©1 Introduction: good medical practice in a changing environment

This book grew out of attempts to remedy gaps in the understanding of ethical and legal issues of everyday medical practice evident among younger doctors and doctors against whom complaints had been made to medical regulators. Since the first national version of our book was published almost 20 years ago [1], much has changed. These changes have taken place in most developed countries and have occurred in medical education, medical workforce, medical practice, medical regulation, medical law, and community attitudes to the medical profession. While most of these changes have eventually benefitted the community and the medical profession, many of them have been challenging and even confronting to experienced doctors [2].

In this opening chapter, these changes are briefly reviewed to set the scene for a more in-depth explication in the following chapter of what it means to be a good doctor. That is, one who engages in good medical practice, upholds the ethical standards of medicine, is committed to all the roles expected of doctors, is professional in their approach to clinical practice, can balance the ‘art’ and the ‘science’ of medicine, and at the same time maintains an appropriate balance between the professional and social spheres of daily living. We focus predominantly on changes that have taken place in Australian medicine but where required mention international movements that have reached our shores.

1.1 Changes in medical education

Beginning with the report of the federal government’s Inquiry into Medical Education and Medical Workforce in 1988 (published as the ‘Doherty Report’), medical student education in Australia has been under constant review and change. Australia has recently seen a doubling of the number of medical schools and of medical students, changes to the methods of selecting students, and major changes to the curricula. We now have more than half of our medical courses conducted as graduate entry, resulting in older and more mature students undertaking more intensive 4-year courses [3]. Medical student education is now more likely to involve experience in rural locations and in general practice. Medical students face greater financial and other stresses (see Chapter 4) and the literature has examined the negative consequences of these stresses [3]. These changes have also brought increased demands on the clinicians who provide much of the education, supervision and mentoring of medical

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students, demands not limited simply to increased numbers of students, but also including expectations of adopting newer approaches to education [3].

Medical courses now strive to inculcate the attitudes and develop the skills that graduates need to fulfil the range of roles that doctors play in our community [4]. This approach is readily apparent in curricula that emphasise communication skills, awareness of ethical and legal issues, cultural competence for our multicultural society, and personal and professional development.

More recently, there have also been changes in junior doctor education and training, and in specialist training. The specialist training programs overseen by the Australian (and New Zealand) medical colleges have been the subject of review. Just as medical schools are accredited by the Australian Medical Council (AMC), since 2001 all medical colleges have participated in a process of external accreditation of their training programs by the AMC [5]. Regular external review as part of this accreditation process has resulted in changes to the curricula and the assessment processes used by the medical colleges. At the same time, greater emphasis has been placed on a broader range of educational requirements. This change was instigated by the Royal College of Physicians and Surgeons of Canada, which identified seven key roles for which doctors need to be equipped: medical expert, communicator, collaborator, manager, health advocate, scholar and professional [6]. Comparable requirements were identified by the AMC [7].

Hopefully, these changes will bring a greater sense of continuity between medical student, junior doctor and specialist training and a significant increase in emphasis on professionalism in junior doctor and specialist training. The changes might also relieve pressure on an overloaded medical student curriculum. The accreditation processes of the AMC (now performed on behalf of the Medical Board of Australia) also extend to the continuing professional development (CPD) programs conducted by the medical colleges. Participation in CPD has become a mandatory requirement for renewal of medical registration; this aspect is addressed below under medical regulation.

While the principles behind the changes to junior doctor training have been very well intended, competing forces may have undermined their potential benefit. On the positive side of the ledger, we have seen resources found to provide medical education officers in major hospitals to support trainee doctors in the first 2 years after graduation [8]. We have seen attempts to ensure that trainee doctors are freed from clinical duties during rostered hours to

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