

# **Wish-fulfilling medicine**

**ceg**

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# 1 Introduction

The term wish-fulfilling medicine is a relatively new umbrella term denoting any sort of medical treatment carried out without direct medical need. Wish-fulfilling medicine occurs in all domains of medicine: in primary care and specialist medical care, as well as the care offered by commercial providers both in the Netherlands and abroad. There are no hard figures, but the general impression appears to suggest that wish-fulfilling medicine is on the increase. Increasingly more can be done and therefore increasingly more is being done.

This report describes the phenomenon of wish-fulfilling medicine in its many facets. On the basis of this kaleidoscopic picture, we examine the question of whether wish-fulfilling medicine is in fact medicine and where the dividing line from conventional medicine lies. To what extent is what we understand by wish-fulfilling medicine determined by the cultural context? We also examine the question of from whom a 'wish' actually comes. It is not just the public who wants something. There are also doctors who are happy to deploy and demonstrate their professional skills. They want to treat and earn from doing so. Then there are the commercial providers who want to sell their 'wares'.

We then examine the social and moral acceptability of wish-fulfilling medicine. With the current increase in medical technical possibilities and rising public care costs, questions about the acceptability of wish-fulfilling medicine are topical and relevant to policy-making. Which wish-fulfilling medical procedures might be reimbursed from public funds? How and by whom is it decided what is and what is not eligible for reimbursement?

In this report we endeavour to offer health care providers, health care users, health care insurers, and the government an insight into what wish-fulfilling medicine is and what ethical considerations are associated with it. Hopefully this publication will stimulate debate about wish-fulfilling medicine.

## **What is wish-fulfilling medicine?**

Sometimes there appears to be almost no possible doubt as to whether a treatment should be regarded as wish-fulfilling medicine. This is the case, for example, with cosmetic procedures that are intended to make a person look young for longer.

*Thus, in recent years what is known as 'Mommy make-over' has also taken off in the Netherlands. 'Mommy make-over' comes from the United States, where it has been a very popular and successful cosmetic procedure for many years. 'The Mommy make-over' includes both breast reduction and a tummy tuck (sometimes liposuction as well).' (<http://www.bergmanclinics.nl/divisies/uiterlijk-en-huid/behandelingen/buik-benen/mommy-make-over>). It combines breast reduction with a tummy tuck and liposuction and thus*

*represents major surgery with long-term recovery. Women who undergo such surgery find it worth the effort in 90% of cases, one of the highest satisfaction scores for plastic surgery.*

However, there are many cases in which opinions can differ about the medical need for treatment, for example in the case of medicines for osteoporosis.

*Osteoporosis often occurs in later life. Medicines that delay the breakdown of bone are a solution for people who struggle with osteoporosis as a result of thyroid problems, for example. However, should these medicines also be prescribed to postmenopausal women, who are at increased risk of osteoporosis? Is the increased fragility of bone something that must be actively combated, including in order to prevent possible hip fractures and surgical procedures later, or is it simply a manifestation of growing old?*

The term wish-fulfilling medicine is mainly associated with the client's wishes. These wishes do not exist in a vacuum but are also influenced by the client's social environment. Thus, it may be that employers play a major role in this. Taking the example of sponsored egg freezing, the question is how important that influence is.

*Since 2014 Facebook and Apple have included the costs of egg vitrification in their secondary working conditions for female employees in Silicon Valley. As a result they are the first major employers to contribute to the costs of egg freezing for non-medical reasons. Brigitte Adams is an advocate of egg vitrification and founder of a patient forum ([www.eggsurance.com](http://www.eggsurance.com)). She says: "By offering this benefit, companies are investing in women and supporting them in carving out the lives they want."*

What we now consider 'normal' in the Netherlands and count as conventional medicine could be qualified as 'wish-fulfilling medicine' a few decades ago and/or elsewhere in the world. Conversely, certain wish-fulfilling medical procedures that are performed relatively little in the Netherlands are the order of the day in other countries.

*While total body scans are forbidden in the Netherlands, Dutch people can get such scans, for example, in Germany and Austria. Patients who have exhausted their treatment in the Netherlands or who need donor sperm or egg cells also go abroad.*

The above examples make clear that wish-fulfilling medicine is a time- and place-related concept and that it often cannot be clearly distinguished from conventional medicine. Because of the elasticity of the term, it is also not easily possible to put a figure to the actual share of wish-fulfilling medicine in health care. However, the impression exists that worldwide as well as in the Netherlands more medical techniques and products are being used for non-medically necessary purposes. It also seems as if this is occurring in more areas of health care, among general practitioners and specialists, as well as commercial providers. This is also apparent from the Letter to the House: "Should everything be done that can be done?" of 1 July 2014, in

which the Minister and Secretary of State for Health state: “Not infrequently, the doctor acts on the basis of what is technically possible, prescribes medication because it can be prescribed, or treats a patient because that is what the patient asks.” (VWS [Ministry of Health, Welfare and Sport] 2014).

### **Social debate about ethical questions**

The term ‘wish-fulfilling medicine’ was coined by the bioethicist Alena Buyx in 2008 (Buyx 2008). However, even before this term existed, there had already been some discussion about the phenomenon. This happened in the Netherlands, for example, with the introduction of ‘the pill’ (in 1962).

*There is usually no medical need to take the contraceptive pill; it is a reliable and cost-effective way of preventing unwanted pregnancy. The introduction of ‘the pill’ resulted in vigorous social and political discussions because of its possible effects. Some thought that the ‘moral decay’ that they observed in society would increase still further as a result of the use of the pill, while others saw it as a means of preventing a worse evil – abortion; still others found it a welcome way of preventing or postponing pregnancy (Struijs and De Beaufort 2010).*

In the current public debate, the term wish-fulfilling medicine is usually presented in an unfavourable light. Some emphasise the fact that certain medical activities are superfluous, others wonder to what extent a particular medical treatment is morally acceptable or socially responsible.

*There are thus questions about labial reduction in young girls: how compelling are certain beauty ideals? In the case of caesarean section on request by women: should nature no longer do its work? In the case of the provision of total body scans: is one seeking a full screen or reassurance? Questions can also be raised about the costs of non-medically necessary treatments and possible complications.*

Various ethical questions are associated with the subject of wish-fulfilling medicine. An important moral problem is the risk of displacement of medically necessary care by non-medically necessary care (for those who can pay). For health care providers and health care institutions, it may be more interesting from an economic perspective to offer treatments that are not medically necessary but that are wanted by the self-paying patient. The expertise and commitment of these care providers is then lost to the possibly less profitable conventional medical care sphere. A related question is the possible ‘after-care’ of complications of wish-fulfilling medical procedures that end up in conventional care. This results in costs that come within the basic insurance package and possibly in a shortfall of care providers and medical facilities.

These questions are of added relevance because medical possibilities are increasing and care costs are rising. Medical technical developments increase the chance of wish-fulfilling

medicine simply because more can be done. On a policy and strategy level, the question therefore is whether everything that is medically possible should also be available and in particular also who should pay for it. Where does the boundary line lie between insured and non-insured care? What do we pay jointly and what is our own responsibility or covered by top-up insurance? This is related to the question of how far the right to care extends. As a result of the insurance structure, the patient is sometimes no longer clear what insured care is and what he must pay for himself.

### **Guide to the report**

This report is structured as follows. In chapter 2 we discuss how wish-fulfilling medicine can be defined as a concept and we debate the question of whether wish-fulfilling medicine can be distinguished from conventional medicine. In the following chapter (3) we identify the regulatory and financial contexts within which wish-fulfilling medicine in the Netherlands plays a role. The debate about wish-fulfilling medicine and the ethical questions that arise in this context we discuss in chapter 4. In chapter 5 we illustrate the changing distribution of roles and relationships between health care users, health care providers, health care insurers, and the government, as well as the effect of this on wish-fulfilling medicine. In the last chapter (6) we take stock of and discuss the ethical implications.

## 2 In search of a definition of wish-fulfilling medicine

How can wish-fulfilling medicine as a concept be defined and can it be distinguished from conventional medicine?

### **Alena Buyx's definition of wish-fulfilling medicine**

The bioethicist Alena Buyx is one of the few to have written about the phenomenon of wish-fulfilling medicine. In her article about theoretical and ethical aspects of wish-fulfilling medicine, she gives the following working definition:

*[W]ish-fulfilling medicine will be understood as doctors and other health professionals using medical means (medical technology, drugs etc.) in a medical setting to fulfil the explicitly stated, prima facie non-medical wish of a patient (Buyx 2008).*

Buyx states that wish-fulfilling medicine can readily be distinguished from other forms of wish-fulfilling practice: it involves the use of medical techniques by medical professionals in a medical setting. Wish-fulfilling medicine is often difficult to distinguish from other forms of medicine. Wish-fulfilling medical treatments can be part of the medical standard in another medical context. The difference from conventional medicine lies in the absence of a medical indication:

*There do not necessarily have to be any symptoms - the only symptom may be the patient's wish for a certain state of affairs -, there is no need for a diagnosis and the indication for treatment is given by the patient corresponding to her personal, non-medical desires and wishes. (Buyx 2008).*

### **Two footnotes entail an amendment to the definition**

First of all, regular medical intervention is based on two pillars: the medical indication and the patient's informed consent. In wish-fulfilling medicine, the first pillar is absent, as a result of which the emphasis comes to be placed on what the patient wants from the doctor. Obviously it is not the case that the patient's wish should not be important in conventional medicine. The patient wants to become better, which is why he goes to the doctor. In this sense, all medicine is wish-fulfilling medicine. However, without a medical need, the doctor has no reason to accede to the patient's request other than the request itself.

Secondly, the emphasis on 'wish' encompassed within the concept of 'wish-fulfilling medicine' raises the question of from whom the 'wish' actually emanates. Is it the citizen's wish, the wish of the doctor who wants to perform the medical procedures, of a commercial care provider (manufacturer) who would like to sell his medications or technology or possibly of the health care insurer who wants to attract customers with a tempting offer? In our view, Buyx's

definition can easily give rise to the misconception that wish-fulfilling medicine is primarily a question of doctors who are confronted with requests from over-demanding patients. However, the patient's request is only one side of the coin. By wish-fulfilling medicine must equally be understood, in our view, the offer of services by medical professionals and commercial providers, by which people are encouraged to make use of medical services for which no medical need exists. It is for this reason that we adopt a broader working definition than Buyx: *wish-fulfilling medicine is the use of medical knowledge, skills, products, and techniques without a medical need existing for them.*

### **Curing or improving people?**

According to Buyx, wish-fulfilling medicine differs from conventional medicine through the absence of a medical indication. Medical knowledge, skills, products, and techniques, which from now on we will refer to jointly as medical therapies, are used primarily in conventional medicine to undertake medically necessary procedures. However, these medical therapies can also serve other purposes. Think for example of sports medicine, which aims to improve sporting performance. Wish-fulfilling medicine is less concerned with curing and more with improving people. Where precisely does the boundary lie?

Jochemsen et al. (2005) take as their basis what Lindeboom has described as the 'core medical situation':

*"The core medical situation is where a sick person summons help from a physician. The sick person is a human being in need, because of his physical or mental condition. In his need he asks for help of someone, whom he believes, is able and willing to give it."*

In this situation, three aspects are important: the question of the suffering patient (his complaint); the knowledge and skill of the doctor; and the professional nature of the medical activity. To what extent do these three aspects also apply to wish-fulfilling medicine? There appears to be no doubt about the second and third aspect: a call is made on the knowledge and skill of the doctor, who deploys these within the professional setting of the medical activity. In this respect, wish-fulfilling medicine is therefore no different from conventional medicine. Is it then the first aspect that makes the difference: the question of the suffering patient, his complaint? Buyx argues: if it is not the complaint but just the 'patient's' wish that gives rise to the treatment, then this is a wish-fulfilling medical treatment. Although the absence of complaint provides a clear distinction, considerable responsibility is then placed on the requester as a result. The role of the providers should also be recognised. In addition: there may well be considerable 'suffering' underlying a non-medically necessary treatment. If the treating doctor does not find the suffering severe enough, the treatment may be deemed non-medically necessary. However, the question then is to what extent this is wish-fulfilling medicine.

### **Fluid transitions between conventional medicine and wish-fulfilling medicine**

There are boundary lines between wish-fulfilling medicine and conventional medicines, but it is not easy to define where these lie. In the public debate, the context often determines whether a certain procedure is regarded as wish-fulfilling medicine. One illustrative example is that of egg vitrification.

*Egg freezing in young women who are due to undergo chemotherapy is regarded as a medically necessary treatment. Similarly, this treatment offers a medical solution to women who undergo premature menopause. The medical indication is less clear in the case of a single woman in her mid-30s with a reduced store of eggs. Is egg freezing here a medically necessary treatment or a natural variation in the decline in fertility? And what is the decision in the case of a 22-year-old woman who does not yet have any clear wish for children but who wants to have her eggs frozen to be on the safe side.*

This example shows clearly where a treatment can lie on the spectrum of medical indication to social indication and how difficult it is to establish whether it relates to conventional or wish-fulfilling medicine (NVOG 2010).

### 3 **Regulatory frameworks: professional, legal and financial**

For our understanding of wish-fulfilling medicine and the possible ethical implications, it is helpful to look at the context within which wish-fulfilling medicine plays a role in Dutch practice.

#### **Wish-fulfilling medicine in the professional and legal context of health care providers**

Do other legal and professional rules apply to wish-fulfilling medical activities than to conventional medical activities? In this section, we examine how wish-fulfilling medical activities and treatments fit into the professional legal frameworks of health care providers.<sup>1</sup>

#### **THE BIG ACT (1993)**

A relevant law in this context is the Individual Health Care Professions Act (BIG Act). This Act relates to 'activities in the field of individual healthcare'. By this is understood, in art. 1(1) of the BIG Act, as well as medical activities, all procedures, including investigations and the provision of advice, that relate directly to a person and serve to promote or monitor their health. It follows from the definition in art. 1(1) that the scope of the BIG Act is not confined to medical activities, but applies also to non-medical care provision. In addition to the focus on the individual, it is also important that it involves activities to be performed professionally and without compulsion. If these requirements are not met, an activity falls outside the scope of the BIG Act. On this basis, we can observe that wish-fulfilling medical treatments, conceived as activities or treatments without a medical indication, come under the BIG Act if they are focussed on the individual and performed professionally.

#### **RESERVED PROCEDURES**

Procedures can constitute a risk to the health of the individual if they are performed by persons who are not qualified. Under the Act, these 'reserved procedures' may be performed only by health professionals qualified to do so. Art. 36 of the BIG Act contains a list of reserved procedures together with an indication of the professional groups who may carry out these procedures.

<sup>1</sup> With thanks to Dr J.H.H.M. Dorscheidt; this paragraph is based on his note on the legal context.

The legal list of reserved procedures primarily includes procedures that are designated by a collective name. In this respect, some designations (medical procedures, obstetric procedures) are broader than others (endoscopies, catheterisations, injections, punctures). This does not always provide the desired clarity about the exact content of the term 'procedure' and the risk potential ('considerable risk') of a procedure if this is performed by a non-expert.

A reserved procedure may be performed only by people who are declared legally qualified for this purpose (art. 36(15) BIG Act):

- *doctors may carry out all reserved procedures.*
- *dentists and midwives may carry out the reserved procedures that belong to their profession.*
- *nursing specialists and physician assistants may also carry out certain tasks independently, e.g. giving injections and prescribing medicines.*
- *Only healthcare professionals listed in the BIG register may use a protected title. Eight professional groups (doctors, pharmacists, physiotherapists, health care psychologists, psychotherapists, dentists, midwives, and nurses) may register in the BIG register. By consulting this register, patients know that they are dealing with a qualified care provider who comes under the disciplinary code. (Nationale Zorggids: BIG register)*

The BIG Act protects patients in principle against incompetent and negligent action by health care providers, even if this involves non-medically necessary (wish-fulfilling medical) procedures. Wish-fulfilling medical procedures thus also come under the BIG Act.

#### **THE WGBO (1995)**

In the Medical Treatment Contracts Act (WGBO), emphasis is placed on the professional standard of the health care provider. The professional standard may be regarded as the 'crystallised expertise of health care providers on the professional group level'. This involves a set of standards, guidelines, and considerations that a health care provider is deemed to bear in mind in a treatment agreement with a health care client. It is up to the health care provider to assess whether a treatment is or is not medically necessary. On the basis of his professional autonomy, the health care provider can deviate from the professional standard on reasoned grounds because it may be more in the interest or well-being of his patient. Legemaate refers to the dual nature of this legal provision: it is not simply a matter of strengthening the patient's rights, but also laying down in law the health care provider's own responsibility. The reasoning in the elaboration of the WGBO was to avoid a 'you ask, we deliver' situation (Legemaate 2013). On the basis of this legal article, the care provider can refuse patients' unjustified wishes such as a non-indicated treatment (Legemaate 1998).

#### **FROM KZI (1996) TO WCZ and WKKGZ (2014)**

With the Care Institutions Quality Act (KZI 1996) a broader approach to the concept of professional standard in relation to responsible health care came into view. Compared with the WGBO, the KZI places greater accent on the patient's perspective as a benchmark for 'responsible' or good health care provision.

*The health care provider offers responsible care. Responsible care implies care of a good standard that is provided in an effective, efficient, and patient-centred way and that meets patient's actual needs (article 2 of the KZI).*

In 2009 the starting shot was fired for a new law, the Consumer Rights in Health Care Act (WCZ), which was to combine all the rights of clients and all the obligations of health care providers in one act. The consolidated act, however, aroused too many questions and

resistance. It was decided to separate out the different parts again and to elaborate them independently of one another. The priority came to be focussed on the revision of the Quality, Complaints, and Disputes in Health Care Act (WKKGZ) and the amendment of the Care Institutions Quality Act. The aim of the intended WCZ, the consolidation of the position of the patient in the doctor's surgery, is still aspired to. In the meanwhile, the WGBO continues to be valid and it is up to the health care provider in consultation with the patient to determine whether a treatment is medically necessary.

#### **PUBLIC REGISTER AND QUALITY STANDARD**

By means of various changes to the law, the professional standard will be included and defined in the public register overseen by the National Health Care Institute (ZiN). Minister Schippers has promised that the term professional standard, as this will be used in the public register of the National Health Care Institute (formerly CVZ [*Dutch Health Care Insurance Board*]), will be amended to the term 'quality standard' to avoid confusion with previous definitions in, amongst others, the WGBO (Parliamentary Documents I, 2013/14; 33243: no. G).

The legal interpretation of the term professional standard will be twofold. On the one hand, it retains its historical function (article 7:453 WGBO), in which the interpretation of the professional standard is determined by the prevailing rules and standards within the professional group and the standards borrowed from science. On the other hand, a new interpretation of the concept of professional standard will occur through the advent of the WCZ and amendments to the ZVW [*Health Care Insurance Act*]. In addition to the professional group, patient organisations, health care insurers and the Health Care Inspectorate (IGZ) will have a say in the compilation of the professional standards that will be included in the Care Institute's public register (these are given the name of quality standards). A health care provider should follow these last-mentioned standards unless he has good reasons for deviating from them.

Increasingly more parties are therefore gaining a say in what exactly is now meant by good care; it is no longer just the doctor who decides. The shifts in the legal and professional framework also mean that in future no clearer dividing lines may be expected between wish-fulfilling medicine and medically necessary medicine. For the time being, wish-fulfilling medicine remains a collective term for medically necessary care that is difficult to define. For wish-fulfilling medicine as a whole, there is no regulation. Certain procedures are sometimes regulated, for example on ethical grounds or because of possible damage. Thus, sex selection (for non-medical reasons) is prohibited by law in the Netherlands. Some wish-fulfilling medical procedures are regulated by the professional guidelines of a professional group. For example, the Dutch Society of Obstetrics and Gynaecology (NVOG) and the Dutch Association of Plastic Surgery (NVPC) determined that labial reduction should not be performed on principle in girls under 18 years of age (NVOG and NVPC 2008).

### **Wish-fulfilling medicine and the financial frameworks**

The starting point for reimbursement in care is that only products and procedures that are intended to cure disease or to stabilise it when a cure is not possible are reimbursed by the public insurance (ZVW and AWBZ) (Schermer 2012). Wish-fulfilling medicine is in principle not reimbursed. In practice, it is different because the boundary between wish-fulfilling medicine and conventional medicine is difficult to draw. Sometimes 'wish-fulfilling medical' procedures are indeed reimbursed from the public insurance. An explanation for this is that medical necessity is not the only criterion and in particular is not a fixed criterion for determining what care is eligible for reimbursement from the basic insurance.

### **DIFFERENT CONCEPTIONS OF MEDICAL NEED**

Conceptions of medical necessity can differ between doctors or health care insurers. Incentives in the current cost system can also ensure that no clear boundary is drawn between what is and what is not medically necessary.

*"The removal of a sebaceous gland cyst that has developed as a result of acne is not eligible for reimbursement from the basic insurance in the diagnosis of 'acne', but is eligible if a diagnosis of 'benign tumour' is recorded. So what do dermatologists or plastic surgeons do? They sometimes record medical procedures as medically necessary care. If the specialist says that the tissue removed must be examined for the presence of malignant cells, cosmetic treatments also can be eligible for reimbursement." (...) "The boundary between cosmetic and medical is not so sharp and you have a patient before you with limited resources. However, the patient has a cyst on his face as a result of acne. If you call it a cosmetic procedure, you know that the patient will refuse treatment because the procedure is too expensive. This also makes the system a little unfair. Once again the question is: do I as a doctor opt for the patient or for the system?" (Kerpershoek et al. 2015).*

### **ASSESSMENT BY THE NATIONAL HEALTH CARE INSTITUTE**

The aim of the National Health Care Institute is to promote access to 'good and sensible care, not more than needed and not less than necessary'. In this way, both the quality and the cost effectiveness of care are served. The Institute must also assess what new forms of care and medication may be reimbursed from the publicly insured package and gives the Minister of Health advice to this effect. Usually the Minister accepts this advice (ZiN 2014).

Whether new or existing care or medication is eligible for reimbursement from the public package according to the ZiN is not just assessed on the basis of the principle of need, whether medical or otherwise. Health care must also fulfil the principles of effectiveness, cost-effectiveness, and feasibility (ZiN 2014).

The package criterion of 'necessary care' itself consists of two parts: in addition to the severity of the disorder (measurement of disease burden), the need for insurance via the basic

package also comes into consideration (are the costs to be self-paid as well?). An example of this is whether or not to reimburse the contraceptive pill from the basic package:

*“In the past, social discussions have often been held about the reimbursement of the contraceptive pill from the basic insurance. There is a general note that ‘the pill’ is non-medically necessary and is also not necessary to insure (from the perspective of costs). This is because the costs are low. However, arguments are regularly put forward for continuing to reimburse the pill from the basic insurance. Formerly, the arguments related in particular to female emancipation (family-planning gives women more chance of self-development). In more recent discussions, the fact that non-reimbursement of the pill for younger girls might lead to more teenage pregnancies and to more abortions in this group of girls has also played a role. This is seen as socially undesirable.”(ZiN 2014).*

#### **ROOM FOR MANOEUVRE IN THE REIMBURSEMENT OF NON-MEDICALLY NECESSARY CARE**

A patient who receives medication prescribed by the general practitioner at his own request (for example antibiotics for a long journey) or who is referred at his own request for additional diagnostic procedures does not have to pay for this himself. In specialist medical care, patients sometimes do pay themselves (as with egg freezing for a social indication) and sometimes not (as with caesarean section on request). Patients who have a non-medically necessary procedure undertaken by commercial providers at their own cost revert to insured conventional care in the event of complications. This can result in inequalities and an inequitable distribution of public resources. It has also been shown in practice, as we have seen already in the example of the removal of a sebaceous gland cyst, that disease categories are sometimes ‘stretched’ so that certain procedures are reimbursed.

*The only legitimate way of slightly improving normal function by means of drugs and of having this reimbursed is to classify the function as abnormal, as a disease, or as an abnormality in the first place – hence the development of diagnoses such as ‘shift workers’ sleep disorder’ (Schermer 2012).*

#### **A COMPLICATED INTERPLAY**

In summary: it is up to the doctor or health care provider (or their professional group) to assess whether there is a reason for a medical indication. The National Health Care Institute has an important advisory role to the Minister in assessing from this perspective what care is or is not eligible for reimbursement from public funds and can be included in the basic insurance package. Whether or not a treatment is included in the public insurance package is a political decision. Health care insurers can also assess the medical need of a treatment differently. The drawing of a dividing line has been shown in practice to be inconsistent and sometimes appears arbitrary.

## 4 **Wish-fulfilling medicine: ethical questions**

Wish-fulfilling medicine occurs in an increasing number of areas. The government, society, and professional groups must consider how best to deal with this. In this section we discuss the ethical questions behind the debate on wish-fulfilling medicine.

### **Wish-fulfilling medicine inside or outside the limits of conventional medicine?**

According to the Dutch Medical Oath (2003), the aims of medicine are: “to take care of the ill, promote health and relieve suffering.” By focusing on these aims, medicine makes itself a moral practice. For everyone, whatever their further ideals and demands may be, health is of fundamental importance. Anyone who is ill or in constant pain has more limited or no access to options and choices that others (‘the healthy’) do have. In this sense, the wish to be healthy is more than just a wish; it is a need. Naturally it is possible to discuss how ‘health’ should be defined and differentiated from other needs and wishes. Den Hartogh maintains that answers to the question of what exactly health is fall into two categories, both of which are problematical (Den Hartogh 2014). Either health is defined very narrowly, whereby health is conceived purely as a functional state, independent of the person’s lifestyle, priorities, and goals; or a broad definition of health is adopted, as a result of which health appears to be equated to well-being. The problem of a broad definition is that medicine then assumes a very considerable responsibility: “it is clear that your well-being is determined by all sorts of factors other than just your health.” (Den Hartogh 2014).

The debate about health is important for the debate on wish-fulfilling medicine in two respects. According to our definition, wish-fulfilling medicine is concerned with medical activity (or medical ‘services’) for which no medical need exists. This means that there is no question of a health problem. Viewed in that light, the debate on wish-fulfilling medicine concerns the acceptability, not least in moral terms, of medical activity outside the confines of what is traditionally considered to be medicine. The clearest examples are those in the field of aesthetic surgery. However, because the boundaries of health and therefore also of medicine cannot be sharply drawn, the debate also concerns what procedures are the task and responsibility of the health care provider. An example of this is a medically non-indicated caesarean section as a result of anxiety about the birth. Is this treatment wish-fulfilling medicine in nature or is there in fact a question of a certain medical need?

### **Debate about wish-fulfilling medicine outside conventional medicine**

If we consider wish-fulfilling medicine as an independent phenomenon, then various questions arise. We discuss these below.

#### **DOES WISH FULFILLING MEDICINE GO AGAINST NATURE?**

That wish-fulfilling medicine would go against nature is a frequently heard argument in the public debate. If this were the case, then that raises a second question of whether that is a problem. What exactly is ‘natural’ is sometimes difficult to establish in our high-technology

society. However, even if we know what is natural, that still does not mean that it follows from this that it is also good. Conventional medicine constantly intervenes in natural processes.

It could be said that conventional medicine endeavours to restore the natural situation, while wish-fulfilling medicine endeavours to alter the natural situation without any idea of restoration. In the practice of wish-fulfilling medicine, it has been shown that this distinction is not quite so simple to draw. By way of illustration, the example of vaccination may be taken: here too there is a question of a change or improvement, but not of restoration of the natural situation. Vaccination is used to prevent the natural situation from being placed at risk.

Even if naturalness is not conceived as an absolute limit, it may be wondered whether it is sometimes not better to accept a given, i.e. 'natural', situation than to intervene medically. Both in conventional medicine and in wish-fulfilling medicine, that is a personal choice.

#### **ARE NON-MEDICAL WISHES REALLY INDEPENDENT?**

To what extent are requests for wish-fulfilling medicine based on independent choices? This question is particularly relevant in that wish-fulfilling medical procedures are not necessary. With a request for wish-fulfilling medicine, the patient's independent choice is the only motivation for a doctor to proceed to act; there is no objectively definable disease or abnormality on the basis of which action must be taken. At the same time, this means that there is no objective benefit of the procedure relative to the potential damage. Any benefit for the patient is dependent on his personal assessment and therefore it is important that this assessment is genuinely that of the patient himself (and thus independent) (Buyx 2008) (Health Council 2003). People are deemed in principle to determine their own needs and to make their own choices about their life. The assessment of a wish-fulfilling medical procedure is therefore in the first place that of the person concerned (Health Council 2003). The question of whether there are external influences is indeed relevant, but at the same time we must realise that there is no such thing as choice free from the influence of others. Nevertheless, with a non-necessary treatment, a doctor or health care provider will want to know with even greater certainty whether the person really does want it himself than in the case of necessary treatment. In the event of disproportionate social pressure or if the choice for treatment clearly contradicts previously made choices or standards and values of the person concerned, it may be wondered whether the request for a specific treatment is in fact based on an independent choice (Asscher et al. 2012). It is another matter if the person in question is not fully able to make his own choices, for example because he is legally incapable or under age. In this case there is even the question of whether wish-fulfilling medicine may be administered, as the person in question cannot themselves give informed consent.

#### **WHAT ARE THE POSSIBLE CONSEQUENCES OF WISH-FULFILLING MEDICINE FOR SOCIETY?**

Various questions are asked in the public debate about the effect of wish-fulfilling medicine on society. Does wish-fulfilling medicine result in the reduction or abolition of differences? Is this desirable or actually not? When wish-fulfilling medicine is used to produce improvements, can

this result in a better world, but also in uniformity or simple inequality because it is not available to all. Examples of this are aesthetic surgery or performance-enhancing drugs. If it is used on a large scale, this could have consequences for social plurality (everyone becomes equally beautiful or equally slim, or certain groups become more beautiful or slimmer than others). Wish-fulfilling medicine can also result in unwanted medicalisation or lead to biomedical solutions to problems that can also be tackled in another way. Wish-fulfilling medical procedures naturally do not have to produce any improvements; think for example of a caesarean section or a request for diagnostic investigations without any indication. A number of dangers are also lurking here, in that it will become increasingly more common to seek medical solutions to non-medical problems.

The CEG report *The Makeable Human* (2003) gives an example of unwanted medicalisation: changing external characteristics of ethnic groups to prevent discrimination, for example using skin whitening products or aesthetic surgery to alter an Asian eye fold or Negroid nose to a more Caucasian look. To adopt a medical approach to a social problem is to opt for a solution that does not tackle the underlying problems of prejudices and racism (Asscher et al. 2012).

The debate on wish-fulfilling medicine also includes the limits of what is feasible, the risk of unjust distribution of the benefits of wish-fulfilling medicine, unwanted social pressure to use wish-fulfilling medicine, and the risk of loss of gratitude and appreciation for what we already have (Sandel 2012). The debate overlaps with the debate on human enhancement, the adaptation of the human body by technology, particularly biomedical technology, with the aim of improving humans. In her talk on enhancement, Schermer observes that the arguments advanced in the debate against enhancement are not all strong enough to reject enhancement morally. "They are instead arguments that state that there are certain risks that may be lurking and that we must be vigilant about." (Schermer 2012).

### **Debate about the effects of wish-fulfilling medicine on conventional medicine**

The debate on wish-fulfilling medicine also involves questions about the interaction between wish-fulfilling medicine and conventional medicine. Should doctors and other care providers participate in wish-fulfilling medicine? Is that problematical or even harmful for conventional medicine? We discuss a number of questions that are raised from this perspective.

### **SHOULD DOCTORS AND OTHER HEALTH CARE PROVIDERS INVOLVE THEMSELVES IN WISH-FULFILLING MEDICINE?**

The aims of wish-fulfilling medical procedures are not always the same as those of conventional medicine. However, the question is whether this is an argument for saying that wish-fulfilling medical procedures or treatments should not be carried out by doctors. Many procedures in medicine that we now regard as entirely common medical procedures are not geared to the traditional aims of medicine. From its very inception, medicine has concerned itself with more than simply caring for the ill, promoting health, and relieving suffering.

*Moreover, it is an illusion to believe that medicine is confined to the prevention and treatment of diseases: that has long not been the case. Cosmetic surgical procedures are the most eloquent example, but in reproduction medicine also, for example, medical treatments are given to people who are not ill. (Schermer et al. 2013).*

Doctors have long been concerned with more than medicine in the strictest sense. If that is acceptable, then wish-fulfilling medical procedures are consistent with this (under certain conditions). Aesthetic plastic surgery may in fact only be performed by doctors, as it involves the performance of reserved procedures.

#### **DOES WISH-FULFILLING MEDICINE UNDERMINE PROFESSIONAL ETHICS?**

The practice of wish-fulfilling medicine on the borderline with conventional medicine probably also impacts on professional ethics within conventional medicine.

*If doctors accede more often to patients' requests that are outside the medical domain, are they then still acting as doctors? The traditional values of medicine come under pressure when non-necessary treatments are carried out simply on the basis of a patient's wishes. (Asscher et al. 2014).*

If medical activity is increasingly based on wishes rather than medical need, what does that mean for the professionalism of the doctor? Does this have an effect on how he views his activity? Are economic considerations more important? Professional ethics are dynamic in nature and adapt to changes in care (CEG 2004). Medard Hilhorst points out here that 'what is vulnerable' is insufficiently reported. This can refer to those people who are not articulate enough to make themselves heard or have insufficient purchasing power to compete. However, it may also relate to certain values that are more vulnerable than others, such as time, good communication, trust, and health as an intrinsic good (Hilhorst 2004).

#### **DOES WISH-FULFILLING MEDICINE PLACE PRESSURE ON SCARCE HEALTH CARE RESOURCES?**

Wish-fulfilling medicine concerns the satisfaction of wishes and not pressing requirements in the area of health. If wish-fulfilling medical procedures are reimbursed collectively, the question arises as to whether scarce public resources should be devoted to fulfilling non-medically necessary procedures. It is not clear how much of the cost of wish-fulfilling medicine is paid for out of public funds. In principle, those undergoing the treatment themselves pay for the costs when there is no question of a medical need. At the same time, it may be that the doctor does establish a medical indication or that demands are in fact made on reimbursed care as a result of complications occurring shortly after treatments. In addition, wish-fulfilling medical procedures carried out by the general practitioner are in any case publicly reimbursed and there are different medical procedures that fall under the definition of wish-fulfilling medicine and are reimbursed from the public insurance package. Whether costs for wish-fulfilling medical treatments should be reimbursed publicly is an important moral question concerning the fair distribution of scarce resources.

### **DOES WISH-FULFILLING MEDICINE DISPLACE CONVENTIONAL MEDICINE?**

Wish-fulfilling medicine is by definition never concerned with medically necessary procedures. Where the fair distribution of scarce resources is concerned, it can be observed that “curing will usually have a greater importance than improving and that scarce medical expertise and skills should be deployed here first of all.” (Schermer 2012). It is not known whether doctors and other health care providers who would regard the healing of diseases differently are now more involved in the performance of wish-fulfilling medical procedures and focus less on healing.

The displacement of regular medical care can occur when wish-fulfilling medical procedures, including those that are self-paid, are undertaken or produce complications requiring after-care. This after-care is often provided in the conventional care system. An example here is the preventive removal of PIP breast implants. The costs of this are reimbursed from the basic package of health care insurance. The displacement of conventional care by wish-fulfilling medicine or its after-care not only relates to the deployment of doctors or health care providers, but also to the capacity and the budget of hospitals. In considering this argument, it should also be realised that after-care is a consequence of risky choices by people; sport, for example, particularly dangerous sport, and smoking are also reimbursed from the basic package.

The funding system in health care generates an interplay of demand and supply and is subject to financial stimuli in which the various players participate. It is then not strange that health care providers should also intervene in patient’s wishes that have nothing directly to do with the recovery of health. Wish-fulfilling medicine can be seen as a fruit of the current organisation of the health care system. There were forms of wish-fulfilling medicine even before the introduction of regulated market forces into health care. Wishes are therefore not just rooted in supply. There is always a question of an interplay between the preferences of the wisher, social norms, and health care provision. Wish-fulfilling medicine is not the consequence of the introduction of regulated market forces, but it can be fostered by the stimuli in the current reimbursement system.

## 5 Wish-fulfilling medicine and shifting roles in health care

The distribution and relationship of roles among health care users, health care providers, health care insurers and the government are highly fluid and this also affects wish-fulfilling medicine. In this chapter we delve deeper into the different and shifting perspectives.

### Health care users

The position of the patient/client in healthcare and in the care system has become stronger and more influential in recent years. The quality standard for 'good care' is therefore no longer determined solely by the professional standard of health care providers but is elaborated in consultation with other involved parties, including the patient movement. In terms of strategy, considerable emphasis is placed on 'self-determination by the patient' through patient-centred care and emphasis on 'self-management' and 'self-direction'. In the treatment relationship, the personal perspective is coming increasingly to the fore. Choices in treatment decisions are not made in isolation and often occur in joint consultation between doctor and patient and to fit in with the personal context, wishes, values, and possibilities of the health care user.

The context in which wishes arise varies. Wishes may be related to character, history, personal situation, or certain emotions (the 'life story'). Wishes can also be encouraged by misleading information from commercial providers or an attractive offer from care providers to carry out a certain treatment without medical reasons. Doctors and other health care providers contribute to a considerable extent to the development of wishes, as Buyx also remarks:

*"Several ways are recognized in which modern medicine takes an important part in generating new wishes in patients, which it then goes on to fulfil (...). These wishes 'produced' by modern medicine - while often perceived by patients as autonomous and as genuinely their own - may be regarded as prime examples for hidden and undue influence on patients' autonomy of choice." (Buyx 2008).*

If a certain medical procedure is included in an insurer's top-up package, this can engender a wish. The idea can develop that the treatment is already paid for and that it would be a sin not to make use of it. Wishes can also be expressed out of anxiety. For example, people may be worried about having a disease in the family without good reason and ask for extensive diagnostic investigations.

In addition to the care provision context, certain forms of social pressure, such as beauty ideals or pressure to perform, lead to wish-fulfilling medical treatments. Examples of this are aesthetic surgery or sports medicine procedures. The media are keen to bring technological possibilities to the attention of the general public. New possibilities can alter the norm and this is followed by demand and supply.

*A new technique does not on its own lead to new possibilities of doing things that could be done less well if at all previously (...), but also results in the fact that we will look differently at the world and ourselves. Technical change in this sense is associated with changes in needs, values, and expectations (Swierstra 2011).*

The number of children fitted with a brace, for example, increased substantially from 1 in 5 in the 1980s to more than a half in 2009 (Health Council 2012).

#### **RIGHT TO SELF-DETERMINATION**

In recent decades, the right to self-determination of health care users has gained influence. In the coalition agreement 'Building Bridges' (2012) it is stated that the beginnings of self-determination are a guiding factor in medical ethical questions. It is an important underlying principle in medical legislation and regulation. ZonMw [*The Netherlands Organisation for Health Research and Development*] commissioned a thematic evaluation of the legislation on the concept of self-determination. In the ZonMw report, three different conceptual interpretations of the right to self-determination are distinguished: self-determination as right of refusal, as freedom of choice and self-development (ZonMw 2013).

#### **RIGHT OF REFUSAL**

As a right of refusal, the right to self-determination can be seen predominantly as 'freedom from', often referred to in the literature as negative freedom (Berlin 1958). This means that the health care user should be free from a controlling, external influence when making a choice. A health care user has the right to refuse a proposed treatment, even if the health care provider is of the opinion that the treatment is the best choice. In practice, informed consent plays an important role: a health care provider may undertake a medical activity or treatment on condition that the health care user is well-informed and agrees to the treatment.

#### **FREEDOM OF CHOICE**

Self-determination can also be regarded as 'freedom of choice' ('freedom to'). This positive freedom (Berlin 1958) centres primarily on the ability to choose and act in order to shape one's life according to one's own vision. It concerns not just the absence of a controlling, external influence, but also the presence of factors to enable us to make choices ourselves.

#### **SELF-DEVELOPMENT**

Self-determination can also mean that choices come about from one's own personality and from the social context within which the individual finds himself. This imposes definite limits on freedom of choice, but the limits are not imposed from outside (ZonMw 2013). They arise from the deep rooted values and norms, one's own vision of life, and one's own convictions about life. Freedom of choice here acquires a deeper interpretation: the freedom to make choices also assumes the responsibility to make choices that fit in with who one really is and what one really wants. And this assumes that an individual is capable of reflecting critically about his own standards, values, wishes, and preferences.

## **SELF-DETERMINATION AND LIMITS TO WISHES**

There are signs of a change of accent in the interpretation of the right to self-determination. Originally, stress was laid on the right of people to refuse treatment (self-determination as 'right of refusal', for example by informed consent). Later, increasingly more attention was paid to 'freedom of choice and self-development' of humans (CEG 2012). Within care, health care users acquired increasing space to develop themselves and to organise their life according to their own vision (ZonMw 2013).

If everyone is free to shape their life according to their own vision and the current health care system also offers room for and encourages this, it appears difficult to define limits. As long as the choice of the health care user is properly considered, every health care request appears to be legitimate. Within the legal framework, 'care' is referred to as 'good care' only if it meets the actual need of the health care user. However, what is a 'actual need' and what is not is not elaborated further.

*Care Institutions Quality Act, article 2: The health care provider offers responsible care. Responsible care implies care of a good standard that is provided in an effective, efficient, and patient-centred way and that meets patient's actual needs.*

It is up to the health care user himself to decide what for him is an actual need or actual care need and whether he does or does not visit the health care provider with his health care request. However, it is not up to the health care user to decide whether there is a medical need (an indication) for this actual need, and specifically this actual care need. That judgement and that responsibility are those of the treating doctor or health care provider. And this is where the crux of the problem lies. As long as the concept of 'actual need' is not further specified, it remains difficult to delineate clearly the concept of 'actual need' and 'legitimate health care request'. The only clear boundary, including moral and legal boundaries, that is defined at present in the legislation and regulations is that the health care provided must not be harmful or must not have any assumed risk of harm.

### **Health care providers**

The position of doctors and other health care providers also is undergoing rapid change. Where just a few decades ago they did not even have to discuss all the aspects of the treatment with the patient, great store is now set by 'shared decision-making', respect for personal autonomy, and informed consent (CEG 2014). In addition, doctors and other health care providers are increasingly more expected to justify their activity to society through the transparency and verifiability of their services. In their medical activity and prescribing behaviour, they must have an eye not only to the patient's interests but also to the public interests of cost-effectiveness and fair distribution of care. From a legal perspective, the disciplinary code applies in full to each BIG-registered doctor. As discussed earlier, the scope of the BIG Act is not confined to medical activities but also applies to non-medical care provision. This means that wish-fulfilling medical treatments, conceived as activities or

treatments without medical need, come under the BIG Act if they are tailored individually and performed professionally (see also page 14).

#### **THE PROFESSIONAL ETHICS OF HEALTH CARE PROVIDERS**

The standards of medical professional conduct are intended to protect the patient's trust and to define the correct activity of the doctor. These standards serve the interests of both society and the patient (KNMG [*Royal Dutch Medical Association*] 2014). Thus, a doctor is bound by a duty of secrecy that guarantees "that everyone can contact a doctor freely for help and assistance", which contributes to the 'equal right to healthcare for everyone.' (KNMG 2014)

The professional ethics of doctors (and other health care providers) change over time. At the beginning of the 20<sup>th</sup> century, for example, it was a complete infringement of a doctor's professional ethics to tell a patient that he would die from a disease. Currently, openness and good and equal communication with the patient are sought above all, even if this means that the patient is unsettled as a result (Dwarswaard 2011). The previous attitude of the doctor is known as 'paternalistic'. Since the 1960s and 1970s, the term paternalism has been used primarily to portray an undesirable situation: the patient is treated like a child as a result of paternalism and therefore does not acquire the opportunity to make his own choices. Since the 1970s, increasing effort has been devoted towards achieving an equal relationship between doctor and patient, in which the patient has all the relevant information available and can make his own choices as much as possible. The doctor's goal remains the same: he is committed to the patient's health, but the way in which this is done has changed considerably over the years (Hilhorst 2004).

#### **DOCTOR-KNOWS-BEST OR YOU-ASK-WE-DELIVER?**

Within the Dutch professional ethics of doctors and particularly where general practitioners are concerned, the principle of reticence has played an important role (Dwarswaard 2011). A good general practitioner, or so was the view for a long time, knows when to act but above all knows when not to act. The principle of reticence appears to be coming under pressure as a result of the current cost structure in health care and the arrival of many new technological possibilities. The attitude of Dutch general practitioners to the advent of health checks is a case in point. In its opinion, Screening - between hope and hype, the Health Council states: "Dutch general practitioners who have always been critical of the benefit of health checks but now see themselves confronted increasingly with health care requests generated by the test provision of others, now would prefer to offer the checks themselves" (Health Council 2008). In its recent opinion on health checks, the Health Council warned against offering health checks in conventional care, particularly non-specific checks, to prevent conventional care and commercial aims from becoming confused (Health Council 2015).

The role of doctors and other health care professionals is changing (Legemaate 2013). On the one hand, they are expected to run their practice as a business. On the other hand, they are wanted to be seen as 'gatekeepers' for care consumption. As a thought experiment, it has

been proposed that in the case of aesthetic surgery those who are simply concerned with the sale of services that require medical and technical knowledge and skills should be referred to as 'schmoctors' (Parens 2007). This group is not bound by the professional ethics of doctors and does not strive for any conventional medical aim. Schmoctors do not focus on patients but on clients or health care consumers; technical knowledge and skills remain a requisite (Asscher 2014). It may be wondered whether the development of wish-fulfilling medicine leads to doctors becoming 'wish-fulfillers' of the patient or client.

#### **FROM PROFESSIONAL AUTONOMY TO PROFESSIONAL RESPONSIBILITY?**

The principle of professional autonomy offers doctors the freedom to form their own professional judgement within legal frameworks and professional standards without the intervention of third parties (KNMG 2007). This means that doctors have a degree of freedom for manoeuvre to decide whether a treatment is medically necessary or wish-fulfilling medicine. Doctors are thus not fully bound by regulations and guidelines. When a specific situation requires acting differently, the doctor has room to 'be able to deviate on a reasoned basis'.

In recent years there has been considerable discussion about the concept of professional autonomy. Some authors find that the term autonomy places too great an emphasis on the freedom of action of the doctor, independently of his responsibility to society. This has led to the proposal to talk of professional responsibility rather than professional autonomy, so that the relationship between doctor and society is more firmly emphasised (Den Hartogh 1997).

#### **WISH-FULFILLING MEDICINE AND THE PRINCIPLE OF MEDICAL PROFESSIONAL ETHICS**

'Good medical activity' is determined by the principles of beneficence, non-maleficence, justice and respect for autonomy (Ten Have 2003). Like every form of medicine, wish-fulfilling medicine also can cause tension between the various principles. The respect for the patient's autonomy can be at odds with the principle of non-maleficence or the principle of justice (Asscher 2014). The principle of justice is also relevant in wish-fulfilling medicine. To what extent is it fair when a doctor carries out unnecessary procedures if they also entail publicly insured costs or result in displacement of conventional care? A doctor is there in the first place for the individual patient, but he also has a responsibility to society.

*Asscher et al. surveyed general practitioners, plastic surgeons, and lay people about wish-fulfilling medicine and the ethical arguments involved. All the parties to the discussion emphasised the importance of an independent choice by the patient for a wish-fulfilling medical procedure. In addition, it was found important that doctors applied the principle of non-maleficence. In various groups, it was found to be justified if patients themselves had to pay for procedures that are not medically necessary. Beneficence emerged less strongly from the interviews, although it was mentioned in the focus group of general practitioners (Asscher et al. 2013, Asscher et al. 2012). Although the interviewees clearly attached considerable weight to the principle of respect for the patient's autonomy, various arguments were mentioned for not acceding to all wish-fulfilling medical requests. If an intervention has serious side effects or is associated with a major risk, the doctors interviewed opted not to carry out the procedure. At*

*the same time, the problem of the subjective nature of beauty and normality was raised in the discussion. Other reasons for not going along with patients' requests lay in the area of justice and funding (definitely when the procedure was paid for from public funds) and the realistic or unrealistic expectations of the patient. In addition, there were reasons for doctors to accede to the patient's request. General practitioners said they acceded to requests by the patient to maintain a good relationship so that they could continue to operate as a point of contact and could keep the patient in primary care. Doctors also said they agreed to medical procedures purely to reassure the patient in order to be able to take a step further in the process with the patient. The extent to which the doctor could exhibit an understanding of the patient's question or problem was also shown to play a role in the considerations. At the same time, question marks were added at this point in the focus groups. (Asscher et al. 2012).*

Although the different principles of good medical activity are still important in practice, a new balance appears to have developed. The principle of autonomy appears to take precedence more often in conflicts with other principles, such as non-maleficence. An extreme example of this is the argument by Schramme in an article in Bioethics that even very radical interventions on someone's body at their request should be legitimised: *"If people voluntarily choose to mutilate their flesh, we better assume that they take it to be in their interest."* (Schramme 2008).

#### **BENEFICENCE AND NON-MALEFICENCE: GOOD HEALTH CARE PROVISION AND WISH-FULFILLING MEDICINE**

A doctor is bound by the duty of good health care provision which is included in the WGBO. This responsibility means that not every choice whether to act or not act is possible. A doctor who does not offer any treatment to a patient with acute appendicitis is negligent, just like a doctor who removes a healthy organ from a patient without good reason. Conventional medicine is in fact delineated by the professional standard in which everything that doctors should do and should not do is included. In the absence of a medical need, a doctor can meet a request by a patient to improve a situation (for example protruding ear correction), but he cannot be obliged to do so (Health Council 2003). Doctors must even not do so if it is possibly harmful. It is up to doctors to ask themselves whether the performance of a wish-fulfilling medical activity comes within their conception of their profession. They must constantly weigh up where they want to draw the line:

*Medicine that does not contribute to the improvement of life is not good medicine; however, that does not mean that everything that improves lives belongs to medicine. Doctors can rightly say that for them it is a case of curing the ill and relieving suffering and not a case of further improving healthy people. They can draw a line here. (Schermer 2012).*

In this context it is not just the question of whether a treatment may possibly harm the patient that is relevant, but also the question of whether a treatment is unnecessary.

### **INCREASED DUTY OF INFORMATION AND THE IMPORTANCE OF INDEPENDENT CHOICES**

When a doctor chooses to carry out a wish-fulfilling medical procedure, he has the same responsibilities as with any usual medical activity. Each BIG-registered doctor is covered by the disciplinary code and should act responsibly and in accordance with the proper conduct of individual health care. The doctor should assess any possible risks and provide the patient or client with good information. The absence of an 'objective or intersubjective improvement of a property' in the patient can result in the doctor having an increased duty of information in wish-fulfilling medicine. This already applies in cosmetic surgery, for example (Health Council 2003). In addition, the doctor has the responsibility to investigate whether a wish genuinely is independent. In so doing, it is important to examine the feelings and motives that lie behind the request and to delve into whether the request fits in with the life story, personality, and pattern of values of the person concerned (Health Council 2003) (Buyx 2008). Where there is disproportionate social pressure, legal incapacity, or an underage patient, additional reticence is required where wish-fulfilling medical treatments are concerned.

### **SUSPECT STANDARDS AND WISH-FULFILLING MEDICINE**

In addition to the question of whether wish-fulfilling medicine fits into the doctor's conception of his profession, there can be moral objections to the conduct of certain treatments. Thus, there is the possible perpetuation of stigmatising ideal images (Little 1998) in the 'widening of Asian eyes' or the prescription of skin whitening cream (Asscher 2012). Stapel notes that there is too little debate in the professional group of aesthetic plastic surgery about these sorts of questions:

*In the absence of handles, [doctors] allow themselves to be persuaded, so to speak, to carry out a procedure that they do not entirely support. As a result, the procedure will become increasingly more accepted and the discussion about professionalism and autonomy will disappear into the background. Although this gives surgeons a breathing space in the sense that they experience the moral dilemmas less intensely, at the same time an opportunity is being missed here to reflect on such new procedures as a professional group (Stapel 2014).*

The conduct of this debate is not only of importance in aesthetic plastic surgery, but is relevant for all professional groups who may have to deal with wish-fulfilling medicine.

### **PROFESSIONAL ETHICAL REFLECTION ON WISH-FULFILLING MEDICINE**

As mentioned above, conventional medical ethical principles still play a central role in medicine. Although more weight is possibly attached to the principle of respect for autonomy, the values of non-maleficence, beneficence, and justice still apply.

*"In short, a shift appears to be occurring in the balance between the values of the patient's autonomy on the one hand and non-maleficence on the other. As a result, the professional ethics of the modern doctor are certainly changing to some extent, but there appears to be no*

*question of an overshoot into a commercial model, in which wishes are interpreted by 'schmoctors' who place little importance on the patient's health interests." (Asscher et al. 2014).*

Doctors find themselves in a force-field of influences. In addition to their own professionalism, the need to keep health care costs under control and the public responsibility for services also play a role (Schermer et al. 2013). It is not possible to give a clear response to the question of how individual doctors should deal with wish-fulfilling medical requests. The professional group can put the subject of wish-fulfilling medicine on the agenda and conduct the debate both within its own circle and more broadly in society. Professionally, this could lead to the formulation of guidelines that can support the health care provider in their decision-making about specific wish-fulfilling medical treatments.

### **The government**

The government has various responsibilities in the field of health and beyond that determine the framework for government interventions. We discuss these responsibilities and the relationship with wish-fulfilling medicine below.

### **HEALTH PROMOTION**

According to article 22 of the Dutch Basic Law, the government has the task of promoting public health. There are various interpretations of the form and scope of this responsibility. The narrowest interpretation is that the government must intervene where there is an acute risk to health or to public health. Other interpretations allow more scope for intervening in developments that may constitute a risk to health.

An argument for the narrow interpretation is that the government should be neutral with respect to the choices that people make about their own well-being. The government must therefore adopt a back-seat approach towards regulating wish-fulfilling medical activities and treatments (Health Council 2003). Its task is limited to the prevention of harm. It can do this by informing about the risks of wish-fulfilling medicine, by protecting underage subjects and those who are legally incapable and by guaranteeing the quality of the wish-fulfilling medical procedures that people can undergo. However, whenever there are found to be significant disadvantages or drawbacks to health from wish-fulfilling medicine that cannot be adequately resolved by the provision of information, further government intervention is not only justifiable but necessary.

### **FAIR DISTRIBUTION OF CARE AND RESOURCES**

'Ability to pay', 'accessibility', and 'quality' are three important starting points for government policy in the area of health care. The government must ensure that the costs of health care are controllable and fairly distributed. In principle, the health care user himself pays the costs of a treatment for which there is no medical indication.

For this reason, the question is to what extent wish-fulfilling medical treatments exert a disproportionate pressure on the fair distribution of health care resources. Doctors sometimes establish a medical indication for wish-fulfilling medical procedures. Complications can occur following wish-fulfilling medical treatments that place demands on insured care. It is conceivable that, where capacity is limited in hospitals, medically indicated treatments may be displaced by wish-fulfilling procedures. If this should happen, 'accessibility' to regular care comes into question. At the moment, it is not known to what extent wish-fulfilling medical treatments place unreasonable pressure on available care. It is also unclear whether this will be a problem in the future.

#### **PERMITTING OR REGULATING**

In most cases, the government is reticent over regulating wish-fulfilling medical procedures. Some treatments do lead to government interventions. For example, sex selection without a medical indication and the use of anabolic steroids are prohibited in the Netherlands. In the first case this is considered to be a choice that is regarded as unethical in the Netherlands. In the second case, the question is how safe these drugs are and whether they can cause harm.

*A known example is that of the PIP breast implants that are now prohibited in the Netherlands because of defective quality (leakage and/or splitting) and the possible harmful consequences for women. The Healthcare Inspectorate (IGZ) has encouraged all women with these implants to arrange an appointment with their treating doctor. In January 2012, the IGZ and the Dutch Association of Plastic Surgeons advised that the implants should be removed preventively (IGZ 2015).*

When there is clear evidence of damage, as in the previous example, the government must protect and intervene for its citizens. In many cases, however, it will leave the development and regulation of wish-fulfilling medicine to the field and the market. One example of this is the guideline which the Dutch Association for Plastic Surgery (NVPC) and the Dutch Society of Obstetrics and Gynaecology (NVOG) elaborated jointly, which sets an age limit of 18 years for labial reduction.

*Aesthetic procedures in the genital sphere such as a labial reduction are preferably only performed when the area concerned has fully matured, which is usually the case around the age of 18. A request for this procedure before that age is a reason for joint counselling of the woman with a psychologist. When a discrepancy between the degree/severity or type of complaints and the size of the labia minora is established on physical examination, the physician should refrain from surgical procedures. This also applies in the case of an unrealistic pattern of expectations in the patient that cannot be corrected. If the woman experiences pain in the vulva not only in different situations but also spontaneously, a non-surgical treatment for her symptoms should be offered (NVPC and NVOG, 2008).*

The starting point of the government in wish-fulfilling medicine is one of neutrality. It only intervenes in the event of proven risk to public health and when wish-fulfilling medical procedures are not ethically justifiable. It is important also to keep an eye on the other risks to public health, such as displacement of conventional health care.

### **Health Care insurers**

The role of care insurer is increasing and is well referred to as the 'engine' of healthcare.

*"Consumers are deemed to choose from competing insurers on the health care insurance market, who in turn have to contract the highest-quality and most effective health care providers on the health care purchasing markets. In this way, the system is regarded as having both a quality-enhancing and a cost-controlling effect." (Halbersma 2013).*

As health care insurers contract health care providers, they exert an influence on the care (treatment methods) that is used. This influence seems to be on the increase:

*"Medical specialists are greatly concerned about the excessive influence of healthcare insurers within the current care system. This is demonstrated by a poll of members of the Dutch Federation of Medical Specialists, to which 1400 medical specialists responded. The healthcare insurer must not take the place of doctor; doctors have the medical knowledge and together with the patient give substance to good quality care." This is the message of the Federation of Medical Specialist, formerly the Order of Medical Specialists ([www.demedischspecialist.nl](http://www.demedischspecialist.nl)).*

What influence do care insurers have on wish-fulfilling medicine? Someone who suffers from drooping eyelids can be helped with an upper eyelid correction. Can this complaint be regarded as an 'actual need'? In some cases, the doctor finds an eyelid correction medically indicated. The insurer may view this differently. An upper eyelid correction is almost never reimbursed, and if so then only in the case of congenital abnormalities or chronic disorders. Care in the basic package is determined by the government on the advice of the ZiN. However, insurers have set additional requirements for the reimbursement of some procedures.

In addition, care insurers exert an influence through the top-up insurance packages that each insurer puts together itself. What care is insured or covered by top-up insurance impacts on the way in which the forms of care are conceptualised. If something is insured, consumers may be expected to see it as useful, important, or as a normal medical activity. The top-up package can therefore exercise a normalising effect. In addition, it can be that the simple fact that something is offered in the top-up package is regarded by patients and consumers as a reason for actually implementing or undergoing the treatment or procedure. Think for example of what are known as 'fun ultrasounds' that can be included in a top-up package. The choice of whether to include a form of wish-fulfilling medicine or not in the top-up package has an impact on care in the broader sense.

**Changing roles and relationships**

The roles of the different parties in healthcare are in flux and the mutual relationships shifting, changes that also impact on the development of wish-fulfilling medicine. Patients are gaining greater freedom of choice and a greater right to self-development. Alongside this, more room is developing for differences between patients/clients. The role of the health care providers and the health care provided is accordingly now more reactive than before. Policy and professional practice no longer start from a one-size-fits-all basis but recognise that there are differences in which care is most suitable. This patient or client orientation of health care as well as a reticent attitude on the part of government and the increasing influence of health care insurers contributes to the lack of a sharp borderline between what is and what is not medically necessary care.

## 6 Taking stock and defining the agenda

In this last chapter, we take stock and discuss the ethical implications. We list the questions that deserve further attention, discussion, and reflection for health care providers, patients, health care insurers and the government.

### **Wish-fulfilling medicine is an elastic concept**

To be able to define the boundary between wish-fulfilling medicine and conventional medicine, 'medical need' appears to be a self-evident criterion. However, this has been shown not to be a firm criterion, but an elastic concept that is sometimes interpreted differently in the same situations. Wish-fulfilling medicine cannot be readily distinguished from conventional medicine and is more the 'overflow area' of conventional medicine, rather like the floodplains of a river.

### **Wish-fulfilling medicine can no longer be wished away**

Wish-fulfilling medicine is a development that will probably increase in the coming years. The altered relationship between health care providers and health care users, the impact of social trends such as beauty ideals, the wish to optimise services or the wish to be reassured, and the 'perverse stimuli' in the healthcare cost structure are factors that can strengthen wish-fulfilling medicine. At the same time, there are 'financial constraints in care'.

### **Does wish-fulfilling medicine come under 'good medical practice'?**

'Good medical practice' is determined by the principles of beneficence, non-maleficence, justice, and respect for autonomy (Ten Have 2003). Wish-fulfilling medicine can generate a particular tension between the various principles. The respect for the patient's autonomy can be at odds with the principle of non-maleficence or the principle of justice. Unlike in conventional medicine, there is no clear health benefit relative to the disadvantages in wish-fulfilling medical procedures. This means that respect for autonomy remains the only justification for the health care provider's actions.

Wish-fulfilling medical treatments also have health risks. Sometimes these risks are large and unexpected, as with the PIP breast implants. It is up to the government and the professional group to protect citizens from the risks of wish-fulfilling medical treatment without at the same time excessively limiting their autonomy. On the one hand this is possible through good information and on the other measures are sometimes needed to restrict particularly risky wish-fulfilling medicine.

When a doctor has chosen to carry out a wish-fulfilling medical treatment, he has the same responsibilities as when practising ordinary medicine. In the absence of a medical indication, a doctor can fulfil a patient's request to improve the situation (for example protruding ear correction), but he cannot be obliged to do so. It is up to the doctor to decide whether the performance of a wish-fulfilling medical procedure falls within his concept of the profession. He

can consult with his professional group (guidelines) or individual or groups of colleagues for his decision.

### **Wish-fulfilling medicine can result in the displacement of conventional care**

A major problem arises if wish-fulfilling medical treatments or their after-care are shown to make major demands on the capacity for care, thereby jeopardising accessibility to conventional, necessary care. Displacement of conventional medical care can occur when wish-fulfilling medical procedures take precedence over conventional care or if there are complications that require, sometimes considerable, after-care. Displacement as a result of wish-fulfilling medicine or its after-care relates not only to the deployment or availability of doctors or health care providers, but also to the capacity and the adequacy of hospitals' budgets to absorb this. It is not possible to say whether these implications currently apply because there are no known figures in this respect.

### **Sometimes wish-fulfilling medicine is reimbursed, sometimes not**

Sometimes wish-fulfilling medicine is paid for out of public funds: for example, for treatment by the general practitioner. In addition, it has been shown that doctors sometimes establish a medical indication where one is not applicable or disputed. Thus, differences arise between health care providers in respect of the establishment of medical indications and resultant differences in the reimbursement of procedures. If this is the case, then not everyone has equal access to these procedures and there is the threat of inequality and arbitrariness.

### **The responsibility of care providers and professional groups**

When a patient/client asks for treatment when there is no medical need for it, then a care provider must himself decide whether to accede to the request and how to substantiate this decision. The decision can be made in consultation with the health care user and in the event of doubt submitted to a, where necessary multidisciplinary, team of colleagues,

Within the professional groups, it is important to discuss the subject of wish-fulfilling medicine and to consider whether there should be guidelines for certain wish-fulfilling medical procedures. An individual doctor who doubts whether he should carry out a certain treatment can find support in a guideline in which the professional group defines the standard method of treatment in relation to certain wish-fulfilling medical requests. An example of one such guideline is that for labial reduction (NVPC and NVOG 2008).

In addition, it can be useful as a professional group to draw up a, where necessary medical ethical, review framework for frequently occurring wish-fulfilling medical requests that takes into consideration possible damage to the patient. An example of this is the model protocol issued by the Dutch Society of Obstetrics & Gynaecology (NVOG 2009): Possible moral contraindications to fertility treatments.

Shared decision-making and personalised care are increasingly taking place in the doctor's surgery. This approach to care possibly offers a way of dealing with wish-fulfilling medical requests at the individual level. The personal perspective or the way in which people wish to run their life can be a starting point for the discussion about wish-fulfilling medical treatment. It offers the possibility of identifying the 'question behind the question' and seeking the most appropriate solution jointly with the client or patient. More room for tailored care, matched care, and shared decision-making can offer a solution but also involve risks. In this way, it can also pave the way wish-fulfilling medicine. In addition, there is the question of to what extent the solidarity-based system can move with this approach to care and what this means for the public responsibility of health care providers.

### **Better choices by health care users and patient and client associations**

Individual patients and clients can be informed in all sorts of ways about wish-fulfilling medical treatments. For them, it is of great importance to find reliable information and to have an assessment framework so that they can take a well-considered decision about wish-fulfilling medical procedures.

It can also be useful for patient associations to place the subject of wish-fulfilling medicine on the agenda and to discuss this with one another and with the professional groups. It may possibly be interesting to draft documents on the model of 'Choosing Wisely' that can help doctor and patient in the discussion about certain wish-fulfilling medical procedures. Choosing Wisely is a campaign by the Order of Medical Specialists and ZonMw [*The Netherlands Organisation for Health Research and Development*] designed to support medical specialists and their patients in shared decisions about the appropriate use of care.

### **Health care insurers have a social responsibility**

By contracting or not contracting care, health care insurers influence the extent to which wish-fulfilling medical procedures are part of care provision. The composition of the top-up package offered by health care insurers impacts on what patients/consumers consume in terms of care and what health care providers offer. It is important that health care insurers are aware that the top-up package has an impact on what is seen as 'normal' care.

### **Government tasks in wish-fulfilling medicine**

The most important questions for the government in relation to wish-fulfilling medicine relate to the protection of citizens from possible damage, keeping costs under control and the just distribution of resources, and the accessibility of care (people who need care must be able to obtain it). To begin with, the government has a task of protection of underage children and other vulnerable groups in society. This applies in particular when they are incapable of making independent choices about wish-fulfilling medicine.

It is also a task of government to inform and warn when there is serious risk of harm from a wish-fulfilling medical treatment. Furthermore, it is up to the government to ensure the quality of procedures that are provided by medicine.

In the context of justice, it is important to examine the extent to which wish-fulfilling medicine imposes a disproportionate pressure on the costs and capacity of the care system with the result that conventional medical care becomes less accessible or its quality has to suffer as a result.

### **Conclusion**

Wish-fulfilling medicine requires constant attention from all those involved in health care. Boundaries are not easy to define and are context-dependent and subject to change over time. The debate about acceptable use of medical techniques and services must be conducted by and between all those concerned.