Task transfer: another pressure for evolution of the medical profession

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ABSTRACT

- Since the 1960s, Australian society and the medical profession have undergone enormous change.
- Our society has moved from a relatively homogeneous and conservative community, supported by limited government services, to one that is multicultural, focused on the individual and consumerism, and supported by extensive government programs, with health care a top public and political priority.
- A defining feature of contemporary society is its mistrust of institutions, professionals, public servants and politicians.
- The medical profession has changed from a cohesive entity, valuing generalism and with limited specialisation, to one splintered by ultra-specialisation and competing professional agendas.
- The medical workforce shortage and efforts to maintain the safety and quality of health services are putting acute pressure on the profession.
- Task transfer or role substitution of medical services is mooted as a potential solution to this pressure. This has the potential to drastically transform the profession.
- How task transfer will evolve and change medicine depends on the vision and leadership of the profession and a flexible pragmatism that safeguards quality and safety and places patient priorities above those of the profession.

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This article is based on an address to the 40th year reunion of the 1966 graduates of Sydney University Medical School

On graduating from medical school in 1966, girded with the invulnerability and impatience of youth, we became members of a proud profession reaching back to antiquity. In the sixties, the profession was in control of its knowledge base and its self-regulation. It was a cohesive entity that valued generalism and had limited avenues for specialisation. There were then only six medical colleges, and the time required to achieve specialist status was relatively short — with all going well, it took either 4 postgraduate years to be admitted by examination to membership of the Royal Australasian College of Physicians (RACP) or 5 years to become a fellow of the Royal Australasian College of Surgeons (RACS). The ratio of doctors to other health professionals was about 1 : 3.[1] The fee for professional service was an agreement struck between the patient and the doctor, with the honorary system in public hospitals attending to the sick indigent. Issues such as medical workforce, the doctor–patient relationship, safety and quality of health care and continuous professional development were not on medicine's radar. But over the next 40 years all this was to change.

Changes to the community have been staggering. Australian society has moved from a relatively homogeneous and conservative entity with minimal welfare support to one that is multicultural with a focus on the individual and consumerism. Government services have become integral to our society, with extensive programs for health care, education and welfare. But if there is one thing that categorises society today it is a wide and deep-seated mistrust of institutions, professionals, public servants and politicians. Accountability and transparency are today's catch-cries.[2] Daily we are alerted about misconduct, mistakes and malfeasance of individuals and institutions by an aggressive and intrusive media. The modern mantra is that life should be risk free. Further lasting changes include the feminisation of the workforce, erosion of the extended family, and changes to the conventional family structure.

The profession of medicine has also fundamentally changed. In 2006, it is in danger of losing its knowledge base and self-regulation. The profession is split into multiple specialties and societies: there are now 12 clinical colleges with their chapters and an ever expanding array of craft groups. The RACP and RACS combined offer nearly 40 subspecialty streams,[3] and today it can take 10 years or more for a medical graduate to achieve specialist status. The health industry itself has expanded, with the ratio of doctors to other health care professionals now being about 1 : 8.[4] The doctor–patient relationship has changed from the paternalistic model of the sixties to one dominated by customers who wish to be involved in their own health management and who have access to health information on the Internet.[5] Current issues occupying the profession are medical workforce shortages, the safety and quality of health care, compliance with continuous professional development and the question of professional revalidation.

But of immediate concern to the profession is task transfer or role substitution of its services and interference with its self-regulation. In this context, an examination of the hallmarks of a profession is apt.

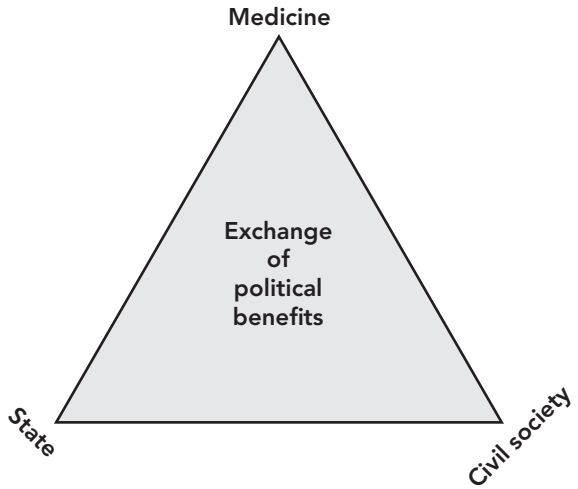
Most authorities agree[6,7] that a profession is a "community within a community" that:

- has a sense of solidarity and a common identity and values, with its members rarely leaving it voluntarily;
- has power over its members (self-regulation) and a unique knowledge base and expertise (performance);
- speaks a common language only partially understood by outsiders;
- produces its next generation through control of the selection of future members, their education and professional socialisation; and
- supports and is involved in the processes that replenish its knowledge base (research). Indeed, knowledge control is the basis of medical power.[8]

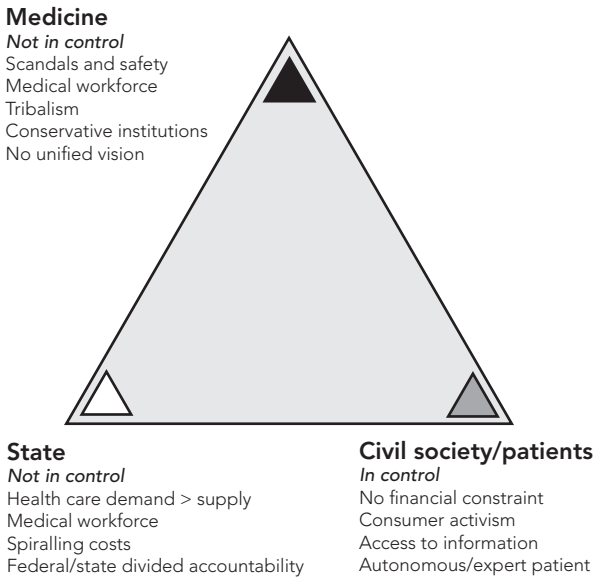
The processes a profession uses to sustain itself are standard-setting, monitoring and evaluation of performance, and intervention where appropriate. Coupled with this is the profession's involvement with knowledge-base creation (research), transmission (education) and application (performance).[8]

The medical profession safeguards its standing in society through active participation in a triangle of political activities in which the major players are civil society, the state and the profession (Box, A). At the centre of the triangle is the exchange of political benefits.[8]

Medicine, the state and civil society



A: *Medicine, the state and civil society are linked in a triangle of forces based on a mutual exchange of political benefits (Source: Salter B. The new politics of medicine. Basingstoke: Palgrave Macmillan, 2004.[8] Reproduced with the permission of Palgrave Macmillan).*



B: *Current status of control in medicine, the state and civil society.*

But, over the past decade, things have not been going too well for some players in the triangle (Box, B). The medical profession has endangered its privilege of self-regulation through a series of damaging incidents. These have included (in the United Kingdom) the children's heart surgery scandal in Bristol,[9] the murder of at least 18 patients by the general practitioner Harold Shipman[10] and the covert postmortem collection of paediatric body parts in the Alder Hey case,[11] and (in Australia) the alleged poor management and clinical performance at King Edward Memorial Hospital,[12] the Campbelltown–Camden affair[13] and the Bundaberg Hospital scandal.[14] As Donald Irvine, previous Chairman of the UK General Medical Council, noted:

> Self-regulation in any system — be it in medicine or parliament — is built on trust. And if a gap grows between those who are regulating themselves and the public they serve, that's when the threat to self-regulation comes.[15]

Other ongoing professional pressures include a widening medical workforce shortage and the profession's public image of tribalism, instanced by medicine's internal divisions and its Greek chorus of dissenting voices.

Governments also appear to have lost control in trying to deal with escalating public demands for health care in the face of soaring costs and to curb the ongoing scandals in health care.

It is the patients who appear to be in control, unburdened by any financial constraints in accessing medicine through government health schemes (albeit tempered with waiting lists and co-payments) and enjoying newfound patient power in accessing health information via the Internet and in self-managing their chronic disorders.[16] Increasingly, as preventive medicine increases in importance, doctors are taking on the role of advisors and health coaches.

In 2006, Australian medicine has reached a fork in the road. Our society's acceptance of the profession's self-regulation has taken a beating with the hospital scandals alluded to above.[12-14] With the emergence of other health professionals and a plethora of health information in the media and on the Internet, medicine no longer has sole claim to its knowledge base and expertise. Its involvement with knowledge generation is threatened with the gradual demise of the clinical investigator and a diminution in the attractiveness of clinical research.[17]

But it is the current medical workforce shortage and the escalating cost of health care that have the greatest potential to transform the role of doctors and the profession. The drivers for this include the political and professional pressure arising from imbalance between demand for and supply of health care through:

- increased demand for health care involving new technology, emergence of chronic diseases, ageing of the population, unhealthy lifestyles, and the relentless medicalisation of daily living;
- the shortening of medical working hours;[18]
- the feminisation of the workforce, with attendant specific career choices[19] and potential implications of women in medicine for the future leadership of medicine[20] through their diminished involvement as graduates in medical bodies and politics;
- the opting out of general practice with the growth of special clinics;[21]
- the generational attitudes to work and the desire to balance work and personal commitments;[22]
- the evolution of multidisciplinary teams that blur some professional boundaries;[23] and
- the ever narrowing specialisation that reduces medical problems to discrete and limited knowledge or expertise "bytes" that can be handled by other health care workers at reduced cost.[24]

All these ingredients bubbling in the medical cauldron have led to "toil and trouble", with increased calls to open up doctors' roles to competition from other health care professionals. Nurse practitioners, nurse anaesthetists, nurse proceduralists, physician assistants, midwives, pharmacists, podiatrists, psychologists, optometrists, radiographers and others now seek increased and autonomous roles in health care. These developments are far more advanced in North America and the UK, but debate in Australia

has been ignited by the recent Productivity Commission Report, *Australia's health workforce*.[25] In short, there are professional and political pressures to unwind the perceived control of health care by the medical profession through task transfer or role substitutions and by opening the workings of its medical colleges to public scrutiny.[26] The debate on task transfer will not go away and the unanswered question is how it will change what a doctor is and whether the doctor's role will be "all changed, changed utterly". This will depend on a clear vision and enlightened leadership by the profession. In this dialogue and debate, the medical profession has to be pragmatic and sufficiently flexible to adapt to change and keep in mind that patient priorities should take precedence over those of the profession. Furthermore, in any change, safety and quality are paramount. But the profession must also temper its penchant for ultra-specialisation and encourage a return to generalism and holistic medicine. If ultra-specialisation continues and threatens the roles of gatekeeper and coordinator of care, role substitution will be a fait accompli. Finally, the profession needs to communicate more effectively with the community on the complexity in medicine and enunciate what it sees as the tenets of professionalism as relevant to the new century and Australian medicine.

One thing is certain. Over the next 40 years, we are likely to see as much change in the role of doctors as we did in the past 40 years.

Competing interests

None identified.

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References

1 Aiken LH. Achieving an interdisciplinary workforce in health care [editorial]. *N Engl J Med* 2003; 348: 164-166.
2 O'Neill O. A question of trust. BBC Reith Lectures 2002. Cambridge: Cambridge University Press, 2002. Available at: http://www.bbc.co.uk/radio4/reith2002/lectures.shtml (accessed Jun 2006).
3 Lennon B. Medical workforce expansion in Australia — commitment and capacity. 9th International Medical Workforce Collaborative Conference; 2005 Nov 15-19; Melbourne, Australia. Available at: http://www.health.nsw.gov.au/amwac/amwac/9conf.html (accessed Jun 2006).
4 Australian Institute of Health and Welfare. Australia's health 2004. Canberra: AIHW, 2004: 259. (AIHW Cat. No. AUS 44.)
5 Madden M, Fox S. Finding answers online in sickness and in health. Pew Internet and American Life Project report. 2006. Available at: http://pewresearch.org/reports/?ReportID=20 (accessed Jun 2006).
6 Goode WJ. Community within a community: the profession. *Am Sociol Rev* 1957; 22: 194-200.
7 Freidson E. Professionalism reborn: theory, prophecy and policy. Cambridge: Polity Press, 1994.
8 Salter B. The new politics of medicine. Basingstoke: Palgrave Macmillan, 2004.
9 Smith R. All changed, changed utterly [editorial]. *BMJ* 1998; 316: 1917-1918.
10 Ramsay S. Audit further exposes UK's worst serial killer. *Lancet* 2001; 357: 123-124.
11 Hunter M. Alder Hey report condemns doctors, management, and coroner. *BMJ* 2001; 322: 255.
12 McLean J, Walsh M. Lessons from the inquiry into obstetrics and gynaecology services at King Edward Memorial Hospital 1990–2000. *Aust Health Rev* 2003; 26: 12-25.
13 Van Der Weyden MB. The "Cam affair": an isolated incident or destined to be repeated [editorial]? *Med J Aust* 2004; 180: 100-101.
14 Van Der Weyden MB. The Bundaberg Hospital scandal: the need for reform in Queensland and beyond [editorial]. *Med J Aust* 2005; 183: 284-285.
15 Smith R. The future of the GMC: an interview with Donald Irvine, the new president. *BMJ* 1995; 310: 1515-1518.
16 Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient self-management of chronic disease in primary care. *JAMA* 2002; 288: 2469-2475.
17 Goldstein JL, Brown MS. The clinical investigator: bewitched, bothered and bewildered — but still beloved. *J Clin Invest* 1997; 99: 2803-2812.
18 Schroeder SA.How many hours is enough? An old profession meets a new generation [editorial]. *Ann Intern Med* 2004; 140: 838-839.
19 Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare. Female participation in the Australian medical workforce. Sydney: AMWAC, 1996. (AMWAC Report 1996.7.)
20 Black C. Women in medicine [letter]. *Lancet* 2004; 364: 837.
21 Could GPs' special interests spell crisis? *Med Observer* 2006; 19 May: 19-20.
22 Gavel P, Evans J, Young J. Who are the doctors of the 21st century? 9th International Medical Workforce Collaborative Conference; 2005 Nov 15-19; Melbourne, Australia. Available at: http://www.health.nsw.gov.au/amwac/amwac/9conf.html (accessed Jan 2006).
23 Lawrence D. From chaos to care. The promise of team-based medicine. Cambridge, Mass: DaCopo Press, 2002.
24 Annandale E. The sociology of health and medicine. Cambridge: Polity Press, 1998.
25 Australian Government Productivity Commission. Australia's health workforce. Research report. Canberra: Productivity Commission, 2005. Available at: http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf (accessed Jun 2006).
26 Lawson KA, Gregory AT, Van Der Weyden MB. The medical colleges in Australia: besieged but bearing up. *Med J Aust* 2005; 183: 646-651.

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