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To health bureaucrats and politicians, what matters is to persevere. Then, marvellous things may happen.

We will all be satisfied in the end

«The scandals in the health services appear never-ending», the doctors Jannicke Mellin-Olsen, Kjetil Karlsen and Sven Erik Gisvold wrote in an op-ed in December (1). We have heard it before. What was new, however, was that these three authors submitted proposals for what the minister of health ought to do. It felt like a breath of fresh air. We have become accustomed to descriptions of the miserable state of the health services, but we rarely see any proposals for what can be done. Albeit not well developed, the three-point plan was noticed (2). If the Minister of Health is capable of turning the prevailing management ideology around, he could become the statesman who rescued Norway's good and well-functioning health services, they wrote (1). «We can't wait to see the result», the editor of the *Klassekampen* daily stated in a comment (2). I believe, however, that there is little reason for excitement.

To all appearances, the health services will – by and large – develop along the same lines that have been evident for many years. A number of factors pull in this direction, not least the need to restrict the growth in health expenditure. No minister of health will be able to change this fact, rather to the contrary. Over the coming years, health policy will most likely be tightened even more than has been seen hitherto. Prioritising of health services, in terms of which, where and to whom, will unavoidably push forward. What are the implications for us doctors? An example from classic social psychology may provide an answer (3, 4).

It is well known that people feel a strong need to be consistent. Therefore, our behaviour and our convictions will tend to converge. We prefer to practise what we preach. There must be a certain order and coherence between ourselves and our environment (5). However, there are exceptions. Everybody knows that smoking is unhealthy. Nevertheless, many continue to smoke. Smokers will therefore perceive an inconsistency between their behaviour and their convictions. This conflict between action («I smoke») and knowledge («smoking is harmful to my health») is hard to endure. Those who smoke will therefore attempt to justify their behaviour, for example by playing down the risk: «Smoking is not as harmful as doctors say» (5, 6). The American social psychologist Leon Festinger (1919–1989) described this phenomenon in the late fifties, and referred to it as «cognitive dissonance» – that there is a conflict between our thoughts and our actions (3, 4). Festinger claimed that such dissonance gives rise to a psychological discomfort that will motivate us to change in order to establish consistency. Here is the parallel to the health services: Doctors perceive a lack of consistency between what they see as the right thing to do and the frameworks that they operate within. For example, many doctors report that they send messages upwards through the system, but without being listened to. This is a state of cognitive dissonance – the things we do are inconsistent with our convictions. Over time, we cannot endure this discomfort.

There are various ways to reduce this cognitive dissonance, one of which is to change your convictions. In other words, cognitive dissonance can help change attitudes (7). And here, my image of the new Norwegian health services emerges: Doctors and other health workers will gradually change, so that we will have different notions than before of what is the appropriate exercise of the profession, of the things that motivate us and the matters that we hold to be paramount. We will adapt to the system and not just accept the prevailing conditions, but also feel that they have to be so, and are for the best. The theory of cognitive dissonance thus teaches us that to health bureaucrats, administrators and politicians, what matters is to persevere. If they do, marvellous things may happen: Those who work in the health services will adapt to the prevailing management ideology. We will feel that the bottom line is what counts, that being production workers in health factories has a number of advantages, and that efficiency is the key issue in the doctor-patient relationship.

An unlikely dystopic horror scenario? I have obviously taken the model and the interpretation to extremes here (8, 9). But let me end on a personal note. I recently underwent a personality test at work. An enterprise was charged with mapping out our personality profiles. On one of the variables I had a top score: I was 100 % «adaptable». The interpretation of such an uncommon result, the consultant explained, was that I could easily adapt to any workplace. I can reconcile myself to any circumstances. Then it suddenly occurred to me: I will be the perfect employee of the New Norwegian Health Services.

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