VIEWPOINT

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The doctor of the future

An invitation to discuss the role of the doctor begs the question, 'What is wrong with the status quo?' Given the guild nature of the medical profession, any reform will need to be well substantiated.

I have previously argued that Australasian health systems do not meet reasonable standards of equity or quality.[1–3] Both Australia and New Zealand have less than the Organisation for Economic Co-operation and Development (OECD) average number of doctors per capita,[4] although the relationship between more doctors and the 'health' of a community is determined by the types of roles in which doctors are employed.[1,5,6] Demonstrably, the doctors of both countries are poorly distributed by way of discipline, ethnicity, culture and demography, against need.[7] Both countries are also highly reliant on importing doctors and nurses, at a time when there is a global shortage of 4.3 million health workers.[8] To date, the diversification and substitution of health worker roles has been underwhelming.[1,9,10]

Claims of a health workforce crisis are longstanding, but have fluctuated between projected feast and famine. Not surprisingly, politicians and the public have become insensitive to iterative cries of 'wolf'. However, a genuine health workforce crisis is imminent.[1,4,8] This is partly due to the aging of the community and of health providers themselves,[11–14] and to a burgeoning health disease industry.[1]

The threat of the cost of health to industrialised countries is now such that treasuries are increasingly entering the health debate – modern economies cannot sustain a health system that employs 20% of all workers and consumes 20% of gross domestic product.[15] Australia and New Zealand are well on track to reach such a situation within 10–20 years, which is one doctor training cycle. The recognition of crisis is generating unconformable questions. The most difficult is what type of role can substantiate a health worker that takes 15 years to train to vocational independence and at a cost of several million dollars? In this environment, the roles of setting fractured bones, removing cataract afflicted lenses, hitting a bone with a chisel, and so on, would seem indefensible. The analogy of using a Boeing 747 aircraft to deliver the milk to households seems reasonable here. Follow up questions, such as why an anaesthetist needs to be a doctor, warrants serious debate.

When I posed that question to a conference of anaesthetists, I was interested to see that they could only agree to two such roles – the determination of whether someone was fit for an anaesthetic, and the management of a critically ill person during anaesthesia.

It is reasonable to argue, given the cost and time to train doctors, that agreeing the role of the doctor is a preface to any discussion of role substitution.[1,7,9,10,16–18] In my opinion, the key role of the doctor, for which a long scientifically based education is essential, is that of patient differentiation (ie. diagnosis) under conditions of uncertainty and the related roles of care planning and oversight. There are both health outcome and economic data that would suggest that not only should the role of doctors be largely cognitive, but, also that the more general the scope of practice the better.[1,5–7,16–18]

The default position that often follows is, 'if a role does not need to be done by a doctor then it should be done by a nurse'. There are several problems with this default. First, there is a nursing shortage, and this is going to get worse as the baby boomer generation of nurses retire.[11–14] Second, the conclusion that a role is not suitable for a doctor needs to be followed by an equally critical examination of whether or not the job should be done by a nurse. While nurses' transferable skills equip them well for running clinics for patients with diabetes, performing cataract surgery or delivering a routine anaesthetic may not require the complex, broad training of nurses any more than the expensive medical training of doctors.

So what is my vision of future primary care facilities? First, they will need to be where most doctors are employed.[19,20] Second, the doctors will lead teams of workers 'from the front' – as the doctor's role in that team will be primarily to diagnose the patient,[1,17,18] and to plan and oversee their care by another member of the team who has been trained for that purpose. I am optimistic that such a reform is achievable, at least in part because of the opportunity afforded by the feminisation of medicine and by synergistic generational changes.

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