormingsprogramma voor de zorg te komen."[43]

Paragraph 2.2.1.1

"[is] de discussie of transparantie moet […] een achterhoedegevecht. De patiënt heeft recht om te weten wat de resultaten zijn van de zorg om op basis daarvan overwogen keuzen te kunnen maken en datzelfde geldt voor diens vertegenwoordiger, de zorgverzekeraar."[44]

Paragraph 2.3

"Professionals werken meer in dienstverband en in deeltijd, in steeds grotere organisaties. […] Het onderlinge vertrouwen lijkt kleiner te zijn in […] een meer concurrerende omgeving. [Zij] richten zich behalve op hun beroepsvereniging ook op de organisatie waarin zij werken." (Groenewegen & Hansen, 2007:??)

Paragraph 5.1

"*Heel lang is de KNMG een zelfstandige overkoepelende vereniging geweest. Daarnaast ontstonden beroepsverenigingen van huisartsen, en specialisten, en andere beroepsgroepen. Omdat dat toch allemaal geëmancipeerde eigenstandige professies werden, die ook eigen belangen te verdedigen had.*" (Respondent 1)

"[De] KNMG is voor alle artsen, dus heel breed. Zo breed dat het wel logisch is dat er in de historie (daarnaast) allemaal specifieke organisaties zijn ontstaan, voor de verschillende specialismen." (Respondent 5)

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[41] http://www.anesthesiologie.nl/p_missie_visie, 20 May 2012
[42] *NRC Handelsblad,* 3 May 2008
[43] http://knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/Val-kabinet-Rutte-onzekerheid-voor-de-zorg.htm, 26 April 2012
[44] http://www.springerlink.com/content/961854t8ml1l8574/, 21 May 2012

“in principe het gezicht naar buiten toe qua medisch specialist, […] dat is het handigste, je hebt één gezicht naar buiten toe voor de specialist.” (Respondent 7)

“En daarnaast zijn de wetenschappelijke verenigingen ontstaan, ook al heel lang, om heel specifiek […] hun eigen beroep te stimuleren en te ondersteunen en te ontwikkelen et cetera.” (Respondent 1)

Paragraph 5.1.1

“De Orde van Medisch Specialisten is een vereniging met individuele leden, net zoals wij. Wij hebben als [wetenschappelijke vereniging] (nog) geen formeel-juridische relatie met de Orde. […] Minder dan de helft van de internisten is lid van de Orde.” (Respondent 7)

“Formeel hebben wij daar niets mee te doen. Wij zijn een losse vereniging. Van de kinderartsen is ongeveer 10 procent ook lid van de Orde” (Respondent 9)

“We zullen nooit echt de illusie hebben dat wij [als wetenschappelijke verenigingen] overal bij de zorgverzekeraars, bij VWS aan tafel zitten. Wel specifieke dossiers, maar nooit als de belangenvertegenwoordiging van alle medisch specialisten. Dat gaat geen enkele wetenschappelijke vereniging doen, want daar zijn er 27 van. Dus één partij, de Orde, moet dat doen.” (Respondent 7)

“De Orde [stelt] het algemene plaatje vast. Algemeen willen ze graag betere voorwaarden, maar hiervoor kan op sommige punten c.q. specialisaties ingeleverd worden. Hierdoor ontstaat interne politiek tussen deze wetenschappelijke verenigingen. Niemand wil gekort worden of minder vrijheid krijgen.” (Respondent 18)

“Ja, dat wekte wat ontevredenheid bij heel veel wetenschappelijke verenigingen. Dat is ook een van de redenen dat al die wetenschappelijke verenigingen nu zo aan het groeien zijn, om hun eigen deelbelangen nu te vertegenwoordigen. Dus de positie van de Orde staat op dit moment wel heel erg onder druk. Als gezicht naar buiten toe. Want de Orde naar buiten toe wordt niet (h)erkend door het grote deel van onze achterban.” (Respondent 7)

“De Orde is geen vereniging van de wetenschappelijke verenigingen, maar een vereniging van individueel medisch specialisten. [Dat] wringt, het klopt niet qua bestuursstructuur. Een casusje voor jou. Je zit met de verkeerde vertegenwoordiging.” (Respondent 11)

Paragraph 5.1.2

“Ja, dat probeer je wel. Je probeert ook aansluiting te zoeken [bij andere beroepsverenigingen. Maar dan bestaat de kans dat je, als een probleem twee ‘soorten’

artsen raakt, op het gebied van de ander komt. Dan zit je veel eerder in een soort domeinenstrijd als dat het in het veld een probleem oplost.'[45] (Respondent 6)

"Aan de ene kant zijn het een soort publieke voorzieningen, onderwijs en zorg. En aan de andere kant wordt je eigenlijk genood om ze meer als markt te zien. […] Elkaar als het ware doodschieten, op de markt concurreren. […] Het zijn eigenlijk twee principieel verschillende systemen, die allebei gehanteerd worden. […] Als je dat doortrekt naar verenigingen, dan moeten wij met chirurgen concurreren. Maar aan de andere kant zijn er een heleboel dingen die wij hetzelfde doen. Als je praat over complicatieregistratie, als je praat over conflictbeheersing, certificering van subspecialismen. Wij doen eigenlijk een heleboel dingen hetzelfde. En aan de andere kant moeten we elkaar soms de tent uit vechten. 'Dat is mijn patiënt, en dat is mijn patiënt' En dat is een beetje raar." (Respondent 11)

"We zijn een klein bureautje, we zijn wel een van de grotere, maar we zijn een klein clubje. Dat je zegt ik heb heel specifiek iemand nodig die weet hoe ik een goede nieuwsmail maak. Dat die bij de Orde dan wel beschikbaar is en dat we die op een bepaalde manier kunnen gebruiken. Zo doen we dat ook met de KNMG, als ik bijvoorbeeld P&O advies nodig heb, dan kan ik de P&O'er van de KNMG bellen." (Respondent 9)

Paragraph 5.2.1

"[Als je niet oplet] krijg je een kind met een waterhoofd. Gevolg is dat de vereniging een eigen visie en beleid ontwikkelt te ver van de leden. Dan krijg je een vereniging die enorm groot is, en niet meer aansluit bij zijn leden. En dat is een gevaar voor verenigingen. Blijf dicht bij je leden. Doe wat ze vragen. Wordt niet te groot. Blijf een vereniging, die dienstbaar is en inspeelt op de problemen van het veld." (Respondent 6)

"I: En hoe reageren artsen [op vernieuwend beleid]?

R: Zoals heel veel groepen reageren: doe eens niet zo raar, het gaat toch allemaal zo goed, en mijn wachtkamer zit toch vol? En na drie, vier jaar 'beuken' krijg je 30 tot 40 procent mee in nieuwe ontwikkelingen. Het is bijna de klassieke voorloper, met een middenstuk en dan heb je nog de slome duikelaars. Zo werkt het altijd. Maar we bewegen wel, letterlijk en figuurlijk. We zijn geen facilitair bedrijf. Zo van 'u roept, wij draaien'. Nee, het is pompen, duwen, beuken en ontwikkelen." (Respondent 11)

"Ja […], we proberen ze er ook wel bij betrekken, via internet, panels of vergaderingen in het land. Waarbij we ook concepten voorleggen van nou, wat vind je er van. We zijn er wel mee bezig. Aan de andere kant: het is ook lastig als je zo'n organisatie bent. Je kunt niet altijd je oren laten hangen naar de achterban. Die is gemiddeld genomen erg conservatief, dus die zijn

[45] Respondent 6 observes this is not a problem in their situation, as problems of their professional group do not easily overlap with other medical specialisms.

niet veranderingsbereid. En soms moet je dus een beetje vooruit lopen. Dus we zeggen niet, wat vindt iedereen ervan, dan gaan we dat zo doen." (Respondent 1)

"Dokters blijven altijd dokters. Ze zijn meestal niet zo handig in communiceren op managementniveau. Het zijn gewoon dokters, gericht op het beste voor de patient. In hun opleiding leren ze genezen. Voor managementtaken zijn ze onvoldoende toegerust, de opleiding gaat over 'dokteren', analyseren van het gezondheidsprobleem en daar de meest optimale/effectieve behandeling bij geven. Dat is een zeer concreet vak, geen vak van onderhandelen. Dokters zeggen gewoon tegen hun bestuurders: als ik dat niet krijg dan gaan mijn patiënten dood en krijg jij de schuld. En dat is heel onhandig." (Respondent 6)

"Het grote verschil is dat wij niet gaan over materiële belangen, dus gewoon inkomen. Dat is enorm bepalend. Het betekent dat de druk van de achterban, want dan gaat het gewoon over centen, veel minder groot is. Organisaties zoals de Orde en LHV moeten meer scoren in de krant (media). Daar hebben wij geen last van. Dat maakt het veel gemakkelijker." (Respondent 4)

"Dat is soms wel lastig. Omdat wij niet direct (concreet) voordeel brengen bij een lid. Dus je moet wat idealistisch zijn, en denken aan het grotere geheel. Het is iedere keer weer een vraag die terugkomt. Ze betalen 600 à 700 euro, en stellen de vraag 'wat krijgen we daarvoor terug?' Ja, een richtlijn. Maar wat hebben we daaraan? En dan moet ik dus betalen voor iets dat ik eigenlijk helemaal niet zo leuk vindt." (Respondent 4)

"Wetenschappelijke verenigingen zijn [in wezen] gewoon een groep mensen die een bestuur kiest uit hun eigen kring met initieel nauwelijks mandaat om een kwaliteitsbeleid te voeren, ook [niet] binnen de beroepsgroep." (Respondent 19)

"Een uitdaging is hoe wij de toekomstige rol en positie van de jeugdarts voor het voetlicht brengen […] en dat dat niet altijd strookt met hoe onze achterban erover denkt. [Als mogelijke oplossing..,] het is eigenlijk informeren, informeren, contact maken. Persoonlijk contact, mensen aanspreken. Zorgen dat de lijntjes kort zijn. Een andere manier weet ik niet." (Respondent 13)

Paragraph 5.2.2

"En dat is eigenlijk wel onze belangrijke functie [in die contacten]. Zorgen dat op de juiste plekken mensen weten wat de kennis is van deze medisch specialisten. Want die werken iedere dag in het zorgproces, die weten als geen ander waar het over gaat. En daar zit nog wel eens een dismatch. Er zitten ambtenaren en die maken beleid, en die maken beleid op basis van berichten die ze ergens vandaan halen." (Respondent 8)

"En de andere partners, daaraan moeten we soms veel meer duidelijk maken wat onze meerwaarde is als medicus." (Respondent 13)

"I: Betekent dat ook iets voor de manier waarop u samenwerkt?

R: Ja, ik denk dat we een veel onafhankelijker positie innemen. […] En wat zelfbewuster, wat duidelijker zijn: 'dit is onze positie, dit willen we doen en dit zijn wij'. Dus wat minder volgend, wat meer sturend." (Respondent 4)

"Je hebt allemaal één heel duidelijk doel, namelijk de bodem drooghouden. In de zorg is dit gemeenschappelijke doel kwalitatief goede, betaalbare en veilige zorg leveren. En als je daar niet aan werkt, ieder vanuit je eigen kunde, de dijken, molens, afwatering et cetera. Het is ongelofelijk helder wat je met z'n allen moet bereiken. En je weet wat je ook doet, als je dat niet in beeld houdt en dat niet de toetssteen van het handelen is, dan kom je allemaal onder water te staan. Letterlijk wat er gebeurt. Polderen is niet iedereen zijn zinnetje laten zeggen totdat iedereen het beu is, maar een helder beeld van het algemeen gemeenschappelijk belang, goede betaalbare kwaliteit van zorg leveren, waarmee met ieders belang rekening wordt gehouden, dat je dat altijd in het zicht houdt. Dat fenomeen houdt de Nederlandse zorg levensvatbaar." (Respondent 19)

"Daar zoek je natuurlijk allianties. Kijk, met de Nederlandse Vereniging van Ziekenhuizen (NVZ) hebben we een aantal gedeelde belangen, maar ook een heleboel dingen daar hebben we niets mee met ze. Dus je zoekt de alliantie, bijvoorbeeld op het gebied van e-Health. Daar zoek je naar wederzijdse steun om een programma te gaan uitvoeren. Of je zoekt steun bij elkaar hoe dat nou met die governance in ziekenhuizen moet, en de kwaliteitsborging enzovoorts. Maar dat zijn dus echt gemeenschappelijke zaken. Dus je zoekt eigenlijk allemaal allianties. […] Blijft over dat je het over een heleboel dingen niet eens bent. Dat laat je dan maar, totdat er een beweging voordoet dat je kunt inhaken. Bijvoorbeeld zo'n budgetdiscussie, minister Schippers wil dat ook, erg actueel, er is ook financiële druk. Er zijn allerlei actoren die dezelfde richting uit bewegen. Dan moet je wel, en dan haakt iedereen ook aan. Dat is vanuit gemeenschappelijk inzicht dat het belangrijk is en het eigenlijk niet anders kan." (Respondent 1)

"Zeker de laatste 10 jaar zie je een soort rondreizend circus ontstaan van mensen die elkaar op allerlei punten in allerlei verbanden tegenkomen. Soms meerdere keren per week. En die, ja, van elke koepel, bureaus van koepels, die zien elkaar. Soms heb je het gevoel dat zijn de meest directe collega's die je hebt." (Respondent 19)

*"Ja, dus als VWS een idee heeft, dan worden we allemaal uitgenodigd en dan zien we elkaar weer. De bekende club zit dan weer bij elkaar." (*Respondent 21)

"Als ik kijk naar de contacten die bijvoorbeeld mijn directeur heeft met de diverse lidverenigingen, loopt dat van zakelijk naar op den duur meer informeel. We komen vertegenwoordigers van onze leden tegen op onze eigen bijeenkomsten, congressen en andere expertmeetings, en tutoyeren elkaar meestal. Die netwerken werken eigenlijk heel soepel." (Respondent 22)

“Er is [vanuit hun functie] niets dat die mensen bindt, behalve dat ze gewoon heel veel gemeenschappelijk hebben. […] Mensen uit de patiëntenkoepel en de verpleegkundigen-koepel, je ziet gewoon, dat zijn mensen met hetzelfde type opleiding, veel iBMG[46] en dat soort dingen. Dat is in de praktijk ook wel essentieel. Omdat de zorg zo complex is dat, al was het alleen maar om te zorgen dat ook op bestuursniveau signalen overkomen.” (Respondent 19)

“De clubs die samenwerken die hebben behoefte aan de kennis die bij ons zit. En je weet elkaar te vinden, dat is eigenlijk wat er gebeurt volgens mij. Dat komt misschien ook juist wel door het ontstaan door bureaus van mensen die geen arts zijn, en die veel eerder geneigd zijn om te zeggen van nou, dan gaan we toch gewoon eens praten. En dat er vroeger meer onbegrip tussen partijen onderling was.” (Respondent 8)

Paragraph 5.3.1

“Ons hogere doel is natuurlijk om een gezondere jeugd in Nederland te krijgen. Dat is gewoon het vak van de jeugdarts, daar zijn we continu mee bezig. En dat doen we door onze leden, de jeugdartsen, dusdanig toe te rusten dat ze hun vak goed kunnen uitoefenen.” (Respondent 13)

“Nou, we zijn er voor de orthopedie, het vakgebied.” (Respondent 11)

“Wij maken ons vooral druk over kwaliteit, opleiding, onderzoek en events. Daar komt het eigenlijk op neer” (Respondent 11)

“Die wetenschappelijke verenigingen, […] die houden zich uitsluitend bezig met de inhoud van hun vak. Dus de wetenschappelijke kant, de zorginhoudelijke kant. Dat is wat ze doen.” (Respondent 1)

“Daar zijn we eigenlijk mee begonnen, de opleiding tot gynaecoloog, daar zijn we [nog steeds] verantwoordelijk voor. Dat die in goede banen verloopt, en dat de opleidingseisen streng genoeg zijn.” (Respondent 8)

“Tweede poot is kwaliteitsbeleid. Dat is iets later ontstaan en heeft de afgelopen 20 jaar met name een grote vlucht genomen. En dan moet je denken aan het maken van richtlijnen. En richtlijnen in de basis, als je ze afpelt, is dat medisch handelen van medisch specialisten allemaal op eenzelfde manier gebeurt. Dat iemand dat niet doet omdat hij het idee heeft dat dat de beste behandelmethode is, maar dat er een richtlijn voor is wat de beste behandelmethode is, en ook hoe je het moet doen.” (Respondent 8)

“Op die manier fungeren deze verenigingen eigenlijk als APK van artsen.” (Respondent 18)

“De KNMG houdt zich in de breedte bezig met de kwaliteit. De KNMG is echt een inhoudelijke club. Zij houden zich dus bezig met ethiek, medische ethiek. Met ‘wat is dossiervorming’, wat

[46] Instituut Beleid en Management van de Gezondheidszorg at Erasmus University Rotterdam, one of the most prominent health care management educational and research institutes in the Netherlands.

hoort in een artsendossier te staan. Dus medisch-ethische zaken. Levenseinde, euthanasie, besnijdenis […]. Dat soort zaken, daar houdt de KNMG zich mee bezig." (Respondent 4)

"Kwaliteitsontwikkeling, dat is zeker iets waar de afgelopen jaren veel meer de focus op is komen te liggen. Ik ben hier ruim 12 jaar werkzaam. Toen ik bij de OMS begon, was de OMS er wel actief mee bezig. Maar zeker in de afgelopen jaren is daar nog een enorme versnelling in en uitbreiding op gekomen. Voorbeelden zijn richtlijnontwikkeling, kwaliteitsvisitaties, een systeem rondom het evalueren van medisch specialisten, een modelreglement rondom disfunctioneren, patientveiligheid, veilig incident melden, etc. " (Respondent 3)

Paragraph 5.3.2

"De Orde is van oudsher een belangenvereniging. Het ging puur om het geld. De laatste jaren wilden ze zich ontwikkelen richting kwaliteitsbeleid. Dat lukt ook wel, maar je merkt toch dat ze het beroepsbelangenimago nog erg om zich heen hebben." (Respondent 8)

"[Kinderartsen] zeggen ja, de Orde is toch de club van de 'maatschappers' die graag in een Porsche willen rijden." (Respondent 9)

"De andere pijler is bij ons de beroepsbelangen, dus de financieel-economische belangen van de internist. En dan gaat het zowel om de DOT, de DBC's, het inkomen, organisatie van het maatschap, anticiperen en signalering van wetgeving, het beheer van data et cetera." (Respondent 7)

"Dat betekent dat je dus wat minder naar binnen gericht bent en wat meer naar buiten. En dat merk je. Zeker de laatste twee jaar hebben we qua werk hier op het bureau een hele duidelijke accentverschuiving gezien: vroeger was het tachtig procent kwaliteitsbeleid, richtlijnen en alles wat ermee samenhangt, en nu is het veel meer beeldvorming en positionering, praktijkvoering." (Respondent 4)

"I: Hoe zou u het werk van deze verenigingen omschrijven?

R: Nou, in eerste instantie een belangenvereniging, dat zijn ze altijd al geweest. Hoe bewaak je je maatschappelijk belang als specialist, van jouw vakgebied, met name ten opzichte van de andere specialismen. Meer nog dan de overheid zijn het andere groepen specialisten die ongeveer hetzelfde doen waar je afbakening mee zoekt." (Respondent 19)

Paragraph 5.3.3

"Als een artsengroep nog een jong specialisme is kent het zijn eigen kracht nog onvoldoende. Dus het imago en de status van de arts dat is ook iets waar je dan continu aan moet werken als beroepsvereniging." (Respondent 6)

"I: Hoe belangrijk is het voor de beroepsgroep om die beeldvorming naar de maatschappij toe goed te hebben geregeld?

R: *Ja, dat is heel belangrijk. Wij komen natuurlijk uit een tijd, en dat is nog niet eens zo heel lang geleden, dat de dokter zichzelf een ander soort mensen vond. Een soort stand, de medische stand. […] Wij zijn ons ook veel meer gaan gedragen als een maatschappelijk verantwoordelijke beroepsvereniging zal ik maar zeggen. We hebben veel meer contact met patiënten, we zijn ook veel meer transparant geworden, dat belang zien we veel meer. Dus hoe je naar buiten komt is dat heel belangrijk. Ik denk als je dat onderzoekt, onze communicatie, dan zie je dat dat veel maatschappelijker is geworden, veel meer gericht op actualiteit die voor burgers belangrijk is."* (Respondent 1)

"Communicatie en reputatiemanagement. Als er iets is wat een medisch specialist zich niet goed genoeg realiseert dan is het hoe belangrijk presentatie, communicatie naar buiten toe en marketing zijn." (Respondent 11)

"Ja, de hele wereld is wel groot. En de hele wereld zit ook niet continu op allerlei mailtjes te wachten, dus je moet heel goed elke keer een aanknopingspunt vinden en daar dan iets gerichts mee doen." (Respondent 5)

"Dus dat klopt, wat niet wil zeggen dat het allemaal even gemakkelijk is. Beeldvorming over van een specialist veranderen is ongelooflijk moeilijk. Met name als het vak aan het veranderen is, van instellingsgericht naar een zorgaanbod, ongeacht waar de patiënt zich bevindt. Dat vereist nieuwe samenwerkingsverbanden, met huisartsen, wijkverpleging, etc. Wat namelijk dan eerst moet gebeuren is dat ze gaan geloven dat ze op die manier kunnen werken. Zij moeten het uitstralen, dan kan ik het verkopen. En we zitten nog in de fase van het vertrouwen krijgen in jezelf." (Respondent 6)

"Dat is het zelfbeeld van onze dokters. Waarvan wij zeggen die is te bescheiden. Te volgend. En die moet meer leidend worden." (Respondent 4)

"Met name, dat klinkt misschien gek, is de beeldvorming omtrent de internist binnen onze eigen vereniging [belangrijk]. Binnen onze eigen vereniging hebben we te maken met verschillende differentiaties. Maar het principe moet zijn dat je primair internist bent en voelt, en daarna past je differentiatie." (Respondent 7)

"Maar we bestaan al 125 jaar, dus ook artsen hebben daarbij een stukje sentiment. NVOG laat je niet zomaar los. Het is ook een soort vriendenclub, als je op die congressen rondloopt, het heeft een hoog reüniegehalte. Jij hebt mij opgeleid, dat houdt elkaar bij elkaar." (Respondent 8)

Paragraph 5.3.4

"We zijn eigenlijk een wetenschappelijke beroepsvereniging, maar we merken wel dat door alle ontwikkelingen om ons heen onze aandacht meer uitgaat naar de belangenbehartiging en het profileren van de [professional] dan het stimuleren van de wetenschap." (Respondent 13)

“Nee, ik denk niet dat het een bewuste keuze is geweest. Ik denk dat de historie zo is dat het primair ging over die inhoud. En toen kwam die profilering en hoe meer je je gaat profileren, hoe dichter je je natuurlijk tegen die materiele belangenbehartiging aan gaat schurken.” (Respondent 4)

“I: Kan het een zonder het ander?

R: Jawel, natuurlijk wel, maar dan ben je geen complete vereniging. Je moet aan de vereniging eisen stellen. De vereniging moet bestaan uit een diversiteit van competenties. En je moet dat kunnen borgen.” (Respondent 6)

“We zitten op dat traject om te kijken of we wat meer kunnen gaan samenwerken. Er zijn dossiers die te groot voor ons zijn. […] Als je het hebt over de autonomie van de medisch specialist, dat is veel groter dan kindergeneeskunde alleen. Dus daar zullen wij als wetenschappelijke vereniging in moeten samenwerken, en daar zal je dus een vehikel voor nodig hebben, en dan ligt het voor de hand om te kijken of je dat met de Orde samen kunt oppakken.” (Respondent 9)

“Dus we zijn nu ook met ze in gesprek, dat noemen we het synergietraject, met alle wetenschappelijke verenigingen en de Orde. Want wij hebben wel een belang dat er één partij voor ons namens de medisch specialist naar buiten treedt.” (Respondent 7)

“breder, en meer gemixt, wat meer de mix tussen inhoud en financiën, verschillende belangen combinerend” (Respondent 1)

Paragraph 5.4

“De wereld is veranderd. De positie van de dokter is anders. Men stelt meer eisen. Men wil meer uitleg.” (Respondent 4)

“We staan veel meer in de schijnwerper. Vanochtend heb ik ook weer telefoontjes gehad van KRO reporter, die weer bezig is met een programma. En TROS radar is ook weer bezig met een programma. Je zit wel onder een vergrootglas. Dat was drie, vier jaar geleden totaal anders. Er wordt heel scherp op je gelet.” (Respondent 11)

Paragraph 5.4.1

“We moeten meer vraaggericht gaan werken, in plaats van aanbodgericht. Dus we moeten meer naast de klant [sic!] gaan staan, en met hen meedenken van wat vind jij nou belangrijk.” (Respondent 13)

“Dat vinden ze [artsen] nog wel moeilijk. Maar dat hoort er ook bij, want daarmee laat je zien wie je bent, wat je kunt en wat je niet goed kunt.” (Respondent 11)

"De medisch specialist staat steeds meer onder druk", want "de kwaliteitseisen, met name ook de verantwoording over kwaliteit, die wordt steeds verder omhoog geschroefd" (Respondent 9)

Paragraph 5.4.2

"Men is nu veel kritischer, en kijkt wat levert het nu op, en kan ik het ergens anders goedkoper inkopen, en jullie zijn zo 'duur', en wat doen jullie daar eigenlijk voor. Dus wij moeten veel meer laten zien wat onze 'opbrengst' is." (Respondent 13)

"Maar ook de bezuinigingen. Dat maakt dat wij als beroepsgroep, we zijn de duurste discipline in de uitvoering van de jeugdgezondheidszorg, dat als wij niet goed kunnen laten zien wat onze meerwaarde is, wij wegbezuinigd worden." (Respondent 13)

"is wel een belangrijke reden voor het bestaan [van beroepsverenigingen]. Maar stel nou eens, dat zou niet eens zo lang hoeven te duren, we laten al die dokters in loondienst. Dan valt er wel een deel van hun reden van bestaan weg. Want als verzekeraar praat ik dan met het organisatieverband. Ik ga niet met de individuele specialist zaken doen."

Paragraph 5.4.3

"De maatschappij vraagt een andere bejegening door medisch specialisten. Zo moeten medisch specialisten veel transparanter werken en zich toetsbaar opstellen. Ook in de omgang met de patiënt is er enorm veel veranderd, alleen al door internet. Een patiënt komt voorbereid bij de medisch specialist met ongeveer zijn iPad in de hand. Als een arts een diagnose stelt, kan een patiënt bij wijze van spreken online opzoeken of het wel klopt wat er wordt gezegd. Een patiënt vindt het niet meer vanzelfsprekendheid dat een arts wel weet wat goed voor hem of haar is. Dat vraagt dus een andere, meer adviserende benadering van de arts ten opzichte van de patiënt." (Respondent 3)

"R: De druk op de gezondheidszorg neemt enorm toe.

I: Wat moet ik me dan bij zo'n druk voorstellen?

R; Wat je ziet is, met het vergrijzen van de bevolking, en dat is echt iets wat we zien, niet iets wat je op tv te zien krijgt, maar echt een constatering. Wat je ziet is dat mensen ouder worden en oudere mensen hebben per definitie meer zorg nodig. En die zorg is bij oudere mensen vaak complexer en duurder. [Dus daar waar vaak vroeger vele jonger, gezondere mensen ook kleine operaties kregen, zie je dat diezelfde operaties bij een ouder iemand al een stuk complexer is, omdat die mensen vaak onderliggende ziektes hebben. Ze hebben suikerziekte, ze hebben hart- en vaatziekten. Dus je ziet gewoon dat de complexiteit bij oudere mensen toeneemt.] Een rustige, ontspannen dag, zoals we die vroeger nog vaak hadden, die zijn er niet meer." (Respondent 12)

Paragraph 5.4.4

"[In de jaren 90 was het kwaliteitsbeleid van wetenschappelijke verenigingen] iets waaraan je mee moest doen, maar je hoefde nog niets met de resultaten te doen. Dat was vertrouwelijk. Je kon ook nog wel, afhankelijk van de vereniging, zorgen dat vervelende dingen niet in het rapport kwamen. […] Maar dat was wel het begin van een soort samenhangende structuur rond kwaliteit." (Respondent 19)

"En zo professionaliseert dat kwaliteitsbeleid zich steeds. Dan gaat het niet alleen om richtlijnen, maar ook om het maken van indicatoren, dus het meetbaar maken. En het bekijken van bepaalde complicatieregistratiesystemen. Als je bepaalde handelingen doet, hoe vaak gaat het wel en niet goed, en wat kun je daarvan leren. Daar hebben we allemaal mee van doen." (Respondent 8)

"Ja, daar wordt je helemaal gestoord van. En iedereen maar eisen stellen. Je moet voortdurend van alles." (Respondent 11)

"Er zijn steeds meer verenigingen die zeggen we hebben ook behoefte aan een directeur die het bureau aanstuurt en het gezicht naar buiten is, in de netwerken rondlopen en die verbinding maken tussen het ministerie en de professionals." (Respondent 8)

"We hebben een groot verenigingsbureau in Utrecht [met een directeur en vier beleidsmedewerkers, en vier secretaresses.] Dus dat zijn negen man die een fulltime baan hebben om de anesthesie in de breedste zin van het woord in Nederland te vertegenwoordigen. Dat is naar de leden toe vooal op het gebied van belangenbehartiging en wetenschappelijk, want je bent bezig met richtlijnen, indicatoren en kwaliteitsbeleid et cetera. Maar ook heel nadrukkelijk met die stakeholders. Wat wil de IGZ van ons, wat wil de overheid van ons, wat willen de zorgverzekeraars van ons, en dat probeer je zo goed mogelijk te behartigen." (Respondent 12)

Paragraph 5.5.1

"Iedereen zou vinden, gouden theelepeltjes zijn heel mooi, maar als het niet betaald wordt, wordt het niet betaald. Dus je zult daar pragmatisch mee om moeten gaan en dan zal je moeten kijken wat je positie in dat spel wordt. En uiteindelijk willen wij die normen kunnen blijven stellen. En je zult pragmatisch toch een beetje mee moeten bewegen. En de tijd dat je kunt zeggen van er moeten gouden theelepeltjes komen, die is voorbij, omdat de zorgkosten zo waanzinnig stijgen. […] Dan moet je het doen. Zowel vanuit pragmatisme, maar eigenlijk ook vanuit maatschappelijk bewustzijn." (Respondent 9)

"Ze hebben namelijk een taak in dat beleid. Dat probeer ik ze ook duidelijk te maken. Ze voelen zich vaak slachtoffer, daar heb je gelijk in. Maar dan nemen ze niet hun rol, roep ik tegen ze. Dan ga ik ook met ze praten. Zo van, je piept, maar wat heb je zelf al gedaan? […]

Dus het opvoeden van mensen in die zin is ook een taak. Bewust maken waar je zelf een rol kunt vervullen, waar de eigen verantwoordelijkheid ligt, mee kunt denken en creatief tot oplossingen kunt komen is iets wat iedereen zich eigen dient te maken" (Respondent 6)

"Je kunt je kop niet in het zand steken. Je kunt niet in een ivoren toren gaan zitten en daar niets van vinden." (Respondent 9)

"Je probeert proactief te zijn, vooruit lopen en niet allemaal achteraf. Maar er gebeurt zoveel, en er komt zoveel op je af, dat je sommige dossiers ook gewoon moet laten liggen. In plaats van alles oppakken, want als je dat doet, dan kom je in een situatie dat je overal achterop raakt." (Respondent 7)

"I: Nou is er ook een nieuwe vereniging, de VVMS. Hoe ziet u die ontwikkeling?

R: Ja, het motief is dat de Orde te slap is, te veel compromissen sluit met verzekeraars en met de overheid. Ook wat betreft bevriezing van de inkomens. Nou ja, een beperkte groei enzovoorts, dat vinden ze allemaal niets. Ze vinden dat het op de oude voet moet doorgaan. Dus het is een conservatieve groep, die vindt dat de Orde niet stevig genoeg in de schoenen staat." (Respondent 1)

"Waar we wel nog over na moeten denken is hoe maken we het voor de dokters beter behapbaar. Dus we zijn nu wel bezig met een project om te kijken of we het via de website op een wat betere manier kunnen presenteren, met samenvattingskaarten, en flowcharts en dat soort zaken. [… Nu zijn dat] soms documenten van 200 tot 300 pagina's. We hebben gezegd: we moeten daar een slag overheen maken om het beter toegankelijk te maken. Zorgen dat er goede samenvattingskaarten van komen, wellicht een app of zoiets." (Respondent 9)

"Wat we wel kunnen doen, en dat doen we ook wel, is pleiten voor geen twintig indicatoren per zorgverzekeraar, maar zorg nou dat je dat gezamenlijk doet. […] Kies gewoon wat wil je weten, en maak daar wat voor, maar bestook ze [artsen] niet van twintig kanten, daar kunnen wij natuurlijk wel een rol bij hebben." (Respondent 8)

Paragraph 5.5.2

"Ik vind dat veel beroepsgroepen laat ik maar zeggen niet toekomstgericht over hun vak denken. […] Als je ziet welke kant het op gaat met de verkleuring, van groen naar grijs en naar veelkleurigheid, dan zou je moeten inzien dat je eigen rol en positionering in dat palet ook veranderd. Als je dan niet weet te verbinden, maar daar met professionele zorgogen blijft staan, dan zet je jezelf echt buitenspel." (Respondent 20)

"hebben wat meer zicht op hoe krijg ik nou voor elkaar, en dan gaan we het over landelijke afspraken hebben, dan weten ze wel dat ze met ons zaken moeten doen. […Voor mensen op de werkvloer is het] allemaal een ver-van-hun-bed-show, en die verzekeraar, wat maakt het allemaal uit. Zodra ze in een bestuur van een beroepsvereniging komen, zullen ze zich

realiseren dat als je landelijk iets moet organiseren, dan moet je overleggen, en dan ben je een gesprekspartner." (Respondent 21)