

## The demise of professional courtesies: *cui bono?*

Peter C Arnold

The past is another country: they do things differently there.

Hartley LP. *The go-between*<sup>1</sup>

One indulgence accorded to those of us in our senior years is the ability to reflect on life's circumstances many decades ago and compare them with those of today. My recollections of medical practice, as the son of a surgeon, stretch back to my schooldays.

A lasting memory is of the many gifts, the so-called "grateful patients". Glassware, silverware, bowls, paintings and books were the permanent items; flowers, Scotch and home-made delicacies the temporary ones. These often came from patients who had paid my father's full fees, but more often from people for whom he had reduced his fees (generally people he considered to be impoverished) or whom he didn't charge at all (mostly friends, ministers of all religions, colleagues and medical students).

I remember other courtesies. He would never see patients who lacked a detailed letter from their general practitioner, and his replies were equally detailed, often complemented by a telephone call. Asked for a second opinion, he gave it to the patient and the GP and allowed them to decide whether surgery should be done by the first surgeon consulted or by himself. He was available, day and night, to advise GPs baffled by obscure clinical presentations. If asked, he would accompany a GP to a patient's home. This joint visit had formal rules, including rules about who entered the room first and who exited last. When surgery was needed, he invited the GP to assist. His reputation relied on the success of his surgical interventions and on the opinions of the GPs who saw his work at close quarters.

Those were the 1940s and 50s: a long time ago. What would my father have made of today's intraprofessional relations? I doubt that he would even have understood commercialism, mercantilism (including advertising and self-promotion) and competition policy. Even if he had, would he have thought that they could ever apply to the practice of medicine? Sir Robert Menzies, born a decade or so before my father, commented about the universities in language my father would have applied to medicine:

Are the universities mere technical schools, or have they as one of their functions the preservation of pure learning, bringing in its train not merely riches for the imagination but a comparative sense for the mind, and leading to what we need so badly — *the recognition of values which are other than pecuniary?*<sup>2</sup> (my emphasis)

Today, Australian doctors jealously hold onto their patients. Many GPs will not share an after-hours roster because they are worried that their colleagues might poach their patients. GPs no longer phone a patient's former GP to let him or her know that the patient is now attending their practice and to obtain information that could be useful in the patient's future care. GPs no longer write comprehensive referral letters to consultants. Today, letters of referral are notoriously inadequate.<sup>3</sup>

Specialist physicians now often arrange to manage referred patients on a regular basis, without sending them back to the referring GP for follow-up. The next time the GP sees the patient is when the patient asks for a new referral to the physician in question, who is now the patient's specialist — no longer the GP's consultant — and is, of course, not available after hours.

Specialists now rarely refer patients back to their GP with the advice that they see another physician with a special interest in their problem, instead referring them directly — leaving the GP out of the loop. The explosion of knowledge in each field means that care is more "expert", with more assured results, than in my father's day. But it comes at a cost. If the patient's condition worsens after-hours, the GP has to manage without feedback from the specialists.

Where once we could discuss with our pathologist or radiologist colleagues just which tests or studies should be done on a particular patient, now the briefest of request forms, containing minimal clinical information, suffices for the laboratory technician or radiographer to perform the requested investigations and for the pathologist or radiologist to interpret the results.

When we doctors attend a multi-doctor practice as patients, we will often be seen by a doctor we don't know, who is not aware that we are colleagues. Even if the request form is marked *Dr* rather than *Mr* or *Ms*, we become just another first name called out by the nurse or radiographer. With billing now separated from the delivery of the service, we are frequently charged fees. Many doctors now charge their colleagues not just the Medicare rebate, or even the Medicare schedule fee, but their full, private fee.

Why have things changed so much?

Politicians after Menzies have persuaded the public — our patients — that medical services are like any other commodity. Each service has a government-designated value. Competition policy applies to the medical practitioner as much as to the television repair man or motor mechanic. Advertising and marketing are commonplace. Many doctors no longer own their practices, but are employed by profit-seeking enterprises beholden to shareholders. What once were thought of as being reasonable professional fees to cover a doctor's training, skills, experience and equipment are now commercial fees expected to deliver a healthy profit to remote shareholders.

Universal medical insurance (Medibank/Medicare) began the process. Once we all had to pay our levy and were "covered" for medical expenses, we began to insist on passing the rebate on to our colleagues for their formerly free medical services. This also relieved us of the burden of having to deliver a "grateful patient" at Christmas or on some other suitable occasion. It was not too difficult to persuade our treating practitioner to bill us for the rebate.

Practice costs have also risen incommensurably with Medicare rebates. Increasing demands such as standards in occupational health and safety, sterilisation procedures, building and fire regulations, management of patient records, confidentiality procedures, and responsibility for following up on advice to patients are all worthy in themselves, but have combined to create an intolerable financial burden for solo practitioners and small group practices. The expensive practice manager has become an essential. Flourishing malpractice litigation has resulted in "procedural" GPs and some specialists having to charge much higher fees than those rebated by Medicare, and patients, even if they are colleagues, must bear the financial cost.

There are those who say that doctors should be treated no differently from other patients. This might stem from a loathing of privilege of any sort (what the Russians call *protektzia*) or a reluctance to place additional pressure on treating doctors by burdening them with the knowledge that they are treating a colleague. Doctors, we

know, make poor patients; furthermore, one interpretation of Murphy's Law states that, if something might go wrong, it *will* go wrong when the patient is a doctor! In the United States, some legal experts even contend that it is illegal for doctors to reduce their fees for colleagues.<sup>4,5</sup>

With the commercialisation of medical practice, many of the courtesies formerly extended between colleagues have disappeared. The remaining septuagenarians might regret these changes, but that is of little practical moment. What does matter is what now confronts Australian *patients* seeking care from GPs and appropriately recommended specialists.

In theory, Australia has one of the world's highest standards of care in our "centres of excellence". But the reality for most Australians, even for many of the minority with private health insurance, is based on a changed ethic. Financial self-interest has come to all but dominate medical practice, even inside hospitals, where it once played no role. *Cui bono?*\* Not the patient's.

It is no longer "worth it" for GPs to do house calls or visits to nursing homes, to assist at their patients' operations or to be available after hours. It is no longer worth it for GPs to acquire a diploma in a special field of interest: patients insist on attending a registered specialist. It is no longer worth it for GPs to spend time phoning specialists to discuss their patients' problems. *Cui bono?* Not the patient's.

It is in the interests of specialists to offer continuing care to patients rather than to refer them back to their GPs. It is in the interests of specialists to refer patients to other specialists, bypassing the referring GP. This sets up a new pattern of inter-specialist referrals that, in turn, benefits all specialists, leaving the GP out of the management loop. *Cui bono?* Not the patient's.

---

\* For whose benefit?

It is in the interests of hospital-based specialists to have patients opting to be admitted as private patients, enabling them to raise fees for their services. It is in the interests of hospital management to have this additional source of income. *Cui bono?* Not the patient's.

The professional courtesies of the 1940s and 50s might seem old-fashioned today. But if, back in those days, we had asked my father, "*Cui bono?*", he would have had no hesitation in replying "The patient's!"

### Acknowledgements

I thank Drs John Allsop, Victor Bear, Richard Gordon, Celina Rappaport and Ben Taaffe for their valuable comments on earlier drafts of this article.

### Competing interests

None identified.

### Author details

**Peter C Arnold**, BSc, MBChB, BA, General Practitioner (retired)  
Sydney, NSW.

**Correspondence:** [parnold@ozemail.com.au](mailto:parnold@ozemail.com.au)

### References

- 1 Hartley LP. The go-between. London: Hamish Hamilton, 1953.
- 2 Menzies RG. The forgotten people and other studies in democracy. Sydney: Angus and Robertson, 1943. Reprinted in: Fullilove M. Men and women of Australia: our greatest modern speeches. Sydney: Random House, 2005.
- 3 Tattersall MHN, Butow PN, Brown JE, Thompson JF. Improving doctors' letters. *Med J Aust* 2002; 177: 516-520.
- 4 Rathbun KC, Richards EP III. Professional courtesy. *Mo Med* 1998; 95:18-20.
- 5 Miller JB. Physicians, the law and professional courtesy. *Physician's News Digest* 2000; Nov. <http://www.physiciansnews.com/law/1100miller.html> (accessed Oct 2006).

(Received 17 Sep 2006, accepted 24 Oct 2006)

□