

What is a doctor, and what does a doctor do?

The Productivity Commission's recent proposal to modify the roles of health professionals raises these important questions

A century ago, the role of doctors was clear and simple. Sir William Osler, Regius Professor of Medicine at Oxford, noted that it was “to acquire facility in the art of diagnosis . . . to grow in clinical judgment . . . to appreciate the relative value of symptoms and the physical signs . . . to give to the patient and his friends a forecast or prognosis . . . [and] to conduct the treatment that the patient may be restored to health . . . or, failing that, be given the greatest possible measure of relief”.¹ It was the age of acute care, and medicine's knowledge base was contained in a single tome — Osler's *The principles and practice of medicine*. Doctors accounted for about one in every three health professionals,² and practised as general practitioners or consultant physicians and surgeons. The payment for health care was a contract between the patient and the doctor, and not the business of government.

One hundred years on, how things have changed.

Doctors now account for one in every eight workers in Australia's health care sector.³ Unprecedented advances in science and technology have splintered medicine into myriad specialist groups, and the information explosion has led to innumerable journals, textbooks and Internet sites. Medicine's focus has moved beyond acute care, to preventive health care and management of chronic diseases and ageing. These require the skills not only of doctors and nurses, but of professionals in fields which have emerged in the last century, such as physiotherapy, occupational therapy, nutrition and social work. These professions have distinct educational programs, different emphases of practice and different professional aspirations.

The demography of doctors has also changed. Women now account for one third of the medical workforce.⁴ They favour disciplines such as general practice, paediatrics, obstetrics and gynaecology, pathology, psychiatry and public health, where hours of work are reliable or can be structured around other commitments.⁴ Furthermore, many doctors, in keeping with their generation, value matters beyond medicine: protected personal time, involvement with family and friends, and a balanced lifestyle.⁴

Australia's society has also changed. Our citizens are more health conscious, access health care more frequently, live longer, and overwhelmingly support unfettered access to free and risk-free health care. This health care is consuming a growing proportion of our gross national product and is becoming a “big-

ticket” item for governments. Governments have tried hard to control health care supply and demand and, in the process, have made policy blunders. For example, the restriction on medical school outputs in the 1990s has contributed in no small way to Australia's dependence on overseas-trained doctors to provide for its health care needs.⁵

In this milieu, Australia finds itself in the midst of a workforce crisis. There are increasingly strident calls for task realignment among health professionals — the development of nurse anaesthetists, and nurse practitioners in general practice, emergency medicine and selected

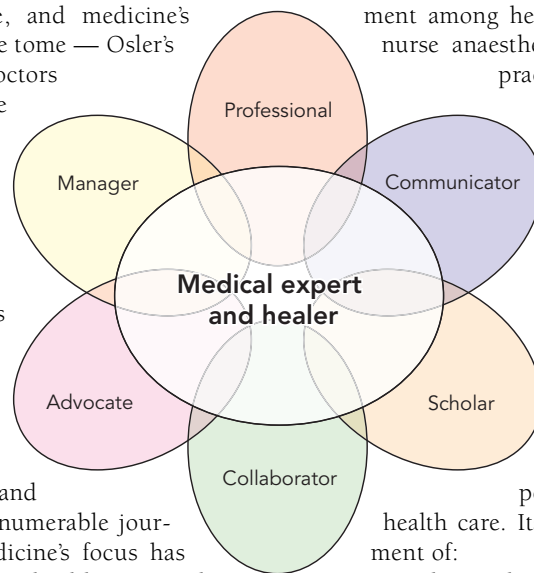
areas of hospital practice, and reporting by scientists on x-rays and pathology tests.⁶ Indeed, the United Kingdom's Labour government has recently sanctioned drug prescribing by nurses and chemists for all but controlled drugs.⁷

It is a political dictum to respond to a crisis by activating an inquiry, and we have had a flurry of reports on potential solutions for the health workforce crisis.^{8,9} But it is the Productivity Commission's recent draft position paper, *Australia's health workforce*,¹⁰ that has the potential to change the face of Australian

health care. Its recommendations include the establishment of:

- An advisory health workforce improvement agency, which will facilitate workforce innovations, particularly those that cross professional boundaries.
- An advisory health workforce education and training council, coupled with the transfer of responsibility for health education and training from the Department of Education, Science and Training to the Department of Health and Ageing. It is envisaged that this council will enable integration of different models of health education and training and a move towards a single national accreditation agency for university-based education and postgraduate specialist training. In the process, the council would assume existing accreditation roles, such as those of the Australian Medical Council and the clinical colleges. There is also a separate proposal by the Commission for a national registration regime based on the work of the proposed national accreditation agency.
- An independent review body to advise on services to be covered by the Medicare Benefits Schedule and on referral and prescribing rules, to encourage better use of available health workforce skills.

The Productivity Commission's draft position paper reflects its quest for efficiency and cost-effectiveness, and a belief that agency-led “top-down” reform will save our faltering health workforce. However, to the cynic, it appears to be a veiled



attempt to downgrade the function of clinical colleges, to “demedicalise” other existing agencies, and to facilitate a change in the roles of health professionals, including doctors. It provides no evidence that its recommendations will improve the standards of health care, produce better patient outcomes, or, for that matter, solve the current health workforce crisis.

All this activity begs the question: in the 21st century, what is a doctor, and what does a doctor do?

Answers are to be found in the Canadian Medical Association (CMA) project to define the role of medicine in the 21st century.¹¹ Its deliberations drew freely on other projects, such as Educating Future Physicians for Ontario (an initiative of medical groups, the Ontario faculties of medicine and the Ontario Ministry of Health) and the CanMEDS 2000 Project (Canadian Medical Education Directions of Specialists 2000, a project of the Royal College of Physicians and Surgeons of Canada).¹¹ The CMA clearly defined the doctor's role as a medical expert and healer, enriched with other roles (Figure). Although no doctor will function in all roles simultaneously, doctors should have competencies to participate in each of these roles as circumstances require.

The CMA's Futures Project advanced values for a future health care system.¹² These include “a team approach to the provision of health care and clarity with respect to roles and accountability”, and “a sustainable, highly qualified health care workforce with opportunities for career development and life-long learning”.¹² Its values for medicine in the 21st century stress “the physician's role as leader of the health care team” and “physician autonomy and accountable self-regulation of the profession”.¹² In all this, it is assumed that the central role in 21st century medicine belongs to primary care and the generalist.

What doctors are, and do, in the 21st century is thus not much different to what Osler espoused 100 years ago. Their tasks are embodied in the questions that preoccupy patients when consulting doctors: *What is wrong with me?* (diagnosis); *What will happen to me?* (prognosis); *What can we do?* (management plan, priorities and coordination); and *Who will do it and be responsible?* (competent, up-to-date and experienced practitioners, who are indemnified, and whose expertise is underpinned by broad and rigorous training).

In this context, the medical profession should welcome task transfer and better use of the skills of the various health care providers, as long as it occurs within the boundaries of team care, and as long as quality and safety outcomes are established.

The enactment of the Productivity Commission's proposals has the potential to realign health care delivery for the 21st century. But it will require wide consultation, a “bottom-up” rather than “top-down” approach, and a modicum of goodwill. It should not be the slippery slope to doctor pretenders.

Martin B Van Der Weyden

Editor, *The Medical Journal of Australia*
Sydney, NSW
medjaust@ampco.com.au

- 3 Australian Institute of Health and Welfare. Australia's health 2004. Canberra: AIHW, 2004: 259.
- 4 Gavel P, Evans J, Young J. Who are the doctors of the 21st century? International Medical Workforce Collaborative 9th Conference; 2005 Nov 15-19; Melbourne. Available at: <http://www.health.nsw.gov.au/amwac/amwac/9conf.html> (accessed Nov 2005).
- 5 Birrell RJ. Australian policy on overseas-trained doctors. *Med J Aust* 2004; 181: 635-639.
- 6 Duckett SJ. Interventions to facilitate health workforce restructure. *Aust N Z Health Policy* 2005; 2: 14. Available at: <http://www.anzhealthpolicy.com/content/2/1/14> (accessed Nov 2005).
- 7 Hawkes N. Plan for nurses to prescribe drugs infuriates doctors. *The Times* (London) 2005; 11 Nov. Available at: <http://www.timesonline.co.uk/article/0,,8122-1867520,00.html> (accessed Nov 2005).
- 8 Australian Health Ministers' Conference. National health workforce strategic framework. Sydney: the Conference, 2004. Available at: http://www.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf (accessed Nov 2005).
- 9 Australian Competition and Consumer Commission, Australian Health Workforce Officials' Committee. Report to Australian Health Ministers. Review of Australian specialist medical colleges. Canberra: Commonwealth of Australia, 2005. Available at: <http://www.accc.gov.au/content/index.phtml/itemId/699578> (accessed Nov 2005).
- 10 Australian Government Productivity Commission. Australia's health workforce. Productivity Commission position paper. Canberra: Commonwealth of Australia, 2005. Available at: <http://www.pc.gov.au/study/healthworkforce/positionpaper/index.html> (accessed Nov 2005).
- 11 Canadian Medical Association. The future of medicine. *CMAJ* 2000; 163: 757-760.
- 12 Canadian Medical Association series of health care discussion papers. Looking at the future of health, health care and medicine. Ottawa: CMA, 2000. □



1 Osler W. Modern medicine. Its theory and practice. Philadelphia: Lea Brothers, 1907: 34.

2 Aitken LH. Achieving an interdisciplinary workforce [editorial]. *N Engl J Med* 2003; 348: 164-166.