



‘A Medical Doctor in Politics’

Els Borst-Eilers and the Rise of Evidence-Based Healthcare in the Netherlands

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This article examines how Els Borst-Eilers, Dutch minister of Health between 1994 and 2002, pursued the cause of Evidence-Based Medicine (EBM) – an influential movement in the medical field that gained a particularly firm foothold in the Netherlands. It focusses on the way Borst-Eilers operated within the nexus between healthcare and politics, discussing whether or not this made her a *boundary person* (analogous to the notion of boundary concepts). In particular, the paper analyses how she deliberately cultivated her persona as a *specialist* minister (‘a doctor, not a politician’) and how she pragmatically utilised EBM as a tool for depoliticising the thorny political issue of cost containment in healthcare. It was not so much the notion of EBM itself, but rather its specific translation into efficient and appropriate healthcare of which Els Borst-Eilers became the foremost advocate in the Netherlands.

‘Een dokter in de politiek’. Els Borst-Eilers en de opkomst van de empirisch onderbouwde gezondheidszorg in Nederland.

Dit artikel onderzoekt de wijze waarop Els-Borst Eilers, minister van Volksgezondheid tussen 1994 en 2002, zich heeft ingezet voor ‘evidence-based medicine’ (EBM) – een invloedrijke beweging in de geneeskunde die een sterke stempel heeft gedrukt op de huidige Nederlandse gezondheidszorg. Het artikel richt zich op de manier waarop Borst-Eilers manoeuvreerde op het snijvlak tussen gezondheidszorg en politiek, waarbij de vraag aan de orde komt of zij beschouwd kan worden als een *boundary person* (analoog aan de notie van *boundary concepts*). Centraal in de analyse staat de door Borst gecultiveerde ‘persona’ van vakminister (‘een dokter, geen politicus’), evenals de wijze waarop zij EBM gebruikte als middel om het vraagstuk van kostenbeheersing in de gezondheidszorg te depoliticiseren. In dat opzicht was Borst-Eilers niet zozeer de grote voorvechter van EBM als zodanig, als wel van de specifieke vertaling ervan tot doelmatige, ‘zinnige en zuinige’ zorg.

Yes, we thought we had done this very cleverly. We presented our ‘message’ as something physicians were already working on themselves. The sensibilities of specialists are easily offended, so if you start by saying that it should be done differently and the way they are doing things is wrong – then you might as well *not* write it down because then the shutter on the other side will close completely. So you sing their praises first about the fact that they have been working on improving their discipline for such a long time, and about the fact that they have been trying to develop increased rational medical practice. And then you say that you have spoken to a great many of them and that they conclude *themselves* that it all can and should be done better. This is how we built this up in a slightly tactical way. And it worked.¹

Thus, Els Borst-Eilers – who is best known for her position as Minister of Health in the Dutch cabinet between 1994 and 2002 (Figure 1) – commemorated the way she and her former colleagues at the Health Council introduced the principles of what would become known as ‘Evidence-Based Medicine’ (EBM). They did this in the influential advisory report *Medical Practice at a Crossroads*, which was published in 1991.² Since that time, EBM has risen to unexpected heights, trading the traditional ‘authority based’ medicine for a more scientific and democratic approach to clinical practice, that was defined as: ‘the conscientious, explicit, and judicious use of the best current evidence in making decisions about the care of individual patients’.³ Currently, medicine can no longer be imagined without EBM. In 2007 it was proclaimed to be one of the ‘15 most important medical milestones [...] since 1840’ – together with, among others, antibiotics (penicillin), the contraceptive pill, and the discovery of the structure of DNA.⁴

Recently, Timo Bolt showed in his dissertation how EBM gained a particularly firm foothold in the Netherlands.⁵ In our opening quotation Borst-Eilers, a self-styled ‘early adopter of EBM’⁶, makes claims about her

1 Interview with Borst-Eilers by Timo Bolt, 3 February 2012.

2 Gezondheidsraad, *Medisch handelen op een tweesprong* (The Hague [1991]).

3 D.L. Sackett, W.M.C. Rosenberg, J.A.M. Gray, R.B. Hayes, and W.S. Richardson, ‘Evidence-Based Medicine: What It Is and What It Isn’t’, *British Medical Journal* 312 (1996) 71-72 DOI 10.1136/bmj.312.7023.71.

4 ‘Medical Milestones: Celebrating Key Advances Since 1840’, *British Medical Journal*, 334: supplement (2007) s1-s22.

5 T.C. Bolt, *A Doctor’s Order: The Dutch Case of Evidence-Based Medicine (1970-2015)* (Antwerp, Apeldoorn 2015) 407-412.

6 Lecture by Els Borst-Eilers at the eight Cochrane Colloquium in Rome, 5 October 1999. National Archives The Hague (hereafter NA): Collection Els Borst-Eilers [temporary inv.nr. 68]. The NA is currently working on a definitive inventory for the Collection Els Borst-Eilers.



Figure 1:
Minister Els Borst-Eilers in her office at the Ministry of
Health, Welfare and Sport, November 2000.
Photo Bart Versteeg.

role in this process – claims that have been supported by other sources.⁷ This paper explores the validity and the scope of these claims. By analysing both the Dutch debate about EBM as it developed over the years and a collection of sources of a more biographical nature, we will examine how and why precisely Borst-Eilers supported EBM. Special attention will be paid to the nature of Borst-Eilers' consecutive positions in the healthcare sector and how these interacted with her attempts to further the cause of EBM. Putting the spotlight on just one individual has the consequence that other actors and more structural factors that contributed to the remarkable success of EBM in the Netherlands remain underexposed. Nevertheless, we think it of interest to gain more insight into the considerable influence Borst-Eilers could exert through her position within the nexus between politics and healthcare.

To help us understand how she operated, we introduce the concept of a *boundary person*, analogous to the notion of *boundary concepts* as explored by Ilana Löwy. This historian of science describes boundary concepts as 'loosely defined concepts which [...] facilitate communication and cooperation [...] between distinct professional groups'.⁸ A boundary concept's 'hard core', she argues, corresponds to a zone of agreement, but its zone of 'fuzzy periphery' allows for a different interpretation by various interacting professional groups. In her study on the development of the field of immunology Löwy examined how such loose concepts allowed for better alliances and collaboration between the two professional groups involved – the scientists and the medical practitioners working within immunology. She also argued the importance of boundary concepts for the development of new knowledge, science and disciplines.

Comparable to a boundary concept, a boundary person can be seen as a person who facilitates alliances and cooperation across distinct professional groups by means of a convincing affiliation to these groups, speaking their various professional languages, and appealing to their various ways of reasoning. This makes a person hard to pigeonhole, but it is precisely this ability to address multiple professional registers that allows such a person to

7 Interview with Patrick Bossuyt by Timo Bolt, 6 January 2012; *Idem* with Pim Assendelft, 26 January 2012; *Idem* with Henk Rigter, 30 January 2012; R. Bal, W.E. Bijker and R. Hendriks, *Paradox van wetenschappelijk gezag. Over de maatschappelijke invloed van de adviezen van de Gezondheidsraad* (The Hague 2002) 100-101, 203-205 and 287-289; P. Bossuyt and M.M. Offringa, 'De wortels van evidence based medicine: gereide

twijfel en gegronde zorg', in: P. Bossuyt and J. Kortenray (eds.), *Schaatsen op dik ijs: evidence based medicine in de praktijk* (Amsterdam 2001) 27-48, 43-45.

8 Ilana Löwy, 'The Strength of loose Concepts. Boundary Concepts, federative experimental Strategies and disciplinary Growth: the Case of Immunology', *History of Science* 30:4 (1992) 371-396, 372-374 DOI 10.1177/007327539203000402.



Figure 2:

Els Borst-Eilers campaigning for D66 in the run up to the parliamentary elections of 1972.

Private collection of Els Borst-Eilers.

make distinct groups join forces. The main difference between a boundary concept and a boundary person is the active role of the latter in this process. Whereas a boundary concept only makes possible for inter-professional interaction to further a common cause, a boundary person will actively pursue this kind of cooperation.

Throughout her career Borst-Eilers was involved with healthcare, be it in various positions. She subsequently worked as a medical scientist and as a hospital manager, she was an advisor to the government, a medical professor, and the minister of Health. As such, she was very well versed in the working of the medical field, its customs and its needs, and enjoyed many connections throughout the field. In this article, we will examine how Borst-Eilers instrumentalised her positions in the healthcare sector to further the cause of EBM, and discuss whether or not that made her a boundary person.

Doctor Els Borst-Eilers

Having studied medicine in the 1950s, Borst-Eilers was a medical doctor, but never really embarked on a career as a practitioner. In order to combine work with a family, she initially opted for a scientific career as an immunohaematologist. In 1976 she switched to a position in (medical) management as Medical Director at the AZU [Academic Hospital Utrecht], one of the largest hospitals in the Netherlands.⁹ A decade later, in January 1986, she accepted the position as vice-president of the Health Council – an independent scientific advisory body for the Dutch authorities, composed of specialists in medicine and healthcare. From 1992 onwards, she combined her work for the Health Council with a position as extraordinary professor of evaluation research of clinical practice at the AMC [Academic Medical Centre] in Amsterdam. This professorship was obviously meant as a final stage in her career, but in 1994 the social liberal party, D66, nominated her as the Minister of Health.

At the age of 62, Borst-Eilers started a career in national politics. To many, this appointment came as a surprise, but the world of politics was not new to her. Together with her husband Jan Borst, she had been a member of D66 since its foundation in 1966 (Figure 2). D66's appeal for a renewal of democracy impressed the couple. In contrast to the existing political parties, D66 rejected the idea of an ideological foundation, opting instead

9 Annemieke Klijn, *Verlangen naar verbetering. 375 jaar academische geneeskunde in Utrecht* (Amsterdam 2010) 265-271.

for the principles of pragmatism and reasonableness.¹⁰ Over the decades, D66's internal operation and political programme would evolve, but its pragmatic approach remained an important foundation for Borst-Eilers. Years later, when she succeeded Hans van Mierlo as D66's top candidate during the parliamentary elections of 1998 she repeated over and over again that 'pragmatism in politics', was what the world needed: 'What's important is not our own rigid opinions, it is the matter at hand. We think ideology is a poor advisor in the debates about the tough questions of our time. That's why we opt for a political attitude that puts virtues such as courtesy and reasonableness at the centre.'¹¹ An exception to this, according to Borst-Eilers, was matters of a more ethical nature, such as euthanasia or stem cell research. They were matters of 'principles'.¹²

The problem of the increasing costs of healthcare

Since the early 1980's discussions about the (financial) boundaries of healthcare had flourished, and by the end of the 1980's the members of government – then a coalition of Christian-democrats and liberals – were eager to finally move from discussing this issue, to real action.¹³ It all came down to one big question: 'how may priorities in healthcare be formulated in such a way that justice, equality of rights as well as manageability can be expressed in the best possible way?'.¹⁴ The government did not have an answer, which is why it requested no less than two committees to advise them on the matter.

First, in a letter dated 11 September 1989, Dick Dees, the State Secretary of Health, asked the Health Council to 'tidy up' the existing insurance package and to purge it of 'superfluous, marginally effective and/or inefficient components'.¹⁵ In practice, it was the Standing Committee on Medicine – composed of 25 medical specialists under the guidance of the Health Council's vice-president, Els Borst-Eilers – that was set to work. A second committee was appointed nearly a year later by a new State Secretary of Health, the social democrat Hans Simons. On 30 August 1990 he installed the Government Committee on Choices in Healthcare chaired by his political

10 Menno van der Land, *Tussen ideaal en illusie. De geschiedenis van D66, 1966-2003* (The Hague 2003) 32-33.

11 Cited in: *Ibidem*, 312-313. See also the many flashcards Borst-Eilers prepared for herself during this campaign, NA: Collection Borst-Eilers, temporary inv.nr. 79.

12 Email from Borst-Eilers to Carla Pauw, 27 February 2011, NA: Collection Borst-Eilers, temporary inv.nr. 62.

13 Bolt, *A Doctor's Order*, 315-320.

14 Gezondheidsraad, *Grenzen van de gezondheidszorg* (The Hague [1986]) 20.

15 *Idem*, *Medisch handelen*, appendix A, 75-78.

associate, the Amsterdam professor of Cardiology Arend Jan Dunning. This ‘Dunning Committee’ consisted of ten members who were experts in a wide variety of fields, including general medicine, psychiatry, medical ethics, philosophy, health law, social health insurance and policy, and organisation in healthcare.¹⁶

Simons harboured great ambitions and soon developed the so called ‘Simons’ Plan’, an attempt for a major reform of the existing system of health insurance.¹⁷ According to this plan, the various existing forms of health insurance would be merged into a single basic insurance. This plan brought to the foreground the question of what kinds of medicine and medical procedures had to be covered in the proposed basic insurance package. Simons hoped the two appointed committees would provide some answers.

The strategy the Dunning Committee developed for making choices in healthcare – published in November 1991 in the report *Choose and Share* – is known as ‘Dunning’s funnel’.¹⁸ A diagnostic technique, treatment method or other medical provision had to comply with four criteria. First, it had to concern necessary healthcare. Second, its efficacy needed to be established. Third, sufficient efficiency of the care provision was required. Finally, it had to be considered whether necessary, effective and efficient healthcare qualified as being at the patient’s own expense and responsibility. Within ‘Dunning’s funnel’ these four criteria functioned as filters or sieves: only provisions that went through all four filters were eligible for inclusion in the basic package. In short, the Dunning Committee provided politicians with an instrument to decide on the composition of the basic insurance package. Ultimately, the Dunning Commission placed the responsibility for making choices with politics and society.

Medical Practice at a Crossroads

The report of the Health Council – *Medical Practice at a Crossroads* – was published a month later and contained something of a totally different order, namely a reflection on the way in which physicians took their clinical decisions and the resulting high degree of variation in medical practice. Under Borst-Eilers’ guidance, the Standing Committee had decided not to focus on the (insured) diagnostic procedures and medical treatments themselves, but on their application by Dutch physicians. This report clearly deviated from the original request for advice, but it felt there was no other way.¹⁹ Twenty years after the event, Borst-Eilers recollected:

16 Commissie Keuzen in de Zorg, *Kiezen en delen* (The Hague [1991]) 5 and 223.

17 J.M. Boot and M.H.J.M. Knapen, *De Nederlandse gezondheidszorg. Bevolking en gezondheid, voorzieningen en beleid* (Houten 2013) 228–231.

18 Commissie Keuzen, *Kiezen en delen*.

19 Cited in: Bal, Bijker & Hendriks, *Paradox*, 96.

So the state secretary thought: you just make a list of things that are no longer allowed: a certain operation, a certain diagnostic intervention and so on. Yet there was almost nothing that had been introduced in practice which was rubbish from A to Z. Most of it was applied too broadly. And this is why we said: it is not just about a list of provisions, it is about the application. And with this application you touch upon medical practice.²⁰

In order to shed light on the daily reality of medical practice, the committee sent out staff to interview about 55 medical practitioners. The result appeared to be a very eclectic picture that brought to the foreground the high level of inter-physician variation, the wide variety in which medical doctors use criteria for determining a certain diagnosis or for the application of a certain treatment. The committee saw this inter-physician variation as a signal that ‘the quality of the medical practice’ varied as well.²¹ The efficiency of medical practice could definitely be increased. In order to achieve this goal, Borst-Eilers and the rest of the committee expected a lot from the systematic evaluation of medical practice and its effectiveness, resulting in more communication and collaboration among medical practitioners, and the drafting and implementation of clinical practice guidelines.²²

Medical Practice at a Crossroads was the result of group work from the entire Standing Committee on Medicine of the Health Council, not of its chairwoman alone. However, R. Bal, W. E. Bijker and R. Hendriks – science and technology studies-scholars who thoroughly analysed the way the Health Council operated in the 1980s and 1990s – have stressed the extent of Borst-Eilers personal influence on the report.²³

In regard to managing the increasing costs of healthcare, the report makes scarcely any claims. However, it echoed ideas about the compatibility of quality and efficiency in healthcare that had already been developed in previous years. In the mid-1980s, several medical opinion leaders and medical professional organisations – among them the Royal Dutch Medical Association (KNMG) – noted that a remarkable shift had occurred. In the 1970s, it was still ‘not done’ to link the economic concern of scarcity of resources to the concept of quality: but since then, the concept of *efficiency* was increasingly being mentioned explicitly and emphatically as an essential (sub)component of the *quality* of medical practice.²⁴ This trend can be understood, to a great

20 Interview with Borst-Eilers by Timo Bolt, 3 February 2012.

21 Gezondheidsraad, *Medisch handelen*, 36.

22 Ibidem, 51-54.

23 Bal, Bijker & Hendriks, *Paradox*, 84, 99-101, see also n. 58 on 100. Their study was based on the minutes of the Health Council committee’s meetings and interviews with ‘insiders’.

24 See amongst others: F.N.M. Bierens, ‘Verantwoorde gezondheidszorg en verantwoordelijkheid’, *Medisch Contact* 40:40 (1985) 1223-1226; ‘Gezondheidszorg bij beperkte middelen: KNMG-commissie rapporteert’, *Idem* 41:12 (1986) 357-373; L.J.M. Groot, ‘Is het veld rijp voor kostenbeheersing?’, *Idem* 37:49 (1984) 39-40; E. Reerink, ‘De kwaliteit van het medisch

extent, from the perspective of the professional interests the KNMG and other professional medical organisations represented. They attempted to keep the government and other ‘third parties’ at bay by integrating the issue of the cost of healthcare – summarised in the concept of efficiency – in the quality of medical practice. As repeatedly stressed by these organisations, the quality of medical practice was very much an issue for the profession itself. At the same time, there was a clear awareness of the importance of accountability and a more efficient use of financial resources in a time of scarcity. The activities of professional organisations with regard to the quality (and thus also the efficiency) of medical practice – e.g. initiatives to develop peer review and guideline programmes – intensified markedly in the 1980s.²⁵ *Medical practice at a crossroads* advised to stimulate this trend even more.

Evidence-Based Medicine

Medical Practice at a Crossroads put the principles of what would become known as Evidence-Based Medicine on the political agenda, even before the term itself was in common usage. The term EBM was launched internationally a year later, in 1992, in an article in the *Journal of the American Medical Association*, written by a group of clinical epidemiologists from the McMaster University in Canada. The authors presented EBM as nothing less than a ‘new paradigm’ for medical practice. Whereas the ‘old paradigm’ had valued pathophysiological principles, teacher authority, experience and unsystematic clinical observation, the ‘new paradigm’ stressed the fallibility of these and gave priority to the numerical evidence that came from clinical research, and in particular form RCT’s (Randomised Controlled Trials) and meta-analyses of RCT’s.²⁶ Within the EBM-ideology, this preference for certain forms of evidence was translated into pyramid-shaped ‘hierarchies of evidence’ (Figure 3).

With its ‘evidentiary hierarchy’, EBM is one of the most striking manifestations of the growing influence of quantification and statistical-epidemiological reasoning in present-day medicine and healthcare. Of great importance was the vision of founders such as Alvin Feinstein, David Sackett and Henrick Wulff who in the 1960s and 1970s started opposing the dominance of the laboratory sciences and strived for the establishment of a clinical science for medicine – clinical epidemiology, a discipline that applied

handelen in het ziekenhuis’, *Idem* 38:11 (1983) 303-304. For many more examples see: Bolt, *A Doctor’s Order*, 294, n.78.

25 Bolt, *A Doctor’s Order*, 295-296.

26 EBM Working Group, ‘Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine’, *Journal of the American Medical Association* (hereafter: JAMA) 268:17 (1992) 2420-2425 DOI 10.1001/jama.268.17.2420.

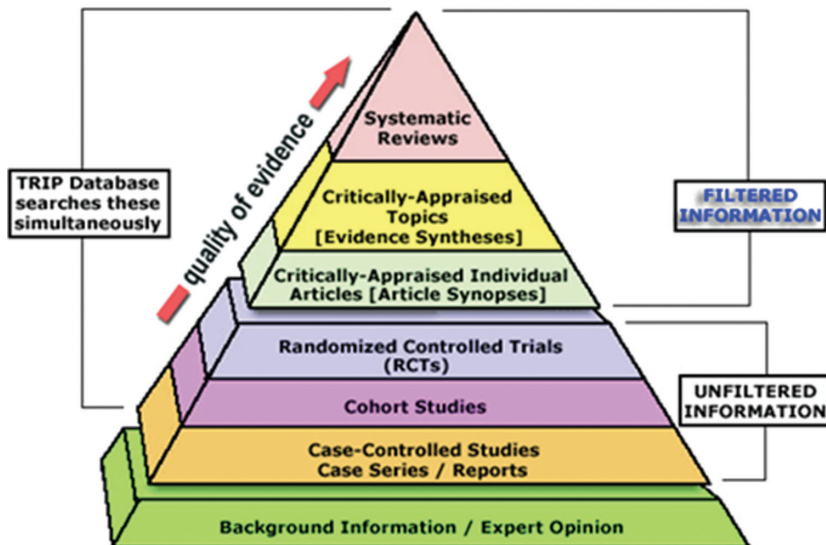


Figure 3: Example of the 'hierarchies of evidence' circulating within the EBM-movement. Weblog on EBM of the Dartmouth Biomedical Libraries: <http://www.dartmouth.edu>.

the statistical methods of 'public health epidemiology' specifically to clinical questions and clinical populations.²⁷

To help individual physicians to access and apply the latest clinical evidence, tools such as *systematic reviews* and *clinical practice guidelines* were developed. Systematic reviews – often called Cochrane reviews after the pioneering work of the British epidemiologist Archie Cochrane – are (critical) summaries of the relevant scientific literature on a specific subject. Guidelines derived almost naturally from systematic reviews as their conclusions were translated into specific instructions, roadmaps and criteria that could assist physicians in taking decisions on the diagnostics or treatment of a particular condition. In the development of an evidence-based healthcare policy, both would become important tools. For the many people involved in healthcare in the Netherlands, the publication of *Medical Practice at a Crossroads* signalled the start of the EBM-era.²⁸

Giving the initiative to the medical profession

By stressing the principles of EBM, the Standing Committee on Medicine of the Health Council – all the members being medical doctors themselves – put

27 Bolt, *A Doctor's Order*, 114-122; J. Daly, *Evidence-Based Medicine and the Search for a Science of Clinical Care* (Berkeley, Los Angeles, London 2005) 25-40 and 53-58.

28 Bolt, *A Doctor's Order*, 136-144 and 264; Daly, *Evidence-Based Medicine*, 75-92 and 154-169.

the practitioner's actions at the heart of the future health policy. They did so for numerous reasons.

First, it appears that the committee under the guidance of Borst-Eilers was not keen on too much governmental influence. This is in accord with Borst-Eilers political commitment as a member of D66, a party that liked to address the public as rational people, able to take matters in their own hands. As a member from the early days, Borst-Eilers had always supported this idea. During the election campaign of 1998, she proclaimed it was 'not the structure, the laws and the regulation that make up the country, but the commitment, the inspiration and the capacities of the people'.²⁹ Her preparatory flashcards and notes for this campaign were interlaced with phrases such as 'investing in trust about what people can do themselves', 'stressing individual responsibility', 'inspirational and motivational political leadership', and 'encouraging people'.³⁰ Where the social-democrat Dunning advocated a decisive role for the government, the social liberal Borst-Eilers wanted to keep the government at a certain distance, and leave the initiative to the medical profession.

Second, Borst-Eilers and her committee genuinely wished to reinforce and strengthen the quality of Dutch healthcare and for that doctors were needed, they argued. Medical doctors had to reclaim their position as medical experts *par excellence*, but in order to do so 'the medical profession had first to adopt a new attitude'.³¹ Systematic critical appraisal of the daily medical practice and the implementation of guidelines would bring the medical profession to a new level. The Health Council appealed to the medical profession, calling on them to make a stand. At the same time the committee also threatened: 'It is up to the profession: it either has to put its affairs in order now, or it has to tolerate the government, the insurers or hospitals taking over the initiative.'³²

A third reason was of a more practical, perhaps even cynical, nature. 'In order to bring about changes in medical practice', Borst-Eilers warned, 'involvement and commitment of the practitioners in the field will be a necessity'. Without that, 'every list of what could be considered effective treatment and what not will be cast aside as a corpus alienum all too easily'.³³ Or in other words, any other kind of policy was doomed to fail. Health scientist R. van Herk speaks in this regard of the 'obstructive power' the medical profession could exercise, which he mainly attributes to the highly specialised character of medical care.³⁴ After all, doctors are the only ones who

29 Cited in: Van der Land, *Tussen ideaal en illusie*, 315.

30 Collection of flashcards and preparatory notes from Borst-Eilers' campaign in 1998. NA: Collection Borst-Eilers, temporary inv.nr. 79.

31 Gezondheidsraad, *Medisch handelen*, 31.

32 *Ibidem*, 12.

33 *Ibidem*, 24.

34 R. van Herk, *Artsen onder druk. Over kwaliteitsbeleid van medische beroepen* (Utrecht 1997) 182.

can diagnose medical problems, and if they conclude some kind of procedure is necessary it is hard to deny this.

Selling *Medical Practice at a Crossroads*

Convincing the Department of Health of the merits of *Medical Practice at a Crossroads* appeared easy. Shortly after the publication of the advisory reports it became clear that Simons' major reform plan was not going to succeed. Resistance to it in both the medical and political fields was simply too strong. For Simons this was a heavy blow, and after this failure – and all the (political) commotion Simons' plan had generated – he and his civil servants were quite happy to take a step back and hand more responsibility to the medical field itself.³⁵ However, in order to implement the recommendations of *Medical Practice at a Crossroads*, not only the government had to be convinced, but also the medical practitioners themselves.

To stimulate a general change in the actual medical practice and attitude, the authors of the advisory report started a campaign of 'missionary work' which, according to Bal, Bijker and Hendriks 'occurred a great deal more vociferously' than usual.³⁶ In particular Borst-Eilers and Yvonne van Duivenboden, the committee's secretary, put a great deal of time and effort into this. In anticipation of this 'missionary work' the committee had composed its report very strategically. Although it spelled out much of what went wrong in the medical field, it also stressed that much of that was not the practitioners' fault: a lot was expected from them, but they often lacked the tools to make the necessary decisions. Despite this situation, the committee reassured the practitioners that many of them already tried to work in what was proposed as the 'new ideal way'.³⁷ In this way the committee managed to present its proposition for a more efficient and coherent medical practice as a bottom-up proposal, effectively establishing a bridge between the medical profession and future healthcare policy. It was presented as something for which many practitioners were asking; and indeed there were existing initiatives within the medical profession in this respect. Particularly in Amsterdam a couple of EBM-disciples had been spreading the ideas of Sackett since the early 1980s.³⁸ The CBO [Centraal Begeleidings Orgaan voor de intercollegiale toetsing], a quality institute concerned with the promotion and supervision of peer reviews in Dutch hospitals, in turn had cautiously started to produce clinical practice guidelines since 1982.³⁹ The NHG [Dutch Society of General Practitioners] had followed this example from 1989 onwards.

35 Bal, Bijker & Hendriks, *Paradox*, 204.

36 *Ibidem*, 223.

37 Gezondheidsraad, *Medisch handelen*, 31.

38 Bolt, *A Doctor's Order*, 232-234.

39 *Ibidem*, 287.

However, support for these initiatives was still scarce and, as remarked during one of the committee meetings, they ‘could do with a shot in the arm’.⁴⁰

Furthermore, this spin also served the purpose of circumventing the obstructive power of the field mentioned above. By praising those practitioners who were already trying to enforce healthcare efficiency, the committee banished those who resisted the proposed reform to the outcast group of old fashioned physicians who did not want to work towards a better healthcare. As such, *Medical Practice at a Crossroads* not only was an honest cry to turn around medical practice, but also a sharp managerial tool provided by the Health Council. All this rhetoric was not a coincidence, but a very deliberate strategy. Years later Borst-Eilers remembered unabashedly that she and the other committee members had made a very important tactical and pragmatic choice. Where all previous reports on the issue of the boundaries of healthcare – including that of the Dunning Committee – remained too much on the ‘outside’ and were therefore not supported ‘from within’, Borst-Eilers and her peers, as she put it in her own words ‘had taken the wise step of “entering the bowels” of the medical profession and having the issues raised from there’.⁴¹

Here Borst-Eilers’ experience as the manager of one of the biggest hospitals of the country appears to have been important. As director of the AZU, Borst-Eilers had personally encountered the obstructive power and professional obstinacy of some doctors. She knew how important it was to motivate medical professionals if you wanted to get something done. As a politician or a manager in the healthcare sector, you cannot say ‘I am your boss’, she argued. Especially what she called ‘the big ego’s of the professors’ will simply not put up with it. Instead, ‘you have to exude at least the impression that you facilitate the work of the professionals themselves!’.⁴² Reflecting on her work as director of the AZU, Borst-Eilers concluded that this approach had served her well, gaining her a much goodwill and respect on the work floor, enabling her to enforce her opinion when she felt it was really necessary.

Borst-Eilers at the AMC

In the wake of the publication of *Medical Practice at a Crossroads*, Borst-Eilers became an apostle of its principles. Important in this regard was her nomination as extraordinary professor of evaluation research of clinical practice at the AMC in 1992 for one day a week, in addition to her work at the Health Council. Accepting this position with an inaugural speech on 11 February 1993, Borst-Eilers set out her programme for this professorship:

40 Bal, Bijker & Hendriks, *Paradox*, 100.

41 Interview with Borst-Eilers by Timo Bolt, 3 February 2012.

42 Interview with Borst-Eilers in: Young Girls Community, *Ik ben aan Z. Vrouwelijke leiders in de zorg* (s.l. 2013) 8-9.

‘We need to establish Evidence-Based Medicine’.⁴³ Basically repeating the same reasoning as in *Medical Practice at a Crossroads* she called for a ‘fight against ignorance’ within the medical field by instigating more goal-oriented evaluation research and by developing guidelines for medical practice.

At the AMC Borst-Eilers became part of the Department of Clinical Epidemiology and Biostatistics where EBM was already on the rise.⁴⁴ Stimulated by Niek Urbanus, president of the Board of Directors, people like Harry Büller, Hans van Crevel, Jan Wouter ten Cate, Hajo van der Helm and Patrick Bossuyt had been spreading and developing EBM-initiatives. A result of this was the incentive programme ‘guidelines for clinical practice’, which gave all hospital departments the opportunity to apply for support in the form of a limited budget and assistance in the development of clinical guidelines, and the research it required. A second notable initiative was the monthly lecture series on EBM that drew a hundred to two hundred staff members and was experienced as a ‘true happening’.⁴⁵ Here, for a short time, Borst-Eilers worked at the front of the EBM-movement in the Netherlands, propagating the merits of EBM and actively stimulating colleagues to apply it.

A doctor-politician at work

After only two years of professorship Borst-Eilers was appointed Minister of Health. Borst argued that her ‘greatest challenge’ as minister was ‘to reconcile the need to control public spending on healthcare’ with the existence of an ‘equitable, high-quality public health and healthcare system’.⁴⁶ Both as chair of the committee that wrote *Medical Practice at a Crossroads* and as a professor, she had advocated that the creation and implementation of guidelines – based on the best scientific evidence available – was the way to ensure both. Now that she was in charge, she resolutely continued along that path. The choice for EBM as a central theme for Borst-Eilers’ policy made sense: it was her pet project. But it served a second purpose: it allowed the minister and her discussion partners to depoliticise the long-running discussion on the need to cut down healthcare costs. The conviction that evidence-based clinical guidelines would reduce healthcare costs meant that policymakers could avoid making hard, and often politically volatile choices – especially within a

43 Els Borst-Eilers, *Geneeskunde op recept? Rede uitgesproken bij de aanvaarding van het ambt van bijzonder hoogleraar in het evaluatie-onderzoek van het klinisch handelen* (Amsterdam 1993) 15.

44 Bolt, *A Doctor’s Order*, 239-241.

45 Irene van Elzakker, ‘Bloedverlies bij open hartoperaties: de verborgen schatten van oud

onderzoek’, in: Bossuyt and Kortenray, *Schaatsen op dik ijs*, 97-100, 100.

46 Lecture by Els Borst-Eilers at the eight Cochrane Colloquium in Rome. NA: Collection Borst-Eilers, temporary inv.nr. 68.

cabinet that combined liberal and social-democratic parties. ‘Evidence’ would decide for them.

In interviews the minister often emphasised that she was not a person who changed her opinions because of a new job title. Therefore, it was no surprise when she announced to leave the initiative in this regard to ‘the field’.⁴⁷ In the policy letter she sent to the Lower House in November 1995 she foresaw an important role for the various scientific medical associations. As an example, Borst-Eilers explicitly mentioned the scientific organisation of Dutch general practitioners, and its (by then) acclaimed guidelines programme, which was also called NHG-standards.⁴⁸ She pointed out that this was an example to be followed, and announced the endeavour to link quality to efficiency. The professional associations in healthcare therefore should ‘take more account of the necessity of efficiency promotion and appropriate use’.⁴⁹ She in turn would make sure resources were available to promote the implementation and evaluation of the use of guidelines, and if progress did not come along fast enough, she would push by threatening to take over, or by installing her own projects.⁵⁰

In order to succeed with her policies as a Minister of Health, Borst-Eilers felt it necessary to remain as close as possible to the medical field. ‘Ideally, the Minister of Health is a medical doctor’, Borst-Eilers repeatedly argued.⁵¹ In other words, she favoured a *specialist minister*. In her view, the complexity of the healthcare sector and the highly specialised character of medical knowledge required a specialist. However, she also had another, more mundane reason. Health is a policy area ‘in which so many psychological mechanisms are at work and in which so many tricks are played’, Borst-Eilers explained, referring to the obstructive power of the medical profession mentioned earlier: ‘With a pious face someone will say: Yes, minister, we are doing our best, but there is no other way. While, having worked in the discipline yourself, you know very well that in fact there is another way. And you can say this as well’.⁵²

In line with this view, it is no surprise that Borst-Eilers cultivated the persona of the specialist minister. Most of her career she had served in the capacity of a manager and policymaker, but as a minister she always spoke about herself as being a physician. Already during the first few minutes of her first appearance in the Lower House she spoke of her ‘career in medicine’.⁵³ Throughout her period of office sentences starting with ‘As a medical doctor,

47 *De Volkskrant*, 20 April 2001.

48 Borst-Eilers’ policy letter *Medische Technology Assessment en doelmatigheid van zorg* from 28 November 1995, see: *Handelingen Tweede Kamer* (hereafter HTK), kamerstuk 24126 nr. 9, 4 December 1995, 15, 17 and 19–20.

49 *Ibidem*, 19.

50 Bolt, *A Doctor’s Order*, 336–339 and 344–345.

51 Cited in: Joost Visser, ‘Artsen mijden de politieke arena’, *Medisch Contact* 55:36 (2012) 1956–1959, 1958.

52 Interview with Borst-Eilers by Timo Bolt, 3 February 2012.

53 HTK, 7 September 1994, 5980.

I think ...' sprinkled many of her public speeches, emphasising her bond with the medical profession time and again.⁵⁴

At the same time, she also kept downplaying her earlier commitment to D66. 'I was a member and had distributed some flyers on occasion', she would say.⁵⁵ Or, 'for a time I was regional secretary because I was handy with the copier'.⁵⁶ Although in fact, she had been a fairly active member at a local level all along, especially in the early 1970s. In her home town, the small town of Bilthoven, as well as at a regional level, she organised many meetings, party conferences, and surveys, while her husband had a seat on the central committee of the party.⁵⁷ So, while politics on a national level truly was new for Borst-Eilers in 1994, her affiliation with D66 certainly went well beyond distributing flyers and making stencils. By minimising her affiliation with D66 while emphasising her medical background, Borst-Eilers distanced herself as much as possible from being seen as a party politician. Invoking the persona of the specialist minister, she hoped to be seen as a companion of the medical profession, rather than as an opponent, so that her propositions could be presented accordingly.

To a large extent this strategy worked: the public and the media were easily convinced, resulting in newspaper headings such as 'E. Borst-Eilers; first and foremost a specialist', 'Minister Els Borst has always remained a medical doctor', 'A medical doctor in politics', or simply 'Doctor Borst'.⁵⁸ Evaluating her first term as Minister of Health, *NRC Handelsblad* even wrote: 'sometimes it seems as if her white coat still hangs around her shoulders'.⁵⁹ While the essayist Kees Fens lamented in *De Volkskrant*: 'If only she was my general practitioner'.⁶⁰

Borst's cultivated persona as a specialist minister was not a lie. She was a medical doctor with a PhD, and she had a rich career in the medical field behind her. Furthermore, she preferred to see herself as a physician and often acted accordingly,⁶¹ but she had never really practiced medicine, and therefore people from the medical profession were not always so easily convinced. Or, as Siem Buijs, a general practitioner who was also a Member of Parliament for the Christian democratic party CDA noticed: 'Of course, Minister Borst has a lot of experience with management in the healthcare sector. But that

54 Lecture at the eighth Cochrane Colloquium in Rome, 5 October 1999, and lecture at the ninth Cochrane Colloquium in Lyon, 10 October 2001, NA: Collection Borst-Eilers, temporary inv.nr. 68.

55 Interview with Els Borst-Eilers: 'Jij krijgt de schuld van alles wat er misgaat in de zorg', *Trouw*, 22 May 2010.

56 Els Borst-Eilers, Speech at the memorial service of Hans van Mierlo, 23 March 2010.

57 NA: Collection Borst-Eilers, temporary inv.nr. 82.

58 *NRC Handelsblad*, 31 May 1997; *Idem*, 24 January 1998; *De Volkskrant*, 15 April 2000; *Idem*, 20 April 2001.

59 *Ibidem*, 24 January 1998.

60 *De Volkskrant*, 20 January 1996.

61 Letter of application from Els Borst-Eilers, 1 May 1977. NA: Collection Borst-Eilers, temporary inv.nr. 121.

is very different from having real hands-on experience'.⁶² Nevertheless, the appointment of Borst-Eilers as Minister of Health indicated a real attempt to bring the medical field and the government closer together. In particular the relationship between the government and the specialists had been seriously damaged in the preceding decades because of a long standing conflict about the specialists' wages. When Borst-Eilers managed to improve the relations and made the specialists agree to a compromise, it was one of the great achievements of the minister that she, precisely in this area, had brought peace and quiet.⁶³ When, for example, her first term in office was evaluated in 1999 by the chief editor of *Medisch Contact* – the journal of the KNMG – he noted: 'She did [...] ensure that fewer people from the field were unnecessarily needed and that we were better listened to. Thus, the work carried out to optimise healthcare was more constructive and collective in nature than it had been under many of her predecessors'.⁶⁴

'I am pleased to say Evidence-Based Medicine has been fully accepted'

During her eight years as Minister of Health Borst-Eilers was applauded, but at times also harshly criticised. Especially the long waiting lists that would come to characterise her time as minister generated a lot of discontent, and twice she was confronted with a motion of no confidence. However, the importance of a general turn towards EBM was never seriously contested; not even in the political arena, such as the standing committee on healthcare of the Dutch parliament, where Borst-Eilers' policy letters were discussed. Endorsement from fellow D66-member Roger van Boxtel was no surprise, but also politicians such as the Christian-democrat Ad Lansink, the liberal Margreet Kamp, the social-democrat Rob Oudkerk – with whom Borst-Eilers would often clash on other issues – and the orthodox Protestant Bas van der Vlies praised the minister for her attempt to come to a more efficient and evidence-based healthcare, illustrating the depoliticising character of EBM on the healthcare policy at the time.⁶⁵ The principle of EBM became the norm. Full of confidence, Borst-Eilers claimed at an international Cochrane

62 Roel Otten, 'De arts-politicus: vriend of vijand?', *Medisch Contact* 53:18 (1998).

63 Ido de Haan and Jan Willem Duivendak (eds.), *In het hart van de verzorgingsstaat. Het Ministerie van maatschappelijk werk en zijn opvolgers (CRM, wvc, vws), 1952-2002* (Zutphen 2002) 283-284.

64 B.V.M. Crul, 'De Minister Gaat', *Medisch Contact* 54:21 (1999) 751. See also: A. Ankoné,

'Minister Borst', *Idem* 50:27/28 (1995) 885-887; C. Spreeuwenberg, 'Verkiezingen', *Idem* 49:17 (1994) 555; R.A.A. Vonk, *Recht of schade. Een geschiedenis van particuliere zorgverzekeraars en hun positie in het Nederlandse zorgverzekeringsbestel, 1900-2006* (Amsterdam 2013) 317.

65 HTK, kamerstuk 24126, nr.11, 4 April 1996.

Colloquium in 2001: 'I am pleased to say evidence-based medicine has been fully accepted'.⁶⁶

In a way this was true. EBM had gained a firm foothold in the Netherlands, but Borst-Eilers' victorious exclamation also blatantly disregarded the criticism that was also on the rise. That EBM had been established in the Netherlands was uncontested, but in the process the phenomenon had lost some of its glow. For Borst-Eilers EBM had been a development that could bring only good things – better and more efficient healthcare. Some critics, however, saw Borst-Eilers' choice of focussing on the efficiency at micro level rather as an 'admission of weakness' or as an 'emergency solution'.⁶⁷ More and more, they complained that the government all too easily passed on the responsibility for controlling the cost of healthcare to practicing professionals. Jannes Mulder for example, a long-standing, high-ranking official at the Ministry of Health, stated in an interview in 2002 that Borst-Eilers had too often avoided making choices at the macro-level, 'consistently' passing the 'hot potato' to the 'professionals in the consultation room or at the sick bed'.⁶⁸ Cor Spreeuwenberg, a professor of 'integrated chronic care' at Maastricht University and former editor-in-chief of *Medisch Contact*, lamented in this journal, that apparently 'politics' was not able 'to withstand the social pressures and political consequences of consistent choices'. 'With some *desperation*,' he continued, 'politics therefore urges healthcare professionals to be serious about efficiency and to participate in "evidence-based rationing"'.⁶⁹

In general, Borst-Eilers largely ignored this kind of criticism. As minister, she followed a very consistent course with conviction. She believed in EBM and, entirely in line with *Medical Practice at a Crossroads* had chosen to invest fully in the (promotion of) *self-regulation* by the medical profession.⁷⁰ However, an additional problem with this choice could not be ignored: the impact of the introduction of EBM as a means of controlling the costs of healthcare, appeared to be more limited than Borst-Eilers had expected. By the end of her second term it had become clear that in terms of cost-containment Borst-Eilers' policy choices had been insufficiently effective. So in the end she had to re-evaluate, which resulted in the memorandum *Vraag*

66 Lecture of Borst-Eilers at the ninth Cochrane Colloquium in Lyon. NA: Collection Borst-Eilers, temporary inv.nr. 68.

67 See amongst others: A.C.A. van den Hout, "'Vallen en Opstaan': Analyse vanuit het "Disasterperspectief", in J.C. Gerritsen and C.P. van Linschoten (eds.), *Gezondheidszorgbeleid: evaluatie en toekomstperspectief* (Assen, 1997) 57-65, 59; A.W. Mulder, 'Medisch Handelen op een

Tweesprong?', *Medisch Contact* 47:8 (1992) 228; C. Spreeuwenberg, 'Verkiezingsprogramma's vanuit Zorgperspectief', *Idem* 53:1 (1998) 25-8.

68 Quoted in: Bal, Bijker, and Hendriks, *Paradox*, 204.

69 Spreeuwenberg, 'Verkiezingsprogramma's vanuit Zorgperspectief', 27.

70 Paraphrased from: N.S. Klazinga, 'Het Keurslijf van de Professionaliteit', *Medisch Contact* 51:40 (1996) 1292.

aan bod [Healthcare on Demand] that was published in 2001.⁷¹ Personally Borst-Eilers remained a supporter of EBM, but in this last memorandum she announced a commitment to make the switch in the short term from a supply-driven approach to a demand-driven approach in healthcare, whereby a new insurance system would have to be introduced as well. As such, *Vraag aan bod* laid the groundwork for the extensive reform of the Dutch healthcare system of 2006, when two new laws came into force – the *Zorgverzekeringswet* [Health Insurance Act] and the *Wet Marktordening Gezondheidszorg* [Health care Market Regulation Act].⁷²

In this new system a ‘directive role’ was assigned to health insurers, pushing the principle of self-regulation by the medical profession to the background. This was, however, not the end of EBM. Even today, EBM is still omnipresent as a reference point for medical practice and research, but, as a policy instrument it has failed to live up to the expectations. After years of promoting and pushing the practice of EBM Borst-Eilers had to acknowledge this fact, and with *Vraag aan bod* she effectively changed course.

Conclusion

EBM appears to have been instrumental in aligning the government and the medical profession during the 1990s. For example, in 2001, Louise Gunning-Schepers – chair of the Board of Directors of the AMC, argued that Evidence-Based Medicine had been ‘able to breathe new life into the sometimes awkward, but in the past successful *symbiosis* of professional and government.’⁷³ Two years earlier, evaluating the various efforts in the field of the evidence-based guideline development, researchers from the institute for Medical Technology Assessment (iMTA) of the Erasmus University in Rotterdam spoke of a ‘*covenant* between the medical profession and the government to work together to promote efficiency in healthcare’.⁷⁴ This symbiosis did not happen just by itself. It is widely acknowledged that Els Borst-Eilers played a central role in this development. She did not do this alone, she did not invent the concept of EBM, nor did she conduct remarkable research in its spirit. However, examination of a variety of sources – such

71 НТК, kamerstuk 27855, nr. 2, 16 juli 2001.

72 K.P. Companje (ed.), *Tussen volksverzekering en vrije markt. Verzekering van zorg op het snijvlak van sociale verzekering en gezondheidszorg 1880-2006* (Amsterdam 2008) 592, 842 and 848; Vonk, *Recht of Schade*, 324.

73 Louise Gunning-Schepers, ‘Solidair zolang het werkt: de ongemakkelijke symbiose van arts en

overheid’, in: Bossuyt and Kortenray, *Schaatsen op dik ijs* 121-131, on 130. See also: Companje *Tussen volksverzekering en vrije markt*, 27-28.

74 F.F.H. Rutten and E.W.M. Grijseels, ‘De voorwaarden voor invoering en financiering nieuwe technieken’, *Nederlands Tijdschrift voor Geneeskunde* 143 (1999) 2329-2332.

as governmental documentation, interviews with people involved in the rise of EBM in the Netherlands, written reflections on this evolution by both opponents and proponents, biographical material, and all issues of *Medisch Contact* published between 1970 and 2015 – brought Borst-Eilers' particular influence to the foreground: she used her consecutive positions in the healthcare sector to promote EBM for nearly twenty years, and she was ideally positioned to do so. As a medical doctor and researcher she could reach out to the field, and speak a doctor's language; as an advisor of the government she worked together with the administration, as a politician she appealed to a very broad public, and as the Minister of Health for eight years in a row she was able to guide the actual policy in this domain. The combination of Borst-Eilers' varied career in the medical sector, her political engagement, and her talent for tactics and negotiation made it possible for her to function as a boundary person. Her claims in regard to knowledge of the medical profession were solid, and her political commitment and interest in healthcare policy on a general level were genuine. Being recognised as well-versed in the issues of the national healthcare policy by all parties involved, she was more than just the representative of the government. As a minister she managed to soothe tensions in the healthcare sector, and facilitate cooperation and alliances between the government and the medical profession, thus circumventing (the possibility) that the latter would exercise its 'obstructive power'. Obviously this did not work for all her plans, but in the case of promoting and pushing EBM – as mentioned before, one of the main developments in medicine of the last decades – she was quite successful.

With regard to the actual instalment of EBM-practices on the work floor her influence was rather limited and indirect, but on the political and administrative level, she really did stand out. However, it is important to remark that in promoting and pushing the development of EBM, she also influenced the notion itself. Originally an instrument to help physicians navigate the growing mass of scientific medical information, Borst-Eilers and her allies turned EBM into an administrative tool. By focusing on the proliferation of evidence-based clinical practice guidelines she contributed greatly to its evolution into a means to enhance the efficiency of healthcare which, she believed, would both increase its quality and contain the rising costs. As such, it was not so much the notion of EBM itself, but rather its specific translation into efficient and appropriate healthcare of which Borst-Eilers became the frontwoman in the Netherlands. In the end, the turn towards EBM failed to deliver the financial policy goals, and at the very end of her reign Borst-Eilers had to change course. But by then, EBM was already well established within Dutch healthcare and was there to stay. Nevertheless, due to this final switch, the current principle of market forces in the organisation of healthcare are as much a legacy of Borst-Eilers' policies, as the lasting foothold EBM has gained in the Netherlands.

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