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Pretenders and performers: Professional responses to the commodification of health care

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Abstract How do professionals respond to the commodification of health care? Using an interactionist perspective, we answer this question by referring to the findings of five qualitative studies of hospital surgeons, mental health-care professionals, emergency and ambulance personnel, and youth workers in the Netherlands. We find that differential levels of professional autonomy, dominance and discretion spawn different combinations of the logics of the market, bureaucracy and professionalism. We discern five new ways of enacting professionalism: (1) entrepreneurialism: embracing commodification as integral part of professionalism; (2) activism: rallying against encroachment on the profession; (3) bureaucratization: seeking reassurance in procedures; (4) pretending: faking compliance to protect autonomy; and (5) performing: upholding the profession through conscious and skillful management of appearance in the eyes of patients and the public. Hidden strategies of opposition, however, support commodification since most professionals outwardly play by the rules and mix the logic of care with those of the market and bureaucracy, rendering alternative courses of action and solidarity more difficult. Uncertainty is increasing for all professionals, leading to feelings of insecurity and reflexivity but also to creativity. Professionalism is increasingly 'disembedded', called into question, and de-routinized.
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Introduction

It is a commonplace that professionalism in Western welfare states is changing under the organizational demands of managerialism, new public management and the marketization of services (for an introduction see Muzio and Kirkpatrick, 2011). While organizational change takes specific forms in different countries (Pollitt, 2000; Evetts, 2011), we are witnessing – in broad strokes – greater standardization, measurement, auditing and bureaucracy, tighter organizational control over work, and an emphasis on the entrepreneurial identities of both professionals and their organizations (Tonkens, 2010).

All of these changes have affected the work of professionals, and are reflected in two main lines of inquiry. First, scholars debate whether professional values are indeed on the decline (Freidson, 2001; Evetts, 2011). MacKinlay and Arches (1985) already referred to the 'proletarianization of physicians' in the mid-1980s; since then, numerous empirical studies have found professional values to be under attack. Harrison and Ahmad (2000), for example, provide evidence on declining professional autonomy and dominance, while others have examined how the professional logic competes with those of the market and bureaucracy (Exworthy and Halford, 1999; Freidson, 2001; Vogd, 2006).

The 'decline of professionalism' is nevertheless a contested idea. Numerato *et al* (2012, p. 12) conclude that there is 'no evidence of deprofessionalization' among medical doctors, though they do discern tendencies towards increasing control, market-like incentives and re-stratification among doctors. Among professionals more broadly, Evetts (2011, p. 415) argues that 'there is, as yet, no established link between the organizational changes and challenges to occupational professionalism and a deterioration of professional values.' As Evetts argues, it would be difficult to assess causation since other processes – including the demystification of professional knowledge and growing public awareness of malpractice – are occurring simultaneously. Again, this need not threaten all professionals alike.

The second line of inquiry has examined the rise of new kinds of professionalism in response to organizational change. Noordegraaf (2007), for example, has pointed to 'hybrid' forms of professionalism, while Witman *et al*'s (2011) hospital study found a mixture of medical and management styles, with a strong emphasis on professional habitus. Professionals can also make use of managerial pressures to further their own interests (Evetts, 2011). Numerato *et al* (2012, pp. 3–6) describe typical professional responses to managerial pressure – including acceptance of its hegemony, co-optation, negotiation, adaptation and resistance – thereby adding nuance to the popular, binary framework of hegemony versus resistance.

The current article further develops this line of research. We wish to gain deeper insight into the changes affecting professional work and the emergence of new forms of professionalism in response to organizational change. We do not attempt

to cover the whole range of organizational changes that professionals face, but focus on those that Evetts (2011) in her review terms 'commodification':

> Professional service work organizations are converting into enterprises in terms of identity, hierarchy and rationality … The commodification of professional service work entails changes in professional work relations … Relationships between professionals and clients are … being converted into customer relations … The service itself is increasingly focused, modelled on equivalents provided by other producers, shaped by the interests of consumers and increasingly standardized (Evetts, 2011, pp. 415–416).

This article analyses the effects of the commodification of care on health-care professionals in the Netherlands. Instead of framing professionals as the victims of commodification, we examine how they make use of their discretionary powers (Lipsky, 1983) to reposition themselves. We do so from an interactionist perspective, focusing on professionals' interactions with other stakeholders. We are not looking for typologies of professionalism as that would produce static images. We rather want to capture processes and understand how professionals respond to commodification by enacting professionalism in new ways.

We build on the findings of five recent studies we performed in the Netherlands on how medical doctors, psychiatrists, psychotherapists, youth care workers, and emergency and ambulance staff respond to specific situations arising out of the commodification of health care. In all cases, we found professional ideas and practices to be subject to subtle but significant changes. In their strategies of dealing with the commodification of care, we discern five ways of professionalism, which we coined entrepreneurial, activist, bureaucratic, pretending and performing. While most of these ways occur in several settings, they are partly tied to specific professions. For example, it is much easier for surgeons to embrace entrepreneurialism than it is for nurses in emergency care.

Ironically, the strategies professionals develop to counter the effects of commodification on their work often seem to further rather than counter this very process. The commodification of care discourages collective protest among professionals: it obscures the object of protest as well as plausible alternatives. As we will see, protest also contains the risk that the discretionary power professionals still enjoy will be taken from them. Before presenting the empirical data, we briefly sketch how commodification has taken shape within Dutch health care.

The Commodification of Dutch Health Care

The commodification of care can entail marketization, greater consumer-orientation, or a combination of the two. As we will see, commodification can occur in

sectors where marketization is absent. Here we give a brief overview of the commodification – and in particular marketization – of Dutch health care.

Market-oriented discourse began in the Netherlands with the introduction of 'New Public Management' in the late 1980s (Kremer and Tonkens, 2006; Duyvendak *et al*, 2009; Newman and Tonkens, 2011; Tonkens *et al*, 2013). Since then, the marketization of health care has affected all subsectors, albeit to varying degrees. Dutch health care is roughly divided into 'curative' and 'long-term' care for the frail elderly and people with mental and psychiatric handicaps. General medical care (including emergency care) comes under curative health care, while mental health care and youth care are spread over both fields, each with their own legal framework. Most of the debates on market reform focus on curative care (Helderman *et al*, 2005; Leiber *et al*, 2010; Pollitt *et al*, 2010) while the long-term or 'incurable' sector tends to be forgotten.

Even where there is no market for health-care products, another facet of commodification – 'demand steering' – has made significant inroads in the Netherlands, with patients recast as consumers entitled to services and choice (Tonkens, 2011). This is true for all sectors of health care, including those where marketization has been absent or marginal, such as emergency services. Although there is no competition between emergency services to 'maximize' production, there is a growing expectation that emergency nurses 'serve the customer' well.

The commodification of Dutch curative care has German parallels. The legal predecessor of the current Dutch health-care law – with mandatory health insurance for people below a certain basic income – was installed during the German occupation of the Netherlands in 1941 (Leiber *et al*, 2010). Both the Dutch health-care reforms of 2006 and the German reforms of 2007–2009 installed regulated competition between private insurance companies, between service providers, and ultimately between health-care professionals. In the Netherlands, insurance companies gradually gained more freedom to (not) sign contracts with organizations and individual professionals and to set the terms when doing so. Compared to their Dutch counterparts, German medical professionals were more successful in softening competition and preserving their autonomy (Kuhlmann, 2011).

To introduce price-competition between professionals and organizations, the Dutch government introduced its own version of Diagnosis Related Groups (called Diagnosis Treatment Combinations or DBC's – Diagnose Behandel Combinaties – in Dutch). The DBC system is comparable to and was inspired by the Diagnosis Related Treatment (DRT) system that we see in, for example, Belgium. The main difference is that the DRT system excludes the honorarium of medical doctors, while it is included in the Dutch DBC. The DBC was meant to be an important instrument in negotiations between insurance companies and

(organizations of) health-care providers. Because of the huge complexity of the system, with 17 000 different 'products', the DBC is currently replaced by a simpler but comparable system called DOT (short for 'DBC On the road to Transparency'). By placing a price tag on diagnosis and treatment, DBC and DOT turn care into a measurable product, enabling comparison and competition.

Commodification introduces performance pressure, not only through price-competition but also through the requirements of transparency and efficiency. Professionals and organizations must prove their performance and submit detailed reports on both the processes and outcomes of their services. Research shows that Dutch medical specialists spend 26 per cent of their time on paperwork and fulfilling procedural demands, up from only 6 per cent 25 years earlier (Kanters *et al*, 2004). The advent of publicly available performance rankings further contributes to performance pressure.

The basic idea informing recent health-care reforms in the Netherlands is that the state remains responsible for the quality, efficiency and accessibility of health care, and sets limits on the market of competing insurance companies and health-care providers (Helderman *et al*, 2005). In the US, private health insurance companies are free to accept or reject clients; the state only takes responsibility for the poorest segment of the population. The situation in the Netherlands has similarities with that in the UK, though the National Health Service there tempers the reach of marketization (though not that of 'demand steering'). There are further similarities at the local level, where the marketization of services proceeds through outsourcing to private companies. (Local) governments have a monopoly on tendering, while the position of private service providers depends on their 'productivity'.

This article does not aim to provide a detailed description of the rise and exact shape of commodification in Dutch health care. The marketization of curative care has already been well documented (Helderman *et al*, 2005; Gaynor, 2006; Cools, 2008; Canoy, 2009; Leiber *et al*, 2010; Pollitt *et al*, 2010). Instead, we focus on how commodification has influenced professionals' relationships with patients/clients and other professionals.

We cannot assume that the commodification of care directly affects professionals' daily work. At least initially, they have significant room for maneuver. Professionals are, in Michael Lipsky's (1983) words, 'street-level bureaucrats'. While Lipsky only looks at the lower rungs of government organizations when examining how policies are eventually implemented, we agree that 'the decisions of street-level bureaucrats … effectively become the public policies they carry out' (Lipsky, 1983, p. iix). Street-level workers deviate from actual policy, Lipsky says, because they are continuously understaffed and face endless demands. Under these conditions, they develop specific coping mechanisms. While this argument may equally apply to professionals, we need to pay attention to the availability of different ideas or logics that inform their coping strategies. Faced

with the commodification of care, professionals may defend professional standards or seek support in bureaucratic procedures.

The question guiding our research, then, is how practitioners use their discretionary power to respond to the commodification of their professional services. Inspired by the symbolic interactionist tradition in sociology (Mead and Morris, 1934; Blumer, 1969), we analyze social phenomena in terms of their basic building blocks – interactions between people and how social patterns arise out of these interactions (for two early examples addressing professionals, see Becker, 1961 and Goffman, 1959).

Methods

At the University of Amsterdam, the first author runs a research program on the relation between professionals and clients under conditions of commodification and democratization (see for example: Kremer and Tonkens, 2006; Duyvendak *et al*, 2009; Fienieg *et al*, 2011; Tonkens *et al*, 2013). This article is based on five qualitative studies on professionalism and commodification in different care settings, which are part of that larger program. All studies were supervised by the first and/or second author, two of the studies in collaboration with the third and fourth author.

The different studies were integrated through a meta-analysis (Campbell *et al*, 2003). Overall, thematic content analysis and coded interaction analysis were the basic analytic procedure (Hsieh and Shannon, 2005). The iterative process of developing hypotheses grounded in empirical observations took place in two phase. In first phase, the study supervisors and the students jointly analyzed the specific data of each study, developing coding schemes and typologies. In phase two, all authors repeatedly hypothesized commonalities and differences between the studies and re-analyzed parts of the data to scrutinize the developing findings. Preliminary typologies were discarded until the typology covered the data. Strictly speaking, we did not, as theoretical sampling procedures would necessitate, collect new data on the basis of intermediate hypotheses.

The first study was conducted in two urban Dutch youth care institutions in the summer of 2009. It consisted of 19 in-depth interviews with managers, treatment coordinators, ambulant and residential care workers on how they experience the commodification of their services. All interviews were recorded, transcribed, coded and analyzed (Bryman, 2004, pp. 401–406; Charmaz, 2006).

The second study, on mental health care, consisted of in-depth interviews with 15 mental health-care professionals on how they cope with the pressures of commodification and the DBC system, de Dutch version of the Diagnosis Related Groups.[1] The interviewees were mainly psychiatrists and psychologists, independent practitioners as well as employees of mental health institutions. The

interviews were conducted in four different regions of the Netherlands in the spring of 2009. The study also analyzed 20 articles from national newspapers and 10 policy documents in order to select relevant themes and issues for the interviews; its researchers attended two conferences on the DBC system. The study further included a survey ($n = 28$) based on Q-methodology. All data were coded and analyzed using the 'framework analysis' approach proposed by Rabiee (2004) and Green and Thorogood (2005, p. 184).

The third study, on somatic care, consisted of 30 semi-structured interviews with medical specialists. The interviewees represented the three largest groups of medical specialists (apart from psychiatrists), namely anesthetists, internists and pediatricians. They were asked about the meaning of commodification for their professions and for health care in general. The interviews were conducted in 14 non-academic hospitals in the western Netherlands, an urban area characterized by a high degree of competition between professionals. All interviews took place in the spring of 2009.

The final two studies, both ethnographic in nature, examined patterns of interaction between professionals and laymen in emergency care – with a special focus on the effects of patients behaving as 'demanding consumers'. The first of these studies was based on two months of observation and informal conversation in an emergency ward in one of Amsterdam's largest hospitals (during 28 shifts). At the time of research in 2007, 120 to 140 patients a day visited the emergency ward. 48 members of staff also completed a survey.

The final study entailed two months of ethnographic research at a regional ambulance service in the region of Utrecht. The researcher accompanied the ambulance staff on 15 shifts, during which they responded to 81 calls; a total of 145 hours of ambulance care was observed. Two shifts at the emergency call center were also observed, during which 65 reports of emergency were overheard. 81 complaints about ambulance care were analyzed at the head office, while informal conversations and a survey completed by 24 ambulance staff and drivers added to the collection of data (Table 1).

A limitation of the five studies is their small sample size, which doesn't allow for the drawing of numerical conclusions, for example at the organizational or sectoral levels. Nevertheless, the data contained in these studies do show the different ways professionals are dealing with the commodification of care in their daily work, to which we now turn.

New Ways of Professionalism

How do professionals in their daily practices respond to the commodification of health care? How does it affect their profession and how do they respond? We

Table 1: Overview of research methods

	Interviews	*Observation*	*Documentary analysis*	*Survey*	*Year of data collection*	*Investigator/ supervisor*
Study 1	$n = 19$	—	—	—	2009	Daniël van Hassel/ Evelien Tonkens
Study 2	$n = 15$	—	30 newspaper articles/ policy documents	$n = 28$	2009	Nienke van Sambeek/ Christian Bröer/ Evelien Tonkens
Study 3	$n = 30$	—	—	—	2009	Bart Vosters/ Evelien Tonkens/ Christian Bröer
Study 4	—	28 shifts (224 hours)	—	$n = 48$	2007	Charlotte Bagchus/ Trudie Gerrits/ Christian Bröer
Study 5	—	15 shifts (145 hours); 81 calls	81 complaint letters/ 61 emergency reports	$n = 24$	2009	Marieke Boele van Hensbroek/ Christian Bröer/ Evelien Tonkens

discern five new ways of professionalism: entrepreneurial, activist, bureaucratic, pretending and performing. Note that any individual professional can enact more than one of these. We begin with two of the most opposing ways: the entrepreneurial way of embracing commodification and the activist rejection of commodification, and then proceed to the three less straightforward enactments.

Entrepreneurial

Entrepreneurial professionalism entails using the commodification of care to gain profit, to diversify your work and to find new sources of recognition. It implies a fusion of the market and professional logics (Freidson, 2001). While non-medical criteria now weigh heavily in decision-making for all health-care professionals, entrepreneurial ways of professionalism adapt to fit these developments. Considerations of financial management are central here and determine the frequency and types of interventions offered to customers. Entrepreneurial professionalism is typically more concerned with efficiency, competition, and patient-friendly behavior than the other ways of professionalism we identify. As medical specialist argues:

> In our hospital we always want to be one step ahead of our competitors … We try to make our clinic as efficient as possible and we investigate customer satisfaction to know what they really want … At pediatrics,

> parents can accompany their kids in the operating room … A lot of other hospitals don't allow that *(Study III, participant II, Anesthetist)*.

Entrepreneurial ways of professionalism are prominent in competitive working environments. Medical doctors report that the move away from fixed prices for treatment in hospitals encourages entrepreneurial professionalisme as they have to negotiate the price of treatment – including their own honorarium – with insurance companies. One might thus expect these doctors to be more profit-focused. In mental health care, entrepreneurial professionalism is welcomed by commercial organizations and independent practitioners who already operated as entrepreneurs before, or in anticipation of, changes to the system. An independent psychotherapist revealed:

> Marketization is great for me! … People are coming from all over and are willing to pay me well. I think I deserve that … Psychologists are not very business-like people you know. They have learned to 'help' people. Running your own business demands a different mind-set. *(Study II, participant XIII, Psychotherapist)*.

While commercial mental health organizations are expanding, professionals working in public institutions remain skeptical. As a psychologist states:

> In the commercial organizations, professionals are very sly. They work with these color schedules in which they can see exactly which treatments are the most profitable to register. *(Study II, participant X, Clinical Psychologist)*.

Many professionals are critical of the commodification of health care but feel forced to adopt entrepreneurial styles of professionalism. We could call this 'involuntary entrepreneurialism'. For example, doctors can feel pressed to give a patient who needs a new hip the cheap, Taiwanese one, though they are convinced that its quality is significantly lower than other more expensive options. Mental health professionals report feeling forced to offer patients less expensive group therapy, even when individual treatment is prescribed, while youth treatment coordinators place their clients in treatment groups while doubting its pedagogical wisdom:

> Clients who are coming from closed groups are very difficult, but sometimes you just have to place them although you expect problems … you have to fill the beds, because of the money. *(Study I, participant XVIII, Treatment coordinator)*.

Professionals argue that competition will lead to the selection of easily treatable and thus profitable patients. They fear that the most vulnerable,

therapy-resistant groups will be passed on or left out. They also report that the market encourages over-treatment. Performing activities that can be registered in the DBC system (such as testing or providing treatment) is more profitable than activities that cannot be registered, such as talking to patients to offer advice on, for example, lifestyle choices or managing fears of improbable illnesses. Over-treatment of course runs counter to the idea of general cost-containment in health care.

We also found traces of involuntary entrepreneurialism in youth care. Dutch youth care institutions are funded on the basis of their 'production' – measured in terms of bed-days. As each empty bed entails a financial loss, treatment coordinators feel pressed to be more concerned with bed occupation than with pedagogical criteria like the balanced composition of groups.

Activism

Activism as a way of professionalism concerns openly challenging the commodification of care, holding fast to the traditional professional logic and defending professional autonomy. A psychologist explains:

> I think that in healthcare, competition and financial interest shouldn't be driving principles. In care another mentality and motivation is needed … I refuse to be part of this system. I don't believe in it. It undermines our profession. *(Study II, participant VIII, Clinical Psychologist)*.

Activism is opposed to the goals and values that underlie the new policies; it sometimes implies outright rejection of outside interference with professional work.

We find this way of professionalism most often among mental health-care professionals. Considering the widespread dislike of current policies and the use of DBC's (Palm *et al*, 2008; Tummers, 2011), activism remains small scale. It is most often found among independent psychoanalysts and (mental) health-care workers associated with the Socialist Party. It comes as no surprise that the most articulate opposition against commodifying care is found among psychoanalysts. Their holistic view of mental illness and the importance of subjectivity makes it hard to standardize methods and measure outcomes. As a psychotherapist states: 'I'm never going to work with protocols. It's an art we are practicing, not a science.' (*Study II, participant XIII, Psychotherapist*).

Psychoanalytic activism is especially concerned about decreased autonomy and erosion of client privacy. Since confidentiality is seen as crucial for the therapeutic process, reporting personal and diagnostic information to third parties is considered to be unacceptable. A small group of activists therefore offers DBC-free treatment, though this means insurance companies don't cover the costs and they risk being fined. Apart from such resistance to implement

obligatory procedures, activists try to influence public opinion; they also legally challenge current policies, in one case obtaining a temporary arrangement to make declarations without mentioning the patient's diagnosis (an outcome still being contested by the national health authorities). While activists have made some headway in protecting client privacy, the issue does not appear to be a leading concern among professionals more generally; none of our salaried interviewees, for example, broached the subject of privacy when talking about DBC's.

Pure activism we only found in mental health care. We need to note, however, that the study on mental health care purposefully approached activists; we thus cannot conclude that activism is absent in the other sectors. In the other four studies, we found milder forms of resistance. For example, residential care workers, ambulant care workers and treatment coordinators in youth care openly criticize certain mandatory reporting protocols as these become distractions from their real work. A youth group leader states:

> We have to fill in forms about so many things, like every incident … and things like the fridge or cleaning equipment … but these are not my priorities and it takes time I rather spend on helping clients. Thus in some cases I just don't use a form although I know that I have to. *(Study I, participant IX, Group Leader)*.

A small group of psychoanalytic activists has been particularly active against the introduction of the new logic in mental health care. Although their actions have led to greater awareness of the negative consequences of current policy, widespread resistance or significant policy changes have not materialized. The Socialist Party, which often mobilizes professionals in the sector, has been unable to effectively counter the commodification of health care in parliament. One of the reasons for limited resistance may be that the broader population of professionals cannot relate to the two largest activists groups. There is no coordinated lobby group free of explicit ties to certain political or professional orientations. Though many professionals may identify with the Socialist Party's arguments, most don't identify with the party.

So far we described two more or less predictable ways of professional–embracing the commodification of health care and opposing it. We now turn to the three unforeseen ways of professionalism.

Pretending

The style of *pretending* implies: pretending to work by the rules, thereby disguising the act of following your own rules in order to protect the quality of your work. It is built on a distinction between performing your real work and reporting about it to external controllers such as the insurance companies, which

are perceived to be driven exclusively by financial interests and to be bereft of expertise to judge professional work. In an attempt to protect your professional discretion and the interests of your clients, pretending implies operating strategically within the confines of commodified care.

We encountered this way of doing professionalism in youth and mental health care. In mental health-care institutions, we found psychologists and psychiatrists manipulating the DBC system. Being familiar with management vocabulary and partly agreeing with the policy goals that underlie the DBC system, they nevertheless remain skeptical of how these goals have been translated into practice and mainly see the DBC system as a bureaucratic burden bereft of meaning for themselves and their clients. They thus distinguish between their real work and how they report their work to insurers. The clearest example of this phenomenon is intentional misdiagnosis. Professionals may report a more severe diagnosis (for example a personality disorder) to the insurer to be able to claim more money, thereby allowing for more thorough treatment. Professionals present this strategy as a form of resistance rather than as fraud. Obliged to work with a system that they reject, they take advantage of the system's loopholes in a way that minimizes damage to their clients. Indifference towards accurate registration is typical among pretenders. A psychiatrist explains:

> Look, I can register my consultation in two different ways. I can write down code B210, which is a supportive/structuring consultation. I can also write B200, which stands for pharmacotherapy. My manager complains I mainly register B210. I tell him I just don't need a lot of time to talk about pills. But if he wants more B200 because it's more profitable, I can do that. I don't really care what I write down, but of course I won't change the real content of my consultations. *(Study II, participant V, Psychiatrist)*.

In residential youth care, where institutions are reimbursed on the basis of their 'production' (measured in bed-days), we encountered pretenders adopting 'creative accounting' practices to keep beds filled on paper. According to residential care workers, 'maximizing production' in reality would lead to complete mismatches and more aggressive or sexual behavior among clients. To protect their clients and professional work, they turn to 'creative accounting'. A group leader explains:

> One of our clients is transferred to a closed group but officially, he occupies no room there … It creates the impression that our group is full, because he is still registered with us … At some point you just perform this kind of creative accounting. *(Study I, participant XII, Group Leader)*.

Pretenders aims to protect the quality of work and the interests of clients. At the same time, it implies working against the overall goals of the system, such as

increased transparency. Insight into clinical practices, the number of clients served, and real costs are hampered by the unreliable data pretenders provide. Pretenders typically solve policy-related problems individually and covertly. As a psychologist states:

> Let people with more political power protest against this system … We just have to let the system fail. Hopefully this will result in more sensible policy. *(Study II, participant IV, Psychologist)*.

The risk of this way of coping with changing policy is that the system's shortcomings remain invisible.

Bureaucratization

Bureaucratization as a way of doing professionalism implies clinging to bureaucratic procedures in order to reduce risks and to secure your own position. This professional style is a response to uncertainty and above all fear being blamed in case of serious trouble with clients. This fear can in large part be attributed to the commodification of care – meaning that professionals must now how to serve their 'customers' and be able to justify their actions at all times. Failing this requirement exposes professionals to the possibility of being sued by their clients or the state.

Bureaucratization as a way of professionalism comes to the fore in the way youth workers deal with reporting protocols for almost everything they do, such as administering innocuous medicines (e.g. a nasal spray) or helping a child who has fallen from a swing. While youth workers have less time for their clients under the new rules, they respect the greater rights these rules provide their clients; bureaucratic procedures are thus followed to the letter. A treatment coordinator explains: '… if physical intervention is required then it must be signed by the client and his parents, otherwise they can sue us … and they will probably win too.' *(Study I, participant XVIII, treatment coordinator)*.

The fear of blame is particularly evident in Dutch youth care. Here the 'Savanna case', in which the family guardian was held accountable for the death of a toddler killed by her parents, has had lasting impact. While the state in the end decided not to press charges against the family guardian, professionals learned that it is crucial to strictly follow procedures; if something goes wrong and clients or the state sues them, they need to show that the rules were followed. An ambulant care worker states: 'Everybody knows the story of that young family guardian … it still frightens everybody … To fill in the right forms is much more important now.' *(Study I, participant XV, ambulant care worker)* While many scholars have focused on the limitation of professional autonomy by bureaucratic procedures (e.g. Exworthy and Halford, 1999; Freidson, 2001; Vogd, 2006), the youth workers in our study did not seem very bothered by this.

It is rather the assertiveness of clients and the state itself that limits their autonomy, while bureaucratic procedures are seen as instruments that protect them from such assertiveness. Safety and security are more important for them than autonomy. A youth group leader states: 'All protocols are useful, it is more work and it takes away some creativity and autonomy, but I still think that safety is more important.' *(Study I, participant X, Group Leader)* An ambulant care worker similarly emphasized the importance of protocols above professional autonomy:

> Protocols are very useful and it is important to follow them properly, because then you are safe and you can show how we do it within the organization … You can prove that you have acted as you are supposed to and that you didn't take any further actions.' *(Study I, participant XVI, ambulant care worker)*.

In our data bureaucratization is most prominent among semi-professionals like youth workers. This is understandable: semi-professionals generally have less discretionary power and cannot protect themselves through membership in strong professional associations such as those for doctors and psychiatrists. We hardly encountered bureaucratization as a professional style in the other studies, in which classical professionals were well represented. Yet we also found a moderately positive attitude towards the standardization of treatments (as opposed to the standardization of procedures) in mental health care and somatic care, where many high level professionals favored the use of scientific guidelines – to a certain extent. But while for professionals enacting bureaucratic style the main motive is to follow guidelines is to avoid blame, higher-level professionals tend to see guidelines as non-compelling tools to augment the quality of care. A medical doctor relates:

> I think that the expanded use of guidelines in itself is a good thing. Especially because protocols are evidence-based. But in the end protocols only give you directions … you can't stop using your own intelligence. *(Study III, participant V, Pediatrician)*.

Though higher-level professionals do not (yet) fear for their positions, there is growing concern over what the future might bring. The same doctor continues: 'So far I have enough freedom, but I don't know what the future will bring … I mean legally … maybe doctors will be sued when they deviate from protocols.'

Though we witnessed a moderately positive attitude towards the standardization of care in different sectors, bureaucratization as a professional style was only found in youth care. The bureaucrat clings to procedural requirements to protect her position against assertive clients and the state, at the risk of losing her

professional discretion and becoming a 'complete bureaucrat' who only follows procedures.

Performance

Professionals have to perform their tasks, make them visible and have their performance accepted. This becomes part of their professional routine. Our research, however, found professionals sometimes consciously striving to regulate their behavior when it could be witnessed by patients or bystanders. Borrowing Goffman's (1959) terminology, we call this way of doing professionalism *performance*. Performance pops up when professionals are uncertain or insecure about their 'front-stage' behavior; feeling watched and evaluated, they adjust their conduct accordingly. Their presentation is meant to create the impression of professionalism in the eyes of others. This is not necessarily the same as conduct defined by the standards of the profession itself.

We noticed this most clearly in the two studies on emergency care. An example is when ambulance personnel enter the site of an accident in public view. There is the 'victim', his or her family members, as well as bystanders. The ambulance personnel first try to sense the mood of those present and act accordingly – authoritatively when necessary, even subordinately when this is deemed more appropriate. An ambulance nurse reported that he sometimes runs faster to reassure the crowd, even when in his professional judgment this is unnecessary.

The architecture of one of the hospitals we studied was telling: the emergency ward's waiting room and the back offices of nurses and doctors are only separated by a glass wall. This transparency – which we also find in restaurants where kitchens are open to scrutiny – leads to the loss of a 'back-stage'. Patients in the waiting room could see the nurses on break, which for some of them was hard to accept when they themselves were clearly suffering. In response, professionals tried to avoid being seen or tried to look busy.

Another example comes from the triage system. Emergency personnel determines which patients receive priority treatment. A silent patient with outwardly invisible pressure on his chest may be more deserving than a screaming patient with a bleeding flesh wound. Nevertheless, the screaming patient will demand help, and will be supported in this by kin and bystanders. In such cases, ambulance staff will try to give the demanding patient more attention, for example by splitting up the team. The pressure to perform is clearly related to the commodification of health care, which has extended patients' rights to file complaints. The 'output' of care is now judged partly by criteria that are not defined by the professionals themselves, but by patient-consumers.

Table 2: The new ways of doing professionalism in four different sectors

	Hospital surgeons	*Psychologists*	*Youth workers*	*Emergency care nurses*
Pretender	—	+	+	+
Bureaucrat	—	—	+	—
Entrepreneur	+	+	—	—
Activist	—	+	—	—
Performer	—	—	—	+

Performance pressure is also related to the experience of professionals with demanding or even aggressive clients. An ambulance driver recalls:

> Recently, we had an accident in the city center. A guy was stabbed and seriously wounded. Bystanders were furious and immediately began to interfere with the ambulance personnel. The nurse who was trying to help the patient was pushed several times. At a certain moment we felt so threatened that we fled with the patient, though it was not necessarily the best option for the aid of the patient. *(Study V, ambulance driver)*.

While professionals can become the targets of verbal and physical aggression, they more commonly report that patients have exceedingly high expectations and are very demanding. As an employee of a hospital emergency ward states: 'When I started, people used to ask for help, now they just command to be helped.' *(Study IV)*. Patients frequently challenge the decisions of professionals and thus also their status and expertise. This puts pressure on professionals to continuously pay attention to their performance. The commodification of health care more generally entails the flattening of power relationships between professionals and non-professionals.

The commodification of health care also differentiates between professions. Hospital surgeons for example have much more discretionary space and can act as entrepreneurs in ways nurses or youth workers usually cannot. Each of the five ways of doing professionalism is more prominent in certain professions (see Table 2).

Conclusion

This article has examined how 'street-level' professionals in the Netherlands – hospital surgeons, psychologists and psychiatrists, emergency and ambulance personnel, and youth workers – are responding to the commodification of health care. We discerned five ways of enacting professionalism in response to commodification. Two were more or less predictable: the *entreprenial* way,

embracing commodification as part of the profession; and the *activist* way, rallying against the encroachment of the market. But the other three ways of professionalism were unforeseen: *bureaucratic* professionalism, seeking reassurance in procedures; *pretending*, faking compliance to protect autonomy; and *performing*, upholding the profession through conscious and skillful management of appearance in the eyes of patients and the public. What we are witnessing are not instances of individual coping, but socially sanctioned patterns of interaction.

The commodification of health care has profoundly altered professionalism. Modern market professionalism is different from its classic ancestor. But this does not mean that the market logic now reigns. It is clearly visible, notably in the entrepreneurial style. But the commodification of care at the same time strengthens existing tendencies towards bureaucratization.

We found the five ways of doing professionalism in different settings, but not equally everywhere. The *entrepreneurial* way was most prominent among surgeons and higher ranking mental health professionals able to – in their own eyes – enlarge their area of expertise. *Activism*, – open protest – was most prominent among established professionals commanding organizational resources. In Germany, medical doctors have successfully rallied against health care's commodification; in the Netherlands, the strong oppositional identity of independent psychoanalysts has been further legitimized by the parliamentary opposition. In contrast, *performance* was most often found among the lower ranks of professionals, where the commodification of care and increasing consumer demands curtail professional autonomy. In light of the growing emphasis on safety and accountability, *bureaucratization*, seeking protection in procedures was also more pronounced among lower ranking professionals.

Alongside open protest, we regularly find professionals as *pretenders*: misusing and faking administrative procedures to achieve what in their opinion is the best outcome. Professionals tend to see this as opposition. But seen from further afield, one could say that this strategy in fact supports the commodification of health care. Professionals outwardly play by the rules and mix the logic of care with the logics of the market and bureaucracy, rendering alternative courses of action and solidarity among professionals more difficult.

All in all, we found that differential levels of professional autonomy, dominance and discretion spawn different ways of weaving together the market, bureaucratic and professional logics. Higher ranking professionals, while losing their dominance, were better able to safeguard their autonomy, while lower ranking professionals lost ground in both respects. Uncertainty is increasing for all professionals, leading to feelings of insecurity and reflexivity, but also to creativity. Professionalism is less and less taken for granted. It is 'disembedded', called into question and de-routinized. The five ways of professionalism we identified amend this in professional practice – but only to a certain extent.

Finally, we discern a number of tensions. First of all, the commodification of health care is meant to guarantee quality care. But we see many instances of professionals under financial pressure reporting the less than optimal treatment of patients. We also find numerous examples of misdiagnosis and fake reporting. Though individual patients may benefit from this, on a collective level transparency suffers. More generally, the commodification of care increases the chances of conflict between patients and professionals. Commodification leads to different ways of professionalism and to greater diversity in citizen demands, increasing the likelihood of mismatches in care provision. The verbal attacks on professionals testify to this conflict between alerted consumers and uncertain professionals.

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Note

1 See above for a description of the Dutch Diagnosis Treatment Combination system.

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