Emergency physicians in the Netherlands
Kathan, C.D.

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2 The Development of EPs as a Professional Occupation: A Comparison of the Netherlands and the UK

This chapter answers the first sub-question (Q1-a) i.e. what are the similarities and differences in the professional development of EPs in the Netherlands and the UK? It therefore brings a cross-country comparative perspective to the question of how differences in the emergence of the EP profession and role can be explained. We investigate whether the development of EPs as a profession in the Netherlands follows the role model of a country where EPs are recognized specialists, the UK.

2.1 Framework for the national development of EPs

In most countries, emergency medicine is not recognized as a medical specialty. Still, EPs are no new phenomena; they have been emergency care specialists in a few countries for decades – e.g. in the UK (McHugh and Driscoll 1999; Rutherford and Evans 1983), in the USA (Pollack et al. 2003; Marx 1997), and in Belgium- (Askenasi and Vincent 1983). In the past two decades, there has been growing interest worldwide in emergency medicine as a separate medical field (Arnold 1999; Kirsch et al. 1997; Noji 1989), and several countries, like the Netherlands, are currently trying to implement and establish EPs as a new profession. Other example countries in the literature include Armenia (Aghababian et al. 1995), Japan (Onji and Tsuyoshi 1983), Costa Rica (Mitchell 1991; Doezema et al. 1991), Turkey (Bresnahan and Fowler 1995), and Israel (Halpern et al. 2004). For an overview of the status of emergency medicine see Arnold et al. (2001), who conducted a survey study on emergency medicine in 36 countries.

Kirsch et al. (1997) note that some countries seeking to develop emergency medicine and planning to train EPs, do so without learning from other countries’ previous experiences. In effect they ‘reinvent the wheel’, which “… leads to both a reduplication of efforts and unnecessary variances in the scope, content, and conduct of training programs” (Kirsch et al. 1997, p. 997). Despite using an analogous term for emergency physicians, differences with regard to their professional role exist

2 These differences do not refer to the distinction described by Arnold (1999) between the Anglo-American model –i.e. emergency medicine being started in the pre-hospital setting and being continued into the ECU, possibly being a recognized specialty- and the Franco-German model –i.e. emergency medicine taking place exclusively in the pre-hospital setting without being a recognized specialty- of emergency medicine.
between countries. The UK is an important example for the development of EPs in the Netherlands. Experts in the field, asked about their vision of emergency medicine in the Netherlands, told us, “we should do it as they do in the UK”. Dutch hospitals also tried to establish training exchange programs with UK hospitals, enabling Dutch EP-residents to spend some months of their residency experiencing the British emergency care system. For this reason, it is interesting to compare the professional development of EPs in the Netherlands and their role models in the UK. The literature on profession development describes several requirements for the sustainable development of new professions (see section 2.1.1). This chapter investigates these requirements in the UK and the Netherlands, enabling us to draw conclusions about similarities and dissimilarities and the extent to which the Netherlands follow the British model.

2.1.1 Theoretical background and method

Theoretical background

According to Nelson and Barley (1997), five quests subsume the sustainable development of new occupations. They are based on the work of sociological writers (e.g. Freidson 1970, Elliott 1972, Larson 1979, Abbott 1988) who are often referred to as the critical theorists (Evetts 2006; Hodgson 2002). (1) Founding an occupational association, (2) developing a training system, (3) linking practice to formal knowledge, (4) securing legal authority to license practitioners, and (5) acquiring the right to self-discipline. By taking these actions, new occupations gain institutional recognition, or as Hughes (1958) calls it, an institutional license. Abbott (1988), in this respect, talks about jurisdiction.

Nelson and Barley (1997) build on Hughes (1958) and point out the incompleteness of this reasoning. They argue that these steps cannot be left to stand alone. They can only become effective after two other requirements are fulfilled: first, a group of practitioners needs to be present, who are self-confident precursors and put forward collective action. Second, the professional community needs to acknowledge

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3 These two countries do not only lend themselves well to comparison because EPs in the UK act as role models for the Dutch development. The Netherlands and the UK are also quite similar countries with regard to their overall social welfare structure.
the tasks that shall be performed by the new group as work (see also Abbott 1988). These two aspects together form the *cultural mandate*. Put graphically, Hughes (1958) and Nelson and Barley’s (1997) argument is conceptualized in Figure 2.1.

![Figure 2.1: Emergence of new occupations](image)

Nelson and Barley (1997) focus their study mainly on the construction of an occupational mandate, the transition from unpaid to paid work, which forms a part in the creation of a cultural mandate.

Both Nelson and Barley and the critical theorists however, neglect another potentially important aspect of professionalization: interaction effects with parallel streams of other newly emerging occupations and organizations’ decisions. Abbott (1988) does refer to the importance of interaction effects with other professionals. However he focuses on jurisdiction by other *existing*, ‘licensed’ professions rather than referring to concurring, newly developing professional groups. We argue that even if a cultural mandate is achieved, and even if institutional recognition has been gained, parallel streams of other practitioners’ groups can influence the success or failure of another occupation’s sustainable development. This may especially be true when the planned task portfolios overlap. Several groups of practitioners ‘battle’ over fulfilling similar tasks; we think that the final decision on which occupation succeeds is being taken by organizations that are loosely coupled with one another. Based on certain aspects, the organizations decide which professionals are employed for certain tasks. Only if several organizations decide on the same professional group, will this group finally be able to establish itself as a new occupation. Besides the cultural and institutional mandate, we hence argue that the final determinant as to whether or not a group of practitioners can become a new occupation depends on parallel streams of occupational developments and on the organizations’ mandate. Figure 2.2 illustrates this reasoning.
In the following we investigate the development of emergency physicians as a new occupation in the UK and in the Netherlands with regard to the existence and creation of the cultural mandate and the institutional license. We will then show how parallel streams of occupational developments interact and finally show the role of organizations employing professionals in the emergence of a new occupation.

**Method**

Expert interviews and documents served as data sources for this chapter. Details about the interviews conducted with Dutch emergency care experts and available documents can be found in chapter 6.1. In addition, interviews about the development and the present role of EPs in the British emergency care system were conducted with ECU staff members from a large UK hospital (Table 3.1).

**Figure 2.2: Emergence of new occupations II**

In the following we investigate the development of emergency physicians as a new occupation in the UK and in the Netherlands with regard to the existence and creation of the cultural mandate and the institutional license. We will then show how parallel streams of occupational developments interact and finally show the role of organizations employing professionals in the emergence of a new occupation.

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2.1.2 Development of EPs in the UK and in the Netherlands

This section describes the development of EPs in the UK and in the Netherlands. After a brief general portrayal, characteristics about the creation of a cultural mandate and institutional license are presented. Subsequently, parallel streams of ECU occupations and the development of an organizational mandate are investigated.

The United Kingdom

The development of A&E medicine in the UK had its early roots in 1962, when the so-called Platt Report recommended new skills for doctors at the ECU which, according to the report, would best be met by orthopedic surgeons (Sakr and Wardrope 2000). In 1971, another report, the so-called Bruce Report, highlighted problems that the Platt ‘package’ had caused: first, the field of orthopedic surgery developed away from trauma to more elective complaints; second, emergency patients showed an increasing number of internal medicine complaints (Wilson 1980). The Bruce Report therefore proposed the creation of 32 experimental emergency medicine consultant posts, i.e. medical specialists. The Department of Health accepted. With the appointment of these consultants in 1972, Accident and Emergency (A&E) Medicine became a new medical specialty. The 32 consultants came from different, mainly surgery specialties (Skinner et al. 1997). The heterogeneity of their skills soon stimulated the need for a new, coherent training system for EPs. Today, over 600 emergency consultant posts exist and over 500 specialist registrars are in training (BAEM 2006).

The Netherlands

EPs were developed as an answer to the changing patient demand and the medical labor supply described earlier. The first advances were made in 1997 when a university hospital started formal education programs for a new job family, the so-called hospital physicians. Hospital physicians are characterized by a short, multidisciplinary three-year training program (Jaspers et al. 1999). EPs can be seen as a type of hospital physician. The first short-track training program for EPs in the Netherlands started in 1998 (Hirschler-Schulte et al. 1999). A university hospital and a number of large teaching hospitals soon followed with a more coordinated three-year program. During the last few years, interest in educating and employing EPs has steadily increased. According to information provided by the SOSG (Stichting
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Opleiding Spoedeisende Geneeskunde), in spring 2006, about 32 fully trained EPs were working in Dutch ECUs with another 75 were in training\(^4\).

\[2.1.2.1\] Cultural mandate

To achieve a cultural mandate, Nelson and Barley (1997) suggest two requirements: 1) the existence of a group of practitioners who are sufficiently self-confident to pursue collective action; 2) members of the culture acknowledge the activity as a form of work.

Members of the culture acknowledge activity as a form of work

The necessity of treating casualties is as old as mankind. FitzGerald (1998) sees the beginnings of organized prehospital emergency care with the Knights of St. John. Sakr and Wardrope (2000, p. 314) describe the care chain of prehospital and intrahospital care as being advanced by Napoleon’s chief surgeon who “collected and treated all the injured in an area close to the front line” where they were brought “by fast light horse drawn vehicles, the ‘Ambulances volantes’.”

Before the introduction of EPs, emergency departments in the UK were mainly staffed by surgeons and orthopedic surgery doctors (Sakr and Wardrope 2000). In the Netherlands, interns and residents fulfill the tasks under the supervision of respective specialists.

The existence of self-confident practitioners

United Kingdom. The Platt Report was supported by the Department of Public Health, which pointed out that ECUs needed to be supervised by consultants who are specifically dedicated to emergency medicine. Still, due to limited career prospects, adequate staffing was a problem and permanent ECU work was regarded as a “dead end” (Sakr and Wardrope 2000). It was only after the Department of Health’s decision, taken in 1971 and realized in 1972, to create 32 consultant posts that ambitious doctors, most of whom were from neighboring medical areas, chose the ECU as their preferred medical field. Only 4 years later, the number of A&E

\(^4\) Please note that these numbers include only trained EPs who are accredited by the SOSG. Likewise, the number of EPs in training refers only to doctors in training programmes within hospitals with SOSG accreditation.
consultants had risen to 105. The Department of Health’s decision thus stimulated doctors to get involved with A&E medicine; it gave them the consciousness to act as professional pioneers.

Professionals state the year 1972 and the employment of the 32 emergency medicine consultants as emergency medicine’s year of birth in the UK.

The Netherlands. Two important differences exist between the UK and the Netherlands with regard to the first doctors working as EPs. First, while the UK appointed non-EPs as emergency care consultants –i.e. a formal specialist position-, the first EPs in the Netherlands were not senior doctors from existing specialties. No EP had completed a residency before commencing the EP-training. All Dutch EPs were hence rather young and had comparatively less experience than medical specialists. Second, most doctors starting out the EP-training in the Netherlands did not have any job security for a future appointment. After the three-year training contracts were concluded, hardly any formal assurance existed for subsequent employment. Due to their limited experience and job insecurity, the Dutch EPs’ work context possibly provided them with less self-confidence than their British colleagues.

2.1.2.2 Institutional license

Nelson and Barley (1997) outline the following five requirements for gaining an institutional license: (1) founding an occupational association, (2) linking practice to formal knowledge, (3) developing a training system, (4) acquiring the right to self-discipline and (5) securing legal authority to license practitioners.

Founding an occupational association

United Kingdom. Two main bodies unite A&E practitioners and their interests in the UK: the British Association for Emergency Medicine (BAEM) and the Emergency Medicine Trainees Association (EMTA).

The BAEM was founded in 1967 as the Casualty Surgeons Association. The initial name, which clung to the nature of the early specialty, was changed in 1990 to British Association for Accident and Emergency Medicine. In 2004, it was renamed again and received its present name (BAEM 2007). Membership of the BAEM is
available to any registered medical practitioner with a professional commitment to emergency medicine. In February 2007, the association had more than 1700 members. According to interviewed experts, the association’s changing names reflect the issues surrounding the specialty’s focus. While emergency medicine was initially regarded as closely related to surgery, changing patient demand and interests caused it to develop into a more stand-alone discipline. For an overview of the association’s explicit roles see Hughes (2005).

The EMTA was established as the national body that represents all emergency medicine trainees. It is partially funded by -and hence closely related to- the BAEM. Membership is free and automatic for trainees.

The Netherlands. In September 1999, shortly before the actual start of most EP training programs in 2000, the Dutch Society of Emergency Physicians (Nederlandse Vereniging van Spoedeisende Hulp Artsen - NVSHA) was founded. Five years after its foundation, in June 2004, the NVSHA had 180 members. By February 2007, it comprised 202 members, of which 59 are trained EPs and 143 EPs in training (based on information provided by the NVSHA).

Development of a training system

United Kingdom. In the early days of UK emergency medicine, consultants’ skills could vary widely due to their previous affiliation and background (see above). The development of a coherent training system for new EPs started in 1975, 3 years after the employment of the first 32 EPs, when the Specialist Advisory Committee in Accident and Emergency Medicine was formed. Its task was to create a recognized training system, leading to equally skilled consultants. Two years later, in 1977, the first specialist registrars –i.e. the British resident equivalent- were appointed for training. The first pre-specialty examinations, which enable senior house officers –i.e. senior intern equivalent- to apply as specialist registrars, took place in 1983. Passing the exam grants the title ‘Fellow of the Royal College of Surgeons of Edinburgh in A&E Medicine’ (FRCSEdA&E).

Since 2005, the College of Emergency Medicine (CEM) is the leading institution to advance education in emergency medicine. It emerged from the 1993 founded Faculty of Accident and Emergency Medicine. Members of the BAEM were involved in its creation. CEM is responsible for setting standards of training and for
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Administering exit examinations, the first of which were conducted in 1996. Passing the exit exam awards the fellowship and membership of the College. The corresponding title is ‘Fellow of the Faculty of A&E Medicine’ (FFAEM) (McHugh and Driscoll 1999).

The Netherlands. At the beginning of the EP development, several hospitals elaborated training systems which were partly based on individual expectations, local requirements, or existing cooperation with other hospitals (de Vries et al. 2001; Hirschler-Schulte et al. 1999; Jaspers et al. 1999). In 2004, a body was created to standardize the various schedules and to develop a coherent national training system, the Stichting Opleiding Spoedeisende Geneeskunde (SOSG). This association emerged from the, initially informal, cooperation of a number of large teaching hospitals and a university hospital. It was formally founded in March 2004 with the explicit goal of creating a nationally accredited EP training scheme. Moreover, it aims at embedding the new schedule into existing medical training structures and at registering doctors who have completed an accredited EP training. The SOSG’s registration and training committee mainly consists of surgery and internal medicine specialists from hospitals offering EP training. In February 2007, only two out of eight members were EPs (in training).

The most important difference with the UK is the relation between the creation of the ‘formal’ specialty and creation of a training system: in the UK, emergency medicine is said to have existed as a medical specialty since 1972, even though no training system existed back then. This is entirely different from the Netherlands, where a training system is currently being established without knowing whether emergency medicine will develop into a recognized specialty.

Linking practice to formal knowledge

United Kingdom. In 1983, the Emergency Medicine Research Society (EMRS) was established as the first attempt to advance research in the field. The society organized annual meetings in EM science. In 1985, the “British Journal of Accident and Emergency Medicine” – renamed in 2000 as “Emergency Medicine Journal” (EMJ) – was launched (Hughes 2005). EMJ is the official journal of the BAEM. Since 1986,

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3 The SOSG does not have an official English name. We therefore suggest translating its name into Association of Emergency Medicine Training in the Netherlands.
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the BAEM organizes an annual spring conference and the CEM organizes an annual autumn conference. Besides, various symposia are held throughout the year (Hughes 2005). Today, the research committee of the CEM plays an important role in advancing formal knowledge in the field.

The Netherlands. In contrast to the UK, emergency medicine research activities are not very coordinated in the Netherlands. Although the NVSHA names “the stimulation and support of academic research in the field of emergency medicine” and “publication of an academic emergency medicine journal” among their future goals, these have not been much advanced yet. Another explicit goal, the organization of an annual symposium, is scheduled to take place for the first time in 2007.

Securing legal authority to license practitioners

United Kingdom. The General Medical Council and the CEM play important roles in licensing practitioners.

The UK medical training scheme is currently subject to change. Before 2006, house officers -i.e. doctors graduating from medical school without having followed any higher training yet- were pre-registered with the General Medical Council (McHugh 1999). After the first year, during which they were junior house officers, they became fully registered with the General Medical Council and worked the subsequent 2 years (at least) as senior house officers. After this period and after having passed the exam(s) of the relevant medical college(s), which award the college’s membership, doctors could apply for specialist registrar positions. This specialist training mostly took five years and was finished with an exit exam, which awarded the registered fellowship of the specific college. In the case of emergency medicine, this was the Fellowship of the College of Emergency Medicine (FCEM). Practitioners were thus at first licensed by the General Medical Council. The second license as a specialized emergency physician was granted by the College. Since 2006, a new training scheme replaces house officer years by two so-called foundation years, followed by up to six specialist training years. The (pre)registration with the General Medical Council stays the same. Changes in the College’s role of granting membership and fellowship status are not yet known at the time of writing. However, experts expect that the CEM will continue to play an important role in licensing emergency physicians.
The Netherlands. In contrast to the UK, the Netherlands started out with several parallel EP training schemes, which had been developed according to single hospitals’ needs and visions. They had not been approved by a superior body. Since 2004, the SOSG took on certifying hospitals for EP training and registering both EPs in training and trained EPs. This entails that EPs who were not trained in a certified hospital are not able to register as an EP with the SOSG. Still, these doctors work as EPs. The hitherto exercised licensing by the SOSG is thus not legally exclusive. However, since most uncertified hospitals did not take on the training, or have stopped it by now, unregistered EPs are limited in number.

According to information from the NVSHA, the SOSG is only intended to be a temporary organization until a consistent training program is established. Its remaining tasks, e.g. registering and licensing practitioners, are planned to be transferred to the NVSHA in the long term.

Acquiring the right to self-discipline

Evett (2006, p. 525) describes self-discipline as a stage in which “key controls are internalized and proactive rather than external and reactive”. Hodgson (2002) explains it as the loss of direct forms of control.

United Kingdom. Although emergency medicine has existed as a specialty in the UK since 1972, it has been closely related to surgery for a long time. The first professional A&E exams were held under the chair of the Royal College of Surgeons of Edinburgh in 1983. This College has also been the superordinate institution for the Faculty of Accident & Emergency Medicine since 1993. A large step for the specialty’s self-discipline was taken in 2005 through the establishment of the independent College of Emergency Medicine. The Royal College of Physicians, i.e. the national body of internal medicine, set strict boundaries between emergency medicine and internal medicine. Despite this restriction, some British emergency medicine consultants stated, they could imagine it to be more intertwined with internal medicine.

The Netherlands. Compared to the UK, emergency medicine has little right to self-discipline on the national level. The development of training goals and schedules is mainly driven by the SOSG, whose members are mainly representatives of long-
established medical specialties. Trained EPs and EPs in training can only contribute to it through participation in the NVSHA.

2.1.2.3 Parallel streams and organizational mandate

Having described the EPs’ cultural mandate and institutional license, we are now investigating the effect that other new professions may have on the EPs’ development. In this respect it is important to look at the traditional standing of doctors and specialists in the health care system. We therefore describe the EPs’ current and ‘competitive’ position in the light of the medical professionals’ historical role in the Netherlands and the UK. We then draw conclusions about the role of organizations in executing the, what we call the “organizational mandate”.

United Kingdom

The history of medical doctors in the UK has for a long time been characterized by relatively little state control (Dent 2003; Burrage et al. 1990). This, as Macdonald (1995, p. 77-78) puts it, “resulted in the hospitals falling under the control of the doctors”. Especially in the pre-Thatcher era, it was the role of the management to support the doctors (Harrison 1999). The autonomy and dominance of medical professionals could only be threatened in the light of escalating costs (Dent 2003). This, however, had not come into play yet when the first emergency physicians were employed in 1972. Emergency care provision was regarded as a traditional medical task that ought to be conducted by doctors. Yet, doctors regarded the emergency department job as a “dead end road” (Sakr and Wardrope 2000). Turning emergency care jobs into a medical specialty thus turned out to be the only thinkable solution, bearing in mind that due to the doctors’ dominant position, tasks were not considered to be transferable to non-medical professionals (i.e. non doctors).

Within the medical domain, EPs had to define their tasks and responsibilities within the old-established medical specialties. Today, most emergency surgery tasks are conducted by EPs; their involvement with emergency internal medicine is more limited.

Since 2003 a new development has taken place: the so-called specialty Acute Medicine was founded as a subspecialty of general internal medicine. This new
profession covers emergency tasks of internal medicine, just like emergency medicine
covers issues that are mainly surgery related. Acute Medicine thus restricts EPs
activities in the field of internal emergency medicine. While acute medicine doctors
have emerged on the internal medicine side, another profession has emerged to treat
minor injuries and traumas: emergency nurse practitioners. The introduction of nurse
practitioners in the UK partly followed the increasing costs and the rise in clinical
patients (Hicks and Hennessy 1999). Emergency nurse practitioners are emergency
nurses, who receive special training which enables them to treat certain medical
complaints themselves by following protocols without consulting a doctor. According
to some interviewees, they see up to 90% of minor injury patients in some ECUs.

Another recently discussed development in the National Health System is the
implementation of so-called physician assistants. Originating in the US, physician
assistants are "health care professionals licensed to practice medicine with physician
supervision" (American Academy of Physician Assistants), and who "work in all
branches of medicine and surgery" (Hutchinson et al. 2001, p. 1244). They have
competencies equally to the senior house officer level and can provide first contact to
patients needing immediate medical care (Katikireddi and Rushworth 2004). In the
discussion ongoing in the UK, physician assistants are regarded as ‘mid-level’
practitioners like doctors in training and nurse practitioners (Hutchinson et al. 2001).
One of their specific characteristics in A&E settings is their large dependence on a
supervising physician, preferably on site, in addition to consultations by phone (Smith
et al. 2005). Therefore, instead of possibly replacing trained EPs, physician assistants
substantially need trained EPs for their work.

Still, with acute medicine doctors on the one side, emergency nurse
practitioners on the other side and only a given number of genuine emergency patients
(i.e. patients in acute life-threatening conditions), EPs in the UK find themselves in a
possibly narrowing niche, especially in small hospitals with comparatively few
emergency patients. However, being a traditional and long-established profession
compared to these newcomers, EPs were reported to have formed a stable occupation
in British ECUs. They are ‘the bosses’ of the ECU. Without their support and
approval none of the newly merging occupations could actually gain ground in
emergency care. The other professions’ development thus relies on EPs. The
interviews revealed that up to now, most hospitals with an ECU opted for the
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employment of EPs, while acute medicine doctors, emergency nurse practitioners and physician assistants are much less represented⁶.

The Netherlands
In the Dutch health care system, specialists play a traditionally strong role and are often more independent from hospitals than in the UK (see Dent 2003). Their self-determination depends on how they are affiliated with a hospital. Two ways of affiliation exist. First, doctors can be employed by the hospital. This is often the case in large teaching hospitals. Medical specialists and their departments are in a hierarchical order within the hospital and report to the board of directors. Second, doctors have a contract to work within the hospital, but are organizationally separate from it by being organized in their own ‘partnerships’ (maatschappen). Partnerships consist of medical specialists of the same discipline. In hospitals with a partnership setting, the relationship between management and medicine is characterized by co-existence rather than by hierarchy. The specialists act as entrepreneurs and provide most of the work and income for the hospital (Dent 2003). According to Schepers and Casparie (1997), partnerships pursue certain financial interests (p. 597: “fees … are pooled and divided … among members”) and play an important role in the definition and introduction of medical innovations. However, since the integration law of 2000 (Integratiwet), the relationship between management and medicine has slightly changed. The hospital has the decision making power for the care provided by the hospital. In return, it has to consult the medical specialists with regard to budgeting issues (Tamboer et al. 2002). According to Scholten and van der Grinten (2000), the integration law strengthens the specialists’ collective power by reducing the individual’s.

In either case, with doctors employed or in partnerships, organizations are likely to consult the traditional specialties’ opinion before implementing an innovation like EPs. Still, unlike in the UK, the organization being only loosely coupled with medicine does not need to directly follow the suggestions. However, in hospitals with partnerships, organizations can use their organizational mandate only with the partnerships’ support due to the budgetary interdependence. The interviews revealed that hospitals are more likely to decide on employing EPs if other hospitals

⁶ Concrete numbers are, especially for nurse practitioners, not available due to the lack of a national training accreditation and registration system.
have done so already. In the literature, this phenomenon is widely known as imitation (see for instance Strang and Still 2006, Haunschild and Miner 1997, or Sevón 1996).

With regard to the development of parallel occupations, Dutch EPs lack their British colleagues’ first mover advantage. While EPs in Britain had the possibility of establishing themselves without many competitors at a time of relatively few budgetary restrictions, Dutch EPs emerged at the time of a changing care system and increasing financial constraints. The interviews we conducted reveal that ECUs have to cope with an increasing number of new occupations developing simultaneously. They mostly require ECU patients for either training or working purpose. New occupations that were mentioned are emergency nurse practitioners and physician assistants. When implemented within ECUs, both groups focus on a comparable patient group as EPs. British EPs can focus on rather complex emergency patients and on providing supervision to interns, residents and other professional groups, leaving minor injuries to nurse practitioners or –under supervision- to physician assistants. Dutch EPs, in contrast, are mostly not meant to provide care for seriously ill emergency patients, especially in large teaching hospitals. They are often restricted to patients with minor injuries and illness. Most EPs do not have any managerial or supervising tasks; often, they have to ask supervision from specialists themselves. This puts EPs in a much weaker and fragile position than their British colleagues. In fact, many patients seen by EPs in the Netherlands could as well be seen by comparatively cheap emergency nurse practitioners. And with specialists still playing an important supervisory role, supervision could also be provided to the comparatively cheap physician assistants.

7 For an overview of recent developments in the Dutch health care system see van Rooij et al. (2002) and MinVWS (2005).
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2.2 Conclusions and discussion: Analogies and differences between the development of EPs in the Netherlands and the UK

The development of EPs in the Netherlands and in the UK is based on similar motives. Yet, their development path and implementation in hospitals and institutions are quite different.

Emergency care provision is recognized as a form of work in both countries, forming the basis for a cultural mandate. However, the existence of self-confident practitioners differs. While the first EPs in the UK were trained and experienced – hence presumably comparatively self-confident - medical consultants from traditional medical disciplines, EPs in the Netherlands were recruited from mostly young and comparatively inexperienced doctors who had just finished medical school. Besides, they mostly did not have any certainty to work as EPs once they finished their training. Unlike the British A&E “pioneers”, Dutch EPs were not provided with trust in advance. They had to perform well in order to secure their existence. Besides sheer performance, EPs in the Netherlands have to put their trust in specialists and hospital management to further advance the development of their profession. On the one hand, these uncertain circumstances are likely to attract self-confident doctors with a real passion for emergency medicine; on the other hand, the EPs’ own power is very limited and they have to rely on other specialties’ support.

This support also plays an important role in the creation of an institutional license. The most remarkable difference between the two countries is the Dutch EPs’ dependency on specialists from the traditional specialties, which shows in nearly all of the five described steps, especially in the limited right to self-discipline, the development of the training system, and the development of formal knowledge. The training system is developed by a group mostly consisting of medical specialists. EPs thus depend on the specialists’ assessment of required skills. Up to now, Dutch EPs only show limited scientific efforts. This is probably to some extent due to their limited history. It can also be explained by the uncertainty of the future status of their field and by the limited scientific experience of most EPs. Again, they rely on senior facilitators from long-established specialties to act as their mentors. Still, compared to the UK where it took more than 10 years to develop scientific fora, the Dutch do not seem to lag behind the British.
In addition to a range of professionalization literature, we investigated simultaneous occupations’ developments and the organizations’ possibility to choose for or against EPs, that is the organizational mandate.

When EPs first came into existence in the UK, organizations followed the –at that time– predominant authority of medical doctors and implemented EPs. The organizational mandate was hence largely influenced by doctors, and it still drives most hospitals to employ EPs. With regard to parallel developing occupations, acute medicine doctors, emergency nurse practitioners and physician assistants can possibly affect EPs. Up to now, most hospitals with an ECU employ EPs. Acute medicine doctors are not widely-used. The number of emergency nurse practitioners continues to increase slowly. Due to hospitals’ increased cost-awareness, emergency nurse practitioners, who are a cheaper human resource than EPs, may narrow down the EPs’ hitherto stable niche. Physician assistants, another occupation with growing numbers, depend on doctors’ onsite supervision. They need experienced doctors at the ECU, who in the UK tend to be EPs. Therefore, they are less of a threat to EPs than nurse practitioners.

In the Netherlands, EPs, right from the start, have been a more endangered medical profession than their British colleagues. In contrast to the UK, the simultaneous development of emergency nurse practitioners and physician assistants could be a threat to the sustainable development of EPs. The benefit of EPs is not sufficiently proven, and hospitals collectively may decide to grant their organizational mandate to other professionals, who compete for a similar patient group at lower costs. Up to now, however, EPs seem to have a more secure standing than emergency nurse practitioners and physician assistants. They are more numerous and have a – controversial but compared to the nurses quite strong- medical lobby. The intensity of the financial pressure on hospitals as well as the EP pioneers’ performance will tip the balance.

We expand on existing professionalization theory by going beyond the traditional focus on the cultural mandate and the institutional license. Traditional approaches neglect aspects that we found to play an important role in EP development: i.e. parallel emerging occupations and organizations’ shared decisions. The parallel development of occupations that are targeted at similar tasks or clients brings about competition; this competition can be mediated by organizations’ shared decision to hire either one or the other. The bases of this decision can be diverse and may be
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rooted in the historical context of the organization, strategic management goals or individual actors’ influences. These aspects should not be neglected in investigations of occupational development.