

The ghost of George Bernard Shaw and Australian doctors' dilemmas

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The more things change, the more they stay the same

Nearly 100 years ago, George Bernard Shaw, in the preface to his play *The doctor's dilemma*, savagely attacked the medical profession for its direct personal and pecuniary interest in the treatment of patients and argued that doctors could not be trusted to act in their patients' best interests.¹ He observed that medicine was not driven by science but rather by patient demand and service. Nor was Shaw particularly impressed with medical science, noting that "medical science is as yet very imperfectly differentiated from common curemongering witchcraft". In short, he argued that the medical practice of his time was mostly ineffectual and that doctors should advise patients that wellness is not attained through a bottle of medicine but through decent housing, clothes, food and clean air. The doctor's dilemma was that providing this advice would jeopardise his already meagre income.

Despite Shaw's vitriolic criticism, doctors of that era enjoyed the respect of society because of their care and compassion — attributes poignantly captured by Sir Luke Fildes' famous painting "The doctor" (1891), which portrays a pensive doctor sitting by lamplight at the bedside of a sick child, with her anxious father hovering in the dark background.

It is tempting to speculate what Shaw would make of the medical profession in Australia if he were sitting in judgement today.

He would note that health care has become an economic giant, consuming large chunks of our gross domestic product (GDP) each year. In the financial year 2004–05, this amounted to 9.8% of GDP, or \$4319 for each Australian.² And this will only increase with the ageing of our population, the increase in chronic disorders, and the public demand for new drugs, biotechnology, medical devices and sophisticated surgery.

As a prominent Fabian, Shaw would enthusiastically endorse Australia's Medicare scheme, with its ideals of universal and unfettered access to medical care and provisions for meeting its costs. But public health insurance comes with a price — the overwhelming bureaucratisation of medical care with regulations, red tape and incessant reviews of activities.³ It also means the dominance of politicians and public servants in health decisions, with the medical profession relegated to myriad special interest and lobby groups.

Considering Shaw's scepticism about medical science, he would welcome evidence-based medicine and marvel at medical research and the role it has played in reducing infectious diseases, in widening the scope of surgery and in providing sophisticated tools for diagnosis. And with stem cell technology and medical genomics on the horizon, the sky's the limit.

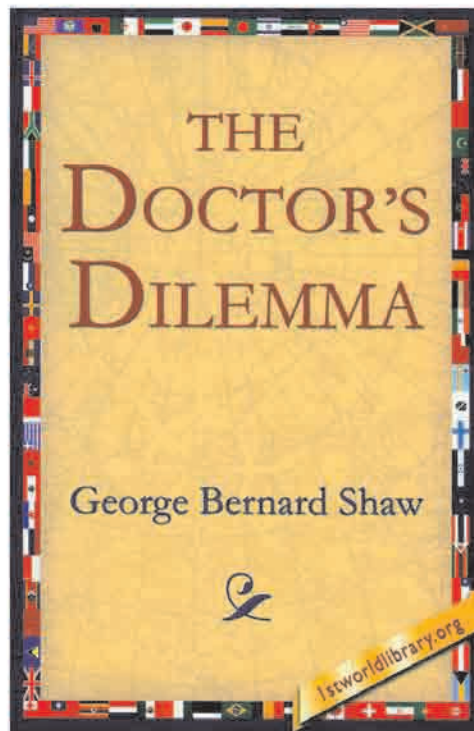
He would note that medical research has become entangled with industry. In 2003, biomedical research funding in the United

States reached the astronomical figure of US\$94.3 billion. Industry accounted for 57% of the funding, the three major contributors being pharmaceutical, biotechnology and medical device firms.⁴ With this level of involvement, the purpose of biomedical research has passed from being purely for the public good to being for the good of researchers, institutions and corporations.⁵ Critical to this process is the promotion of products to doctors through incentives such as "taking meals, gifts, trips and ... joining company advisory boards and speaker bureaus ...".⁶

Shaw might also be taken aback by the complexity of the organisation of medicine. From a simple structure of general practitioners supported by physician and surgeon consultants, it has evolved into numerous silos of medical subspecialties, each with their own technical territory and professional and political purposes. Doctors now work as members of health care teams, and the doctor–patient relationship has shifted from paternalism to partnerships in which doctors are health and social advisors. The ready availabil-

ity of information via the Internet has given patients more knowledge and control of their own health. Patients' expectations have also changed. The success of medical research and medicine's capacity to cure many illnesses have led to unrealistic expectations of what doctors can achieve. Furthermore, Shaw would be amazed at how health concerns have mesmerised modern society, fuelled mainly by hyped reports of cancer "breakthroughs"⁷ and the shroud-waving of epidemiologists about yet another lifestyle danger to health.⁸

Finally, Shaw would congratulate the medical profession for being consistently endorsed by the public as an ethical and honest profession⁹ and be comforted by doctors' prosperity.¹⁰ In his day, doctors were "hideously poor" and were "offered disgraceful prices for advice and medicines".¹



However, Shaw would also detect undercurrents of discontent, and debate and dilemmas for doctors in several domains:

- **Medical practice.** The burden of bureaucracy has had an insidious impact on medical practice and the independence of doctors. Conforming to evidence-based and protocol-driven practice continually erodes the capacity for discretionary practice and dampens its intellectual challenge. These sources of discontent, along with pressure from patients and the need to keep up with rapid changes in knowledge, have eroded professional satisfaction.¹¹ The dilemma for some doctors is whether to continue in clinical medicine, to retire prematurely, or to pursue other career options.

- **The profession.** Subspecialisation of medical practice has hastened the decline of the generalist and led to compartmentalisation and segmentation of the profession, with extra burdens imposed by accreditation, registration and calls for recertification. But more daunting is an emerging identity crisis: firstly, what is a doctor?, and secondly, what does a doctor do? The first question has spawned a spate of definitions of what constitutes a doctor^{12,13} and what modern professionalism means.^{14,15} The second question has prompted calls for devolving medical practice through task transfer,¹⁶ which Shaw, with uncanny prescience, foreshadowed: "There are cases that present no difficulties and can be dealt with by a nurse or student, at one end of the scale, and cases that require watching and handling by the very highest existing skill, at the other." The dilemma for the profession is to decide whether to continue down the subspecialisation route or to encourage a return of the generalist. The profession also needs to decide how task transfer will evolve.

- **Trust in doctors.** Trust underpins the doctor–patient relationship and is critical to society's acceptance of medicine as a profession. In the words of Jerome Kassirer, former Editor of the *New England Journal of Medicine*, "Patients must be able to trust that their doctors' motives are not subverted by financial gain, that their doctors are recommending treatments that benefit them, and that their doctors are involving them in research projects for the right reasons. Their doctors must not only be at their sides, but on their sides."⁶ The entry of industry into medicine has raised questions about its role in continuous medical education, scientific and professional meetings, and support for travel and research. In these relationships, perfunctory declarations of conflict of interest by doctors are seen as the panacea for any concerns about honesty and transparency, but mostly they amount to little more than window-dressing. The dilemma for the profession is whether to confront conflict of interest head-on or persist with its comfortable approach of tolerating many "shoulds" but not many "musts".⁶

- **Leadership.** The Royal College of Physicians' (London) recent report on professionalism stressed the need for a common forum that speaks with a "unified voice".¹⁵ Nowhere is this more applicable than in Australia, if the conflict between professional bodies of general practice is anything to go by.¹⁶ Indeed, there are questions about whether the professional organisation of Australian medicine and its regulatory and representative bodies are appropriate to meet our current challenges, which include inexorable subspecialisation, the ability to absorb the projected increased output of our medical schools, and the development of a

functional e-health system.¹⁷ The dilemma for doctors is whether they will continue to allow multiple leaders of multiple organisations to pursue multiple interests, or whether they will insist on an effective common forum that is proactive and speaks with a unified voice.

Shaw's report card on the medical profession of his time was a harsh and bruising affair. One can only surmise what he would make of medical practice and doctors in Australia today. But, in many ways, the fundamentals haven't changed. The doctor's dilemma remains that of how to deal with personal and professional conflicts of interest in order to maintain a position of trust and independence.

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