

‘We Come as Doctors, We Come as Servants’ Medical Confidentiality and Professional Identity during the Great War

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ABSTRACT

This article explores discussions in the *Nederlandsch Tijdschrift voor Geneeskunde* (NTvG), the Dutch Journal of Medicine, over the limits of medical confidentiality during the First World War. In the early twentieth century, physicians in the Netherlands struggled with the socio-legal limits of the ‘physician’s oath’ (i.e. ‘*artseneed*’), the vow of secrecy sworn by Dutch medical doctors since 1878 at Dutch universities upon the acceptance of their profession. While the 1865 codification of medical confidentiality in the Netherlands had significantly contributed to the socio-legal status of the profession vis-à-vis ‘quacks’, it became clear in the late nineteenth and early twentieth century that the traditional ideal of the *secret absolu* did not fit well with the growth of modern state structures. With the development of elaborate bureaucratic institutions and the subsequent need for population statistics and formalized accountability mechanisms, Dutch physicians were asked more and more often to provide information which had traditionally fallen within the realm of medical confidentiality to third parties. This article examines this ‘dilemma of modernity’ by looking into discussions in the NTvG over the respective identities of military and civilian physicians between 1914 and 1918, and argues that, during the war years, the professional identity of the health officer – with his explicit double function as doctor and as servant – came to function as a projection screen for civilian physicians in the Netherlands to debate existing anxieties regarding their role in the modern Dutch state.

Keywords: medical confidentiality; professional identity; First World War

‘We, physicians, [...] have gradually become inspectors for anything and everything, willing as we always have been to write down each statement that corresponds to the truth and does not violate our professional oath on a piece of recipe-paper.’¹ – NTvG, 1915.

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1 L.W.H. Tjeenk Willink, ‘Het “uitgestelde” voorstel tot een algemeen bindend besluit in zake ziekenbriefjes’, *Nederlandsch Tijdschrift voor Geneeskunde* (hereafter NTvG) 59 (1915) 614–616, m.n. 614–615.

Introduction

For historians interested in the growing entanglement of health professions with modern bureaucracies in the late nineteenth and early twentieth century, the legal codification of medical confidentiality in most European states after the 1850s has proven fertile soil for exploration. Historians and sociologists have traced, for example, how the legalisation of the ‘artseneed’ (‘physician’s oath’) went hand in hand during this period with the professionalization of modern medical practice.² By including medical confidentiality in official state legislation, states recognized that their medical professions were capable of moral self-regulation, an important characteristic of the so-called ‘free professions’. In addition, it effectively created a socially recognized and respected space for private exchange in the advancing public domain of the modern state, thereby setting the medical profession apart from more mundane occupations.

In the Netherlands, it was Thorbecke’s legislation of 1865 – meant to suppress ‘the social evil that was quackery’ by granting a monopoly on health care to physicians (including surgeons), pharmacists and midwives – which stipulated that physicians would officially promise not to ‘reveal the secrets entrusted to them while exercising their profession’.³ From 1878 onwards, this oath was officially taken at most Dutch universities, signifying the *rite de passage* from student to professional.⁴ Similar developments took place during this period in France, Belgium, Luxembourg, Germany, Austria, Hungary, Switzerland, Italy, Spain and Portugal.⁵

During the same period that medical confidentiality came to be legalized in most European countries, however, the growth of administrative and other modern-bureaucratic institutions increasingly put strict compliance with the physician’s oath under strain. Governments and insurance organizations in the nineteenth century, for example, progressively sought to collect aggregate medical data in order to develop or implement their respective policies.⁶ Similarly, with the steady increase of out-of-home labour and the development of early social security plans, individual patients more and more started to request doctor’s notes with specific medical details in order to prove to their employers that they were truly ill or impaired and thus entitled to sick days. Although these breaches of

2 E. Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (New York 1970); J.L. Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (Berkeley 1975); I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin 1984); A. Abbott, *The System of Professions. An Essay on the Division of Expert Labor* (London 1988); J.C. Burnham, ‘How the Idea of Profession Changed the Writing of Medical History’, *Medical History* (supplement no. 18, 1998).

3 ‘Wet van 1 Junij 1865, regelende de uitoefening der geneeskunst’, *Staatsblad* nr. 60 (1878); H. Festen, ‘Honderd jaar wetten betreffende de uitoefening der geneeskunst’, *Medisch Contact* 20 (1965) 413–431. See also: F.G. Huisman, ‘Wie geneest? De strijd om culturele autoriteit in de Nederlandse gezondheidszorg’, in: F. van Lunteren [et al.], *De opmars van deskundigen. Souffleurs van de samenleving* (Amsterdam 2002) 99–118.

4 ‘Wet van 25 december 1878, houdende regeling der voorwaarden tot verkrijging der bevoegdheid van arts, tandarts, apotheker, vroedvrouw en apothekersbediende’, *Staatsblad* nr. 222 (1878); J.J.E. van Everdingen & H.F.J. Horstmannshoff, ‘De nieuwe Nederlandse artseneed’, *NTvG* 149 (2005) 1062–1067; E.S. Houwaart, ‘Historie van de eed’, in: Westerveld [et al.], *De Nederlandse Artseneed* (KNMG/VSNU, 2010).

5 A.-H. Maehle, ‘Protecting Patient Privacy or Serving Public Interests? Challenges to Medical Confidentiality in Imperial Germany’, *Social History of Medicine* 16 (2003) 383–401, esp. 385. Original sources referenced by Maehle: S. Placzek, *Das Berufsgeheimnis des Arztes* (Leipzig 1893, 1–34; W. Rudeck, *Medizin und Recht*, 2nd edn (Berlin 1902) 3–5.

6 See for example: F. van Poppel & J.P. van Dijk, ‘The development of cause-of-death registration in the Netherlands, 1865–1955’, *Continuity and Change* 12 (1997) 265–287.

professional secrecy did not necessarily have to be out of line with official state legislation (in the Netherlands, for instance, the physician's oath was formulated in such a way that it could be waived in cases doctors were 'required by law to notify the authorities or to act as witness or as expert')⁷, they often caused unrest as it was left up to individual practitioners to decide in which cases they were bound to their oath and in which cases they could freely provide information of those under their care to interested third parties.⁸

Dutch sociologist Klasien Horstman has traced, for example, how in conjunction with the rise of life insurance policies after the 1880s fierce debates arose in the Netherlands over the correct interpretation of the physician's oath.⁹ Upon admission to these policies, applicants usually had to submit health certificates. Similarly, after their death, family members had to hand over certificates which included details concerning the exact cause of death. If physicians therefore failed to provide these documents, insurance companies might refuse to accept applications by their patients, who in turn might look for another doctor to cater to their need for medical proof. Being lenient with the ideal of medical confidentiality could thus be propitious for both patients and physicians. At the same time however, certificates that were given out by practicing physicians were usually double-checked by employees of the insurance companies, challenging their traditionally recognized medical expertise and forcing them to comply with standardized procedures for describing disease categories. Hence, a strict nation-wide adherence to the physician's oath could also protect physicians from a type of auditing culture *avant la lettre*. As a result, there existed much confusion over the ways in which the oath was to be applied and who precisely benefitted from it.

Horstman shows that it was not easy for the organized Dutch medical profession to decide upon a single collective policy in these instances. The members of the *Nederlandse Maatschappij tot bevordering der Geneeskunst* (NMG) (the Dutch Organization for the Advancement of Medicine) were strongly divided between so-called 'hardliners', who advocated a *secret absolu* (i.e. an absolute adherence to the ideal of medical confidentiality) and 'moderates', who felt that leeway was permissible in writing certificates of proof for their patients.¹⁰ Both in 1898 and in 1910, therefore, the NMG issued official reports, drawn up with the cooperation of Dutch life insurance companies, in order to offer its members appropriate guidance. According to Horstman, it was only with the 1910 report that the moderates decisively drew the longest straw in these debates. From then onwards, the organized Dutch medical profession officially gave up its defence of 'absolute medical confidentiality' in favour of a more congenial approach towards the disclosure to third parties of secrets which had traditionally belonged to the sacred dyad between patient and physician.

This article takes up Horstman's analysis and details how the controversy over medical confidentiality flared up once more in full strength among the ranks of the organized Dutch medical profession with outbreak of the First World War. In 1914, mobilization forced a

7 'Wet van 25 december 1878' (n. 4).

8 See: A.-H. Maehle, *Doctors, Honour and the Law. Medical Ethics in Imperial Germany* (Basingstoke 2009); L. Sauerteig, 'Health Costs and the Ethics of the German Sickness Insurance System', in A.H. Maehle and J. Geyer-Kordesch (eds.), *Historical and Philosophical Perspectives on Biomedical Ethics: From Paternalism to Autonomy?* (Aldershot 2002) 49–72; A.H. Ferguson, *Should a Doctor Tell? Medical Confidentiality in Interwar England and Scotland* (PhD thesis, University of Glasgow 2005).

9 K. Horstman, 'Het geheim van de dokter (1880–1920). Ingrediënten voor een historisch-sociologische analyse van het medisch beroepsgeheim', *Medische Antropologie* 7 (1995) 27–39.

10 *Ibidem* 31–35.

multitude of physicians to leave their practices and join the Dutch Militair Geneeskundige Dienst (Military Health Service, hereafter MGD), as stand-by officers of health in case the fighting should reach the Netherlands. Consequently, the previously largely separate worlds of civilian and military medicine came into close contact with one another. The MGD had been struggling with a chronic shortage of health officers before the war broke out and with the mobilization of civilian physicians into their midst, trained military doctors now constituted only one part of the entire MGD.¹¹ In turn, civilian physicians received regular visits from their military colleagues, whose task it was to check up on mobilized civilians who had failed to report for duty.

This intensified encounter of two worlds provoked a new round of debates over the status of the physician's oath and the medical certificates of proof. Between 1914 and 1918, the double function of the officer of health, who was clearly both a doctor and a 'dienaar' ('servant')¹², became the subject of frequent discussions in the pages of the *Nederlandsch Tijdschrift voor Geneeskunde* (NTvG), the Dutch Journal of Medicine – the main organ of the NMG and, hence, of civilian Dutch medicine. Both editors and concerned correspondents (who all tended to write about the Dutch physician as being a singular entity) used the journal as an outlet to debate the role of the Dutch medical profession vis-à-vis the country's military and, by means of analogy, vis-à-vis Dutch society at large. In times when the needs of the nation were so clear and dire, who was the physician ultimately obliged to serve? Was this the individual patient, who might put the nation in danger by 'malingering' (i.e. pretending to be ill and thereby failing to fulfil his duties – an affliction which suffered itself from a strong class connotation) or was this the state?¹³ If the latter was the case, the ideal of medical confidentiality (even in a moderate form) might have to make way for an ethic which allowed physicians to report the 'rotten apples in the system' and thereby in the long run strengthen the health of the Dutch body politic in its entirety. How the physician's oath was to be employed in times of war, therefore, stayed a hot topic for discussion throughout the Great War. For when visiting their patients, under which guise did Dutch physicians ultimately come? As doctors or as servants?

Mayhem in the military

On 28 July 1915, the 'krijgsraad' (court-martial) of the Navy in Willemsoord sentenced the Dutch officer of health Cornelis Maria Beukers of the warship *De Ruijter* to one day of military imprisonment, because he had refused to provide his superiors with the names of a list of military officers who had been suffering from venereal diseases. This verdict caused an uproar in the Netherlands, also among civilian medical practitioners, who traditionally

11 L. van Bergen, 'The Malingerers are to Blame: The Dutch Military Health Service before and during the First World War', in: R. Cooter, M. Harrison & S. Sturdy (eds.), *Medicine and Modern Warfare*. Special issue of *Clio Medica* 55 (Amsterdam 1999) 59–76.

12 In their discussions, Dutch doctors used the word 'dienaar' to refer to servants of the state (both military and civil personnel). In addition, the Dutch noun carries the connotation of serving. Using the word 'dienaar', Dutch physicians wrote about their obligations vis-à-vis their patients and outside parties, such as insurance companies, schools, etc. 'Dienaar' proved a difficult word to translate into English. The English noun 'servant' comes closest. Therefore, even though it does not fully capture the same meaning as the Dutch noun, 'servant' will serve as replacement for 'dienaar' throughout this article.

13 See also: M. Harrison, 'Medicine and the Management of Modern Warfare: an Introduction', in: Cooter a.o., *Medicine and Modern Warfare* (n. 11) 1–27.

voiced their concerns in the *NTvG*. Opponents wrote that the military doctor was in any case more capable than a 'mere military official' to decide when it was necessary to break the physician's oath the doctor had sworn to each patient upon the acceptance of his profession.¹⁴ If Beukers had broken his vow, he would have greatly harmed the bond of trust that is necessary to exist between the doctor and his patient.¹⁵ Proponents stated that soldiers were not in any way entitled to a 'free medical treatment', since the state had appointed health officers for one reason only and that was to keep soldiers fit for fighting, just like veterinarians were hired to maintain the horses and engineers for the barracks and ships.¹⁶ Some advocated a re-installment of the *secret absolu* and to inform no authority whatsoever – not even the Minister of War – about the nature of a soldier's disease. Others maintained that each piece of information that could possibly 'affect the state' should be passed on to the right authorities.¹⁷ Interestingly, the dividing line between the two camps did not seem to be determined by the professional identities of military and civilian physicians. A retired colonel of the MGD wrote that the oath existed unabated towards all patients and there was no military or civilian authority that would be able to annul it.¹⁸ A civilian practitioner, on the other hand, wrote that the officer of health was not the trustee of his patients, but of the state.¹⁹

The Dutch Hoog Militair Gerechtshof (High Military Court) had the last word. On 26 November 1915 it overruled the verdict of the court-martial by stating that the officer of health was a doctor before he was a soldier and that the only reason that he could have become a soldier, was for the reason that he was a doctor.²⁰ Therefore, it would be unreasonable to ask him to ignore the oath that he had taken upon becoming a medical professional. Instead, the officer of health, like any other medical practitioner, should function as a confidential counsellor for his patients, for otherwise no prosperous doctor-patient relationship could be possible and healthy soldiers were important for the state.²¹ Hence, Beukers was to be reinstated as a health officer without a criminal record. This did not fall well with the court-martial. Vice-president Eysten responded with an article in the *Militaire Spectator*, wherein he fulminated that the officer of health should not be considered as holding a special position in the army; the military knew strict rules which should apply to *all* officers and soldiers without any exception.²² This was a matter of general interest, because if exceptions could be granted to some, all would start seeking a way to expand their territory. Eysten's article was subsequently sent as a newsletter to each of the leading health officers of the Dutch Navy, with a reminder noting that the officer of health was appointed by the state. A crushing response to this letter came in the *NTvG* from the hand of the journal's

14 A.J. Olivier, 'Het beroepsgeheim van den officier van gezondheid', *NTvG* 59 (1915) 1374; Pinkhof, 'Militair geneeskundige beroepsgeheim', in: *NTvG* 59 (1915) 682–683; 'Beroepsgeheim van den Geneesheer', *De Tijd, Godsdienslig-Staatskundig Dagblad* (10 November 1915) 7.

15 J. Slingenberg, 'Het beroepsgeheim der officier van gezondheid', in: *NTvG* 19 (1915) 2087–2100.

16 D. Snoeck Henkemans, 'het beroepsgeheim van den officier van gezondheid', in: *NTvG* 59 (1915) 1296.

17 J.D. Koster, 'Bijeenkomst, op 30 Augustus 1915, van officieren van Gezondheid der Ite Divisie', *Militair-Geneeskundig Tijdschrift* 19 (1915) 258–261.

18 Olivier, 'Het beroepsgeheim' (n. 14) 1374.

19 Snoeck Henkemans, 'Het beroepsgeheim' (n. 16) 1296.

20 'Drie, voor den militairen geneeskundigen dienst belangrijke uitspraken', *Militair-Geneeskundig Tijdschrift* 20 (1916) 1–21.

21 'De uitspraak van het hoog militair gerechtshof', *NTvG* 59 (1915) 2517–2519.

22 J. Eysten, 'Het Ambtsgeheim van den Officier van Gezondheid', *Militaire Spectator* 85 (1916) 128–137.

famous editor Hermanus Pinkhof (a notorious 'hardliner', according to Horstman),²³ who wrote that Eysten had 'struck a jarring note'.²⁴ Did the MGD really seek to treat its patients as numbers instead of persons? According to Pinkhof, the army would do well to remind itself that health professionals could exist perfectly without the Navy, but that the Navy would be nothing without medical doctors.

Although both camps proclaimed their interpretation of the (military) physician's oath to constitute an *a priori* principle, more instrumental professional interests played an important role in the indignant responses generated by the Beukers case. This becomes clear when comparing the outrage to a second court case against an officer of health in the summer of 1915. On 21 July 1915 the health officer Willem de Vries was freed of all charges after having been brought to trial by a military officer for revealing the nature of the latter's illness to his superiors.²⁵ This case also made it to the Hoog Militair Gerechtshof (High Military Court), and again this Court ruled in favour of the health officer. Yes, it had been proven beyond any doubt that De Vries had given up his oath by providing his superiors with the controversial information, but he could not be persecuted for this, since it was prescribed in the rules and regulations of the military that the oath did not exist for the officer of health with regards to his superiors.

In contrast to the Beukers case, there was little public noise around the case of De Vries. Eysten wrote that he was happy that the Hoog Militair Gerechtshof had not overruled the court-martial; it was fit for a health officer to obey his military superiors.²⁶ The *NTvG* did not give the matter much attention. No commentary was printed arguing that De Vries should be punished because he had failed to respect his patient's wishes. So apparently, for most contributors to the debate on medical confidentiality during wartime, the physician's oath did not present a non-negotiable principle a physician should live by no matter what after all. More likely, no uproar was generated over the De Vries-ruling because in that case the interests of both military and medical authorities had been congruent with the final verdict: i.e. no medical doctor was sentenced and no military authority was breached. Only the sick military officer was disadvantaged by the ruling of the Hoog Militair Gerechtshof. Hence, the contrast with the outrage generated by the Beukers ruling – first from the side of the medical practitioners when he was sentenced, and later from the side of the military authorities when he was vindicated – indicates that, instead of a negotiation of principal standpoints, the generated upheaval was rather one of (re)defining professional interests and power. Did the health officer first belong to the free profession of medicine or was he first a servant who should adapt to the military system like any other soldier?

Paradoxically, as a result of the contradictory nature of the Beukers and De Vries rulings, the Hoog Militair Gerechtshof established that it was both. This provided a strong precedent for the health officer that he inhabited a fairly autonomous position within the Dutch military and could act as he saw fit. This was an ideal outcome for the Dutch medical profession, although in reality not all military officials actually respected these verdicts. Both in 1916 and in 1917 health officers kept being punished for refusing to cooperate with their

23 J.J. Van Loghem Sr, 'Hermanus Pinkhof', *Nederlands Tijdschrift voor Geneeskunde* 131 (1963) 878; Horstman, 'Het geheim van de dokter', 31.

24 In Dutch: 'een wanklank laten horen'. Cf. H. Pinkhof, 'officieel ontzag voor een onaantastbaar vonnis', *NTvG* 60 (1916) 1960–1963.

25 'Drie belangrijke uitspraken' (n. 20) 14–17.

26 Eysten, 'Het ambtsgeheim' (n. 22) 134.

superiors, among them notably Cornelis Maria Beukers, who was sentenced once more by the court-martial to a day of military detention in 1917 for refusing to waive the physician's oath with regards to his military superiors. When such cases found their way to the *NTvG*, they would ignite another round of indignation. In those cases, the rulings of the Hoog Militair Gerechtshof served to underscore the unique position of the health officer.²⁷

Comparing and contrasting military with civilian medicine

In addition to their function as precedents for the military position of the health officer, the 1915 verdicts of the Hoog Militair Gerechtshof were deployed in *Journal* discussions about the rights and duties of civilian physicians. When the case of Beukers was brought before the Hoog Militair Gerechtshof in 1915, for example, Pinkhof wrote in the *NTvG*:

How will this play out for the physician who functions as a civil servant? Because civil authorities also often demand, thoughtlessly or purposefully, that their medical officials communicate information falling under the professional oath. If they refuse, they are *at least* considered to be 'annoying'; it will even happen that those who refuse are told that their views, although respectable, cannot be reunited with the function of civil servant [...] One hopes that soon an opportunity will arise, where also the medical civil servant can, through an appeal in court, provoke a ruling. But already he will be stronger against those who demand that he violates his professional oath, because he can now refer to the view of the advocate-general, even if the High Military Court would disagree.²⁸

Pinkhof hoped that the Beukers and De Vries rulings would provide a strong precedent for civil servants, precisely because the explicit double role of the medical officer resembled the much more dense and 'unwritten' conflicts of interests medical practitioners were confronted with in civil structures. After all, the ultimate authority for both the military officer and the civil servant was eventually the state. The only difference was that for the officer of health the state was clearly delineated in the Minister of War.

Cases like those of Beukers and De Vries were followed closely by the civilian medical establishment, precisely because civilian practitioners experienced similar dilemmas as their military colleagues, even if they did not work for government authorities or in other forms of wage labour. In the late nineteenth and early twentieth century, Dutch medical doctors often commented on the pages of the *NTvG* that they struggled with their responsibilities towards their individual patients versus the communities both patient and physician participated in. When, for example, a discussion flared up in 1917 in the *NTvG* about the responsibility of a physician to a patient's family in case of the discovery of a venereal disease, doctors and authorities were notoriously divided. For whom was the medical doctor in these instances precisely responsible? Did he have to protect and inform the husband's wife (who could also be a patient) or did he keep his mouth shut to any third party?²⁹ Similarly, the *NTvG* would publish on a regular basis articles that had appeared earlier in American, English, French or German journals on the issue of the 'physician as witness'. When

27 H. Pinkhof, 'Beroepsgeheim van den officier van gezondheid', *NTvG* 60 (1916) 2084–2085; idem, 'Het beroepsgeheim van den militairen arts is nog niet veilig', *NTvG* 60 (1916) 1238–1239; idem, 'Het beroepsgeheim bij de marine', *NTvG* 60 (1916) 2106–2107; idem, 'Het verzet tegen de militaire rechtspraak', *NTvG* 61 (1917) 258–259.

28 H. Pinkhof, 'Het militair-geneeskundig beroepsgeheim', *NTvG* 59 (1915) 2149–2150.

29 H. Pinkhof, 'Het geneeskundig beroepsgeheim bij geslachtsziekten van gehuwden', *NTvG* 61 (1917) 1078–1079.

a medical doctor was called to court to testify, should he be obliged to reveal information of patients? The authorities were not sure. Sometimes a judge would remind the physician that it was really a moral duty of each good citizen to help the court of justice in any way he could.³⁰ In other instances, a medical authority would claim that not even after the death of a patient would the physician ever be allowed to reveal any information whatsoever.³¹

Analogies with military medicine could prove helpful in solving these dilemmas. In Germany, for example, the spread of syphilis among the armed forces caused a heated debate in 1917 over the exchange of data between health officers and state insurance offices, which was followed and reported upon in the *NTvG*. State insurance offices required specific information of the nature of diseases in order to reimburse soldiers, which the venereal sufferers (for obvious reasons) often did not want the doctor to supply. Linkages between the state insurance offices and the military authorities were quickly made in these cases. If health officers could call upon their oath of secrecy with respect to their military superiors, because they had first and foremost a humane (and civil) treating function, then why would that right be waived in matters with a civil institution?³² It was decreed, therefore, that only with the explicit permission of the soldier such data could be passed on. This, in turn, provided a relevant precedent for civilian practitioners who were often requested to provide specific details of their patients to insurance companies regarding labour disabilities.³³ Hence, in cases like these, the rights of soldiers and citizens became linked and congruent through a dialectic process of exchange.

The health officer in civil society

In addition to comparisons, the onset of the First World War also brought an important distinction between civilian and military medicine into focus. Traditionally, when soldiers fell sick while on leave, the responsible civilian physician was asked to write up a certificate of proof for the appropriate military authorities, who might send over a health officer to verify the reliability of these statements. Military physicians thus had an important ‘control function’ (trans.: ‘*den controleerende arts*’), a role which greatly intensified when the war broke out in 1914 and many Dutch citizens were mobilized to join the armed forces. Much more often than before, ‘treating’ (trans.: ‘*behandelende*’) civilian practitioners received control visits from their military colleagues, which was a loss of autonomy and authority they lamented and compared to the growing cadre of control physicians who worked in the service of insurance offices and other bureaucratic institutions. As one civilian physician wondered in the *NTvG* in 1914: was the fuss over certificates of illness for soldiers not the ‘biggest punishment for mistakes made by us during peacetime?’³⁴ By giving up the *secret absolu* in dealing with life insurance companies and the like, Dutch physicians had become vulnerable to requests by all sorts of third parties, which left them weak in their resistance to those who claimed that in times of war the needs of the nation prevailed over those of the individual patient. The increased oversight that the threat of the First World War brought to physicians in the neutral Netherlands, therefore, contributed to another reconsideration by

30 ‘De arts als getuige’, *NTvG* 59 (1915) 197.

31 H. Pinkhof, ‘Het beroepsgeheim na den dood’, *NTvG* 60 (1916) 183–184.

32 *Ibidem*.

33 Notably: W.R.H. Kranenburg, ‘De aangifte van ziektegevallen in gevolge art. 21 der arbeidswet 1911’, *NTvG* 61 (1917); H. Pinkhof, ‘Arbeidswet en artseneed’, *NTvG* 61 (1917) 1977–1978.

34 A. Kropveld jr., ‘Straf’, *NTvG* 58 (1914) 1465.

Dutch medical practitioners during the 1910s of the limits of medical confidentiality when operating within the structures of what they believed to be ‘the modern Dutch state’.

In 1918, near the end of the war, for example, this tension between the conflicting roles of military and civilian medicine came to a head on the pages of the *NTvG*. On 8 June the civilian practitioner C. Metzlar had an angry letter published in which he stated that he would no longer allow any military authority to visit his patients.³⁵ The provocation for this statement had been the visit of a health officer to a twelve year old dying patient of Metzlar. When it had become clear that the boy was terminal, Metzlar had sent a certificate of proof to the army so that the boy’s older brother – who was currently serving as a soldier – could come home and pay his final respects. Subsequently, an officer of health had come to check if the boy was really ill or if the family was faking their way into allowing the elder son to return to his loved ones. Metzlar was furious. First of all, the officer had not told the family why he had come, but had apparently just gone to the boy’s room to do a check-up without properly introducing himself. Secondly, Metzlar was highly offended that first the army had obliged him to draw up a certificate of proof in order for the soldier to get his leave and then subsequently decided to doubt his official word by sending another doctor to make sure he was telling the truth.

The next week an officer of health by the name of A.C. Nicolai replied in a soothing tone. He agreed with Metzlar that this was not a way any patient should be treated, but that the visits in themselves were essential for all involved, because without them the military authorities would not allow soldiers to return home.³⁶ Nicolai had the habit of making an appointment with the treating doctor to talk through the case or invite the civilian doctor to join him during his examination. Nicolai stated: ‘We come as *doctors*, so we have an utmost humane standpoint’.³⁷ One week later, however, health officer G. van der Reijden wrote to the *NTvG* that Nicolai’s standpoint concerning the identity of the health officer in relation to the patients of civilian doctors was severely flawed: ‘During a control visit, we come as *servants*, and we are required to execute *carefully*, albeit *most punctually*, the legally prescribed instructions’.³⁸ Metzlar himself seemed not to care with what intention the health officer made his visits. In another *NTvG*-letter, this time directly addressed to Nicolai, he wrote that officers of health were hardly in any position to check up on the work of civilian practitioners, who in general were much better qualified than their military colleagues.³⁹

The culprit himself also had something to say about the whole ordeal. The health officer who had gotten Metzlar this angry turned out to be J. Jansen, who, also in a letter to the *NTvG*, sneered that the control visits by military doctors were necessary because civilian physicians in the Netherlands took their own interests and those of their patients into consideration when drafting up a certificate of proof, but not those of the military.⁴⁰ It was well-known that for this reason medical certificates, sent by civilian practitioners to the army, had to be signed by the mayor of the relevant municipality in order to testify to their authenticity. For this same reason, control visits by health officers could not be announced in advance, because patients or civilian practitioners would ‘prepare themselves’ for the

35 C. Metzlar, ‘de geneesheeren en de militaire autoriteiten’, *NTvG* 62 (1918) 1592.

36 A.C. Nicolai, ‘De geneesheeren en de militaire autoriteiten’, *NTvG* 62 (1918) 1651.

37 Ibidem 1651. (*Italics in original*).

38 G. van der Reijden, ‘De geneesheeren en de militaire autoriteiten’, *NTvG* 62 (1918) 1721. (*Italics in original*).

39 C. Metzlar, ‘De geneesheeren en de militaire autoriteiten’, *NTvG* 62 (1918) 1721–1722.

40 J. Janzen, ‘De geneesheeren en de militaire autoriteiten’, *NTvG* 62 (1918) 1720–1721.

military examination.⁴¹ Civilian practitioners, Jansen thus implied, could not be trusted. And they certainly did not have the interests of the Dutch state as their number one priority.

This perception of civilian medicine was shared by more military personnel in the Netherlands during the Great War. In 1933, in his memoirs of this period, former Dutch Minister of War and military officer Nicolaas Bosboom recalled that 'no cooperation in the military interest could be expected from civilian doctors.'⁴² Civilian practitioners simply did not understand which responsibility they had to the state 'from a military point of view'.⁴³ Indeed, Bosboom was convinced that during his term of office between 1913 and 1917, civilian physicians had 'far too easily handed out certificates, which made controlling visits by military doctors inevitable, with loss of time and withdrawal from more important duties as a consequence'.⁴⁴ The statesman thus effectively blamed civilian practitioners for many of the shortcomings of the MGD during its mobilization phase of the First World War. This is significant, because, as Dutch historian Leo van Bergen has detailed, the MGD and its leaders were themselves subject to much criticism in the early twentieth century for being an ineffective and amateurish organization.⁴⁵ Civilian physicians, for instance, often joked about the medical services offered by their military colleagues. In 1916, for example, the medical journal *Vox Medicorum* republished an opinion piece relating the story of a soldier who was 'appropriately treated by his civilian doctor' after he had started suffering from food poisoning while on leave. The MGD, however, had come to pick him up from his home as it was obligatory for a soldier to be treated in a military hospital so that he could be kept under surveillance. Having arrived in the hospital, it had apparently taken 24 hours for the soldier to be treated by a military doctor who eventually prescribed him the same diet and medicines as his civilian doctor had done. It took another so many hours before the nurses had adjusted his meals to his diet. The satirical conclusion of the article was, therefore, that it could only be considered 'life threatening to contract a disease in the Dutch military'.⁴⁶

The MGD justified its strict policy of control, however, by pointing to the corrupt nature of the common Dutch soldier. As Van Bergen has shown, Dutch military authorities suspected the majority of their subordinates to be guilty of 'malingering': i.e. many Dutch soldiers allegedly feigned illnesses or exaggerated wounds in order to avoid serving time. Already prior to the war, reports had been published that less than five per cent of military hospital patients were in fact truly ill.⁴⁷ And, 'because a mobilized army differed from a peacetime army', this percentage would even increase once a war broke out.⁴⁸ According to Bosboom, military doctors were therefore forced to operate both as policemen and as medical men.

41 Ibidem.

42 Van Bergen, 'The Malingerers are to Blame' (n. 11) 66, quoted from N. Bosboom, *In Moeilijke Omstandigheden*, Aug. 1914-Mei 1917 (Gorinchem 1933).

43 Ibidem 66.

44 Ibidem.

45 Ibidem.

46 'Militaire Geneeskunde', *Vox Medicorum*. *Orgaan tot het behartigen van de belangen der geneesheren in Nederland en zijne Koloniën en van allen, die tot de geneeskunde in betrekking staan* (hereafter: *Vox Medicorum*) 16 (1916) 35–37.

47 Van Bergen, 'The Malingerers are to Blame' (n. 11) 66, quoted from D. Romeyn, 'De geneeskundige dienst', *Wetenschappelijk Jaarbericht Krijgswetenschap* 6 (1910) 416–434, esp. 524.

48 Ibidem 65, quoted from Bosboom, *In Moeilijke Omstandigheden* (n. 42) 183.



Fig. 1: The gentlemen responsible for the physical examination of Dutch soldiers during the early days of the First World War. Amsterdam, 1914 (Nationaal Archief, Den Haag & Spaarnestad Photo).

Civilian practitioners were argued to frustrate this dual task. They 'sooner believed the so-called sick than their military colleagues' and they generally seemed reluctant to notify the authorities of a malingering soldier as they feared it would reduce their future clientele.⁴⁹ Of course, civilian practitioners rather felt that health officers abused their power and did not have the right authority to override the judgment of the attending (civilian) physician.

⁴⁹ Ibidem 66.

Health officers were assumed to have less medical training (and hence a lower status) than their civilian counterparts and, in addition, their professional judgment was argued to be clouded by their conflicting military interests. Already in 1914, civilian practitioners had openly worried about their position versus that of the MGD. Could a military officer really ask a civilian practitioner what the condition of the illness of the relevant patient was? Was this not a violation of the oath of secrecy? And, most importantly, did this not make civilian practitioners submissive to the wishes of their military colleagues? Now that the war had broken out, interactions between the two fields of medicine would be much more frequent, which led some doctors to argue that the NMG had to issue guidelines stipulating how the MGD was allowed to interact with civilian practitioners.⁵⁰ Some were convinced that the civilian physician should not write any certificates for the military and that it should be the patient himself who had to convince the authorities that he or his family member was really ill.⁵¹ Authors went as far to state that there could also be moral reasons for lying to the military, thereby allowing a soldier to stay home and take care of his family.⁵²

In general, civilian practitioners felt they were not responsible for the military, but for their patients and, indeed, by extension for themselves. After all, if a doctor did not cooperate with his patients, there was the possibility that they would leave his practice and join another practitioner who would be more willing to provide the appropriate certificates. Officially, such policies were of course condemned, but the fact that official measures were indeed taken against such practices indicates that they were not entirely exceptional.⁵³ In 1915, for example, the General of the Dutch ground forces gave three subsequent orders that soldiers were no longer entitled to their leave when they or their families refused a control visit by the officer of health.⁵⁴ These orders were republished in full in the *NTvG* to make sure that civilian practitioners understood the rights and obligations of soldiers.⁵⁵ In addition, medical officers started writing letters to the *NTvG* in order to provide their civilian colleagues with information concerning the military prescriptions that existed for the treatment of soldiers by health officers and their military superiors. This of course always with the official reason that it was not the civilian doctors who abused the system, but that it was the 'common men' who feigned illnesses and forsook their duty towards the Fatherland, which made it important for civilian and military physicians to cooperate and outsmart these malingerers.⁵⁶ One suggestion for cooperation that was made during the war years, for example, was to realize a governmentally run institute that would produce clear guidelines and standardized certificates in order to end the quarrelling and confusion.⁵⁷

The 1918 row between Metzlar and Jansen indicates, of course, that such calls for bureaucratic cooperation were not particularly successful. There remained a significant number of health officers who did not trust the motives of civilian practitioners. Military officers continued to feel that civilian practitioners handed out certificates far too easily, which forced

50 H. Pinkhof, 'Geneeskundige inlichtingen betreffende militairen', *NTvG* 58 (1914) 1550–1551; H. Waller, 'Geneeskundige inlichtingen betreffende militairen', *NTvG* 58 (1914) 1642.

51 H. Kruijne, 'Geneeskundige inlichtingen betreffende militairen', *NTvG* 58 (1914) 1642–1644.

52 A.H.J. Nord, 'Geneeskundige inlichtingen betreffende militairen', *NTvG* 58 (1914) 1711.

53 H. Pinkhof, 'Geneeskundige inlichtingen betreffende militairen', *NTvG* 58 (1914) 1644.

54 'Publicatie orders opperbevelhebber in zake geneeskundige controle', *NTvG* 60 (1916) 1313–1316.

55 *Ibidem* 1313.

56 E.J. Denekamp, 'Geneeskundige verklaringen ten behoeve van militairen', *NTvG* 60 (1916) 259–260.

57 J.B.F. van Gils, 'Geneeskundige verklaringen ten behoeve van militairen', *NTvG* 60 (1916) 330.

military doctors to make control visits. In turn, there remained a significant proportion of civilian doctors that detested the superior position that officers of health had in respect to the authority of the civilian physician.

A certificate-embargo

An important explanatory context for the uproar in the *NTvG* over the control visits by health officers during the First World War is the general discontent experienced by Dutch medical practitioners in the early twentieth century over the growing demand for medical certificates of proof. In 1915, for example, a physician complained in the *NTvG*:

It started with the nursery teacher, who wanted to be convinced of the illness of her playmates, after which the head of the primary school followed suit, although the existing compulsory education laws do not impose any obligation upon us. Why would we not pander to the carpenter who wants to know where his pupil is? And of course there are the factory directors, the national and other unions, the insurance companies and *tutti quanti*. And we? We wrote what we were asked to write [...] free controllers for everyone and everything.⁵⁸

Letters like this were no exception. On a weekly basis, physicians complained in the *NTvG* that they had to function as detectives for each and every institute and organization in the Netherlands, which increasingly cost them more time and money.

Clearly, malingering was considered to be no exclusive affliction of Dutch military personnel. In both military and medical journals, ‘simulating and aggravating’ was argued to be part of the ‘character of the national spirit of a people’, an ‘evil which had to be combatted strongly’.⁵⁹ It could happen therefore that the official ‘controlling powers’ of the Dutch state (i.e. Dutch law enforcement) would pressure physicians to cooperate and demand that they only sparingly give out official doctor’s notes. In 1918, for example, the police commissioner of the municipality of Maastricht sent all general practitioners in his region a letter, reminding them that they could be punished with a jail sentence of up to three years if they were to write any more ‘false certificates of proof’.⁶⁰

It was as if malingering presented a national scare which had to be combatted with all possible resources available. To win this fight, each Dutch physician was expected to operate not just as healer, but also as a policeman – a configuration of the professional identity of the (civilian) medical practitioner which bears clear resemblance to that of the health officer. No wonder, then, that when the discussion over the authority of the health officer versus that of the civilian practitioner first broke out in 1914, civilian physicians openly wondered whether the fuss concerning certificates of illness for soldiers was not the consequence of the course followed by the NMG during peacetime with regards to the ideal of medical confidentiality. This included giving up the *secret absolu* with respect to all these authorities which had become more and more persistent that they were entitled to the secrets which had traditionally belonged to the sacred dyad between patient and physician.

58 Tjeenk Willink, ‘Het “uitgestelde” voorstel tot een algemeen bindend besluit in zake ziekenbriefjes’, 615.

59 Red., ‘De Militaire Geneeskundige Dienst’, *Vox Medicorum* 18 (1918) 67–68, esp. 67.

60 H. Pinkhof, ‘Geneeskundige distributie-genoegens’, *NTvG* 62 (1918) 102. NB. Subsequently, the doctors in Maastricht went on strike and the regional health officers had to take over their work. H. Pinkhof, ‘Staking in Maastricht’, *NTvG* 62 (1918) 268.

In 1914, the annual assembly of the NMG voted in favour of a decree which stipulated that Dutch physicians should 'henceforth only write doctor's notes when they start and finish a treatment'.⁶¹ In both 1915 and 1916, the professional organization even tried to decree a national 'certificate embargo', even though various local chapters repeatedly pointed out that this was practically unrealizable.⁶² During the height of the 'certificate discussion' in 1915, the *NTvG* received a multitude of letters debating the possible problems and benefits of a certificate embargo. Those who disagreed with any official instructions wrote that such measures would severely impede the doctor's influence over his patients, as he would no longer be able to authorize when an individual patient was unfit to work.⁶³ Or they felt that such regulations should not be organized on a national basis, but rather per regional division, so that it would leave more freedom for the individual practitioner to reach consensus on what sort of regulation would fit best.⁶⁴ Those who applauded the initiative wrote that it was statistically proven that a refusal to provide patients with a certificate improved the 'ratio workmen/sickdays', meaning that workers were less likely to report ill when they could actually work (because if they were *really* ill, they would not be capable of going to work anyway).⁶⁵ Or they claimed that if doctors were to continue to write doctor's notes, patients would increasingly try to fool the doctor by pretending to be sick. If they succeeded in this, and of course sometimes they would, it would seriously damage the reputation of the general practitioner. The mutual distrust, resulting from such practices, would be harmful for both patient and physician.⁶⁶

In contrast to the life insurance policies debate (see Horstman), it was the hardliners who prevailed in the discussions over the embargo initiative. During the general assembly of the NMG in 1916, the professional organization officially decreed that Dutch medical practitioners should no longer write any doctor's notes. The official reason for this decision was that the certificate of proof made controlling doctors out of treating physicians – two identities could not be reunited in one person. The treating physician had to think *only* of the well-being of the patient and the controlling doctor *only* of the interests of those who asked him to verify the patient's reasons for being absent from work.⁶⁷

The court case of the health officer Cornelis Beukers which made headlines during this same period made it clear, of course, that separating this dual role was not always so easy. Nor did successful separation of the two identities necessarily contribute in securing the professional interests of individual medical practitioners. In 1917, for example, a worried physician wrote to the *NTvG* that 'although the recent certificate embargo had brought many blessings, it had also given rise to a vast increase of controlling doctors, working for insurance companies or other large-scale businesses, who had 'sprung like fungus from the

61 J. Leydesdorff, 'Bindend besluit in zake het afgeven van ziekenbriefjes', *NTvG* 60 (1918) 2322–2323.

62 See, for example: 'Het voorstel B van het Hoofdbestuur', *NTvG* 60 (1918) 2322.

63 D. Snoeck Henkemans, 'Geen ziekenbriefjes meer?', *NTvG* 59 I-B, No.14 (April 3, 1915)1154; A. van IJsendijk, 'ziekenbriefjes', *NTvG* 59 I-B, No.25 (June 19, 1915) 2214–2215.

64 H.J. Coert, 'Het voorstel tot algemeen bindend besluit in zake verklaringen omtrent ziekte of ongeval', *NTvG* 59 II-A, No.1 (July 3, 1915) 458–460.

65 A. Staverman, 'ziekenbriefjes', *NTvG* 59 I-B, No.25 (June 19, 1915) 2214.

66 Pinkhof, 'het ziekenbriefje wel ten behoeve der ziekingeldkas', *NTvG* 59 I-B, No.15 (April 10, 1915) pp.1226–1227.

67 H. Pinkhof, 'De keurende en de behandelende arts', *NTvG* 60 (1916) 969–970.



Fig. 2: The header of the Dutch Journal of Medicine in 1914. The journal functioned as an important platform for Dutch physicians to express their concerns and debate ongoing matters of professional importance, usually under the section 'Beroepsbelangen'.

ground'.⁶⁸ Who were those controlling physicians now really checking up on? If the treating doctor had ordered the patient to stay at home, the patient should stay at home. It happened all too often that the controlling doctor ordered the patient to get up and maintain work, because he did not feel that the patient was really ill. This was a direct breach of the authority of the treating doctor! The worried physician therefore underscored in the *NTvG* that 'the controlling doctor should check up on the patient and not on the treating physician, as he is *not allowed* and *not capable* to do so'.⁶⁹

It is the same tune which can be heard in the complaints of Metzlar about controlling health officers in 1918. It was up to the treating (civilian) practitioner to decide whether he would breach his vow of secrecy and write a certificate of proof, and when he chose *not* to do so, his authority was not to be impaired by those who inherently, because of the nature of their function, were less qualified to judge whether a patient was truly healthy or ill. Physicians could provide services to society, but they would never be in service of it. They were, after all, doctors not servants.

Concluding remarks

On the one hand, the legalization of medical confidentiality in the late nineteenth century served the professionalization of modern medical practice in the Netherlands. From 1865 onwards, only those physicians trained at Dutch universities according to the wisdoms of the modern sciences were officially entitled to practice medicine in the Netherlands – a monopoly position which was underscored with the legal codification of the physician's oath. At the same time, however, upholding the traditional ideal of the *secret absolu* became more and more unrealistic over the course of the nineteenth century with the rise of more large bureaucratic institutions and intricate administration systems. Physicians were no

68 W. Polak, 'Behandelend geneesheer en controleerend geneesheer', *NTvG* 61 (1917) 1706–1707. See also: D. Snoeck Henkemans, 'Het ziekenbriefje', *NTvG* 61 (December 1, 1917) 1999.

69 Ibidem 1707.

longer considered to be merely accountable to their individual patients; they carried obligations towards society as well. How was this dual responsibility to be organized? Legislation was not always clear, which offered leeway but also inaudibility and ambiguity, resulting in ad hoc jurisprudence. In order to realize collective and standardized procedures, therefore, the organized Dutch medical profession had to negotiate compromises with relevant parties, as in the case of the life insurance policies detailed by Klasien Horstman.

This article has sketched how the onset of the First World War once more exacerbated the existing difficulties with medical confidentiality in the Netherlands. Even though the Dutch did not participate in the war, the mobilization of the national forces brought the role and identity of the health officer in the Dutch army into focus. His explicit double function as treating and controlling agent – with clear authorities to report to – presented a microcosm of social anxieties experienced by physicians in the Netherlands at large. Civilian practitioners in the late nineteenth and early twentieth century often complained that they no longer operated alone at the patient's bedside, but were accompanied by all sorts of third parties pressuring them to breach their oath and willingly hand out professional secrets. But often such pressure was of a socio-economic nature and the precise boundary between a legitimate and an illicit breach of the physician's oath was difficult to determine. The clear hierarchical and forceful structures of the army thus offered an important projection screen to clarify the more thick power structures present in civil society. Similarly, the growing tension during the First World War between (controlling) health officers and (treating) civilian practitioners functioned as an analogy for broader dilemmas about the societal responsibilities of the Dutch physician in an age in which modern bureaucratic structures and medical expertise were becoming increasingly dependent upon one another.

The difficulties experienced with the oath of medical confidentiality, with the certificates of proof and with the emergence of full-time controlling physicians raised questions about the identity of the medical profession in the modern Dutch state. Did physicians ultimately serve the individual or the community? Were they primarily autonomous professionals or should they consider themselves to be servants of the state? Interestingly, the First World War converged with a conservative stance towards these issues. With the promulgation of a national certificate embargo in 1916, the NMG made it clear that the doctor's note made inspectors out of physicians, which were two identities that could not be united in one person. In times of war, therefore, when Dutch physicians were explicitly called upon to serve the Fatherland, the organized Dutch medical profession desired to go back to the days of the *secret absolu*.

In practice, the national certificate embargo did not prove very effective. Local chapters of the NMG complained it was next to impossible to implement and it only resulted in the multiplication of controlling agents, who questioned the expertise of the individual practitioner and threatened his autonomy. Nevertheless, the Dutch medical profession continued to try and put an end to the increasing demand for certificates of proof by issuing similar embargos until long after the end of the First World War. Until the late 1930s, the pages of the *NTvG* were regularly filled with complaints about breaches of the physician's oath and with rhetoric of 'the growing sick notes disease'.

Interestingly, it seems that it was the Second World War which brought an end to many of these discussions. One reason might be that during the German occupation, in 1941, the National Health Insurance Decision (trans.: Nationale Ziekenfondsbesluit) was proclaimed, thereby realizing a novel financial and administrative configuration between the state, its citizens and the various health professions. Another reason might be that the NMG

decided in 1947 that ‘the occupation had made Dutch physicians realize that their organization had in the past focused too much on material gain’.⁷⁰ The organized Dutch medical profession therefore sought to prove that ‘it was not just a trade union’ and that a ‘better balance between material and spiritual values needed to be established within the NMG’.⁷¹ With this aim in mind, the professional boundary-work between controlling and treating physicians in the Netherlands might have disappeared to the background during the post-war reconstruction era. This is a connection which needs further investigation, however, as does the status of medical confidentiality in Dutch military circles (and civilian responses) prior to the First World War, when health officers in colonial contexts were undoubtedly faced with similar dilemmas regarding their professional identity. Hopefully, this article might serve therefore as fertile soil for further exploration.

⁷⁰ F. Wibaut, ‘Reorganisatie der Maatschappij, betekenis der te stichten secties’, *Medisch Contact* 2 (1947) 1–4.

⁷¹ *Ibidem*.