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THE MEDICO-LEGAL SOCIETY OF VICTORIA

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"Professional Ethics in Medicine; its History and its Future"

PRESENTED BY: Professor Russell Gruen

1 "Professional Ethics in Medicine; its History
2 and its Future"

3 DR FRENCH: I would just like to welcome everyone here on
4 behalf of the Medico-Legal Society and, in particular,
5 welcome our speaker tonight Professor Russell Gruen and
6 his wife Dr Theresa Yee.

7 Professor Gruen is a professor of surgery in public
8 health at Monash University, Director of the National
9 Trauma Research Institute and a surgeon and head of trauma
10 quality assurance at the Alfred Hospital. He graduated in
11 medicine from the University of Melbourne, trained in
12 general surgery at St Vincent's Hospital in Melbourne and
13 then in trauma surgery and surgical critical care at
14 Harbourview Medical Centre in Seattle. From 2006 to 2009
15 he was associate professor of surgery at the University of
16 Melbourne and the Royal Melbourne Hospital.

17 Russell aims to support the integration of higher
18 quality research, clinical practice and policy decision
19 making and has a variety of research and policy
20 experiences. He received a PhD for his study of the
21 delivery of surgical services to remote and disadvantaged
22 Aboriginal communities in Northern Australia. In 2002 and
23 2003 he was a Harkness Fellow in healthcare policy and a
24 Fellow in Medical Ethics at Harvard University in Boston
25 studying medical professionalism and the public roles of
26 doctors.

27 The focus of his recent research has been clinical
28 quality improvement, optimising systems of surgical and
29 trauma care and improving the use of evidence in clinical
30 and health policy decision making. He is editor of the
31 effective practice and organisation of Care Group in the
32 Cochrane Collaboration, an international organisation

1 dedicated to making up to date accurate information about
2 the effects of healthcare readily available. He also
3 established the global evidence mapping initiative to
4 bring together a network of people and organisations to
5 develop innovative methods of characterising and
6 texturalising and increasing the accessibility of research
7 in broad clinical areas and he leads a program of
8 translational research in traumatic brain injury.

9 He has received research funding totalling more than
10 \$5m and holds an NH & MRC career development award and has
11 authored over 55 publications in peer review journals. He
12 has also been awarded an RACSGJ Royal Medal, a general
13 surgeon Australia medal and a travelling fellowship of the
14 James IV Association of Surgeons.

15 I must say when I was reading Professor Gruen's CV I
16 felt like I waste my time a lot. He really has done an
17 enormous amount in a relatively short period.

18 His topic tonight is "Professional Ethics in
19 Medicine; its History and its Future". Let us welcome
20 Professor Gruen.

21 PROFESSOR GRUEN: Thank you very much, Rebecca, and as a
22 Melburnian I thank you very much for this generous
23 invitation and the opportunity to come to this fine venue
24 with such an important crowd to talk about a topic that I
25 think is important now and important in the past and I
26 think it will be important in the future.

27 When Steve Bolson, a 43 year old anaesthetist blew
28 the whistle on the Bristol Royal Infirmary's high death
29 rates for children's cardiac surgery; the hospital's
30 unwillingness to investigate the surgeons responsible,
31 medicine would be - as Richard Smith, British Medical

1 Journal's editor, put it - all changed - changed utterly.

2 I am sure the events of that are well known to many
3 of you. Bolson had worked for over six years to reduce
4 the number who died on his operating table from one in
5 three to one in 20. What was probably the most important
6 single handed clinical outcomes improvement initiative
7 ever brought about in the National Health Service.

8 It was his decision to go to the media in 1995,
9 however, with catalysed changes of global significance,
10 such as public reporting of performance, public interest
11 disclosure act and the now well entrenched concept of
12 clinical governments. It was also a decision that
13 sacrificed his job, national popularity and ultimately his
14 young family's life in Britain. Being unable to obtain
15 work in the UK after the ensuing scandal, Bolson took up a
16 senior appointment in exile at Geelong Hospital, Victoria.

17 Important as the legal and clinical governance
18 ramifications were, Bolson's story also focuses the
19 spotlight squarely on professional ethics. On the face of
20 it, Bolson was a good doctor who in his own words "just
21 couldn't go on putting those children to sleep with their
22 parents present in the anaesthetic room knowing it was
23 almost certain to be the last time they would see their
24 sons or daughters alive". The medical establishment
25 closed ranks denying there was a problem, resisted any
26 change until they were forced to do so by an angry public.

27 Of course there were many complexities in the
28 Bristol case that were brought out in the Kennedy report
29 and opinions about right and wrong were deeply divided
30 within the profession. It was obvious though that at the
31 end of the 20th Century on both sides of the Atlantic

1 organised medicine was under siege. While people
2 desperately wanted to trust their own doctor when they
3 were sick, it seemed they had a deep mistrust of the
4 profession when they were well.

5 Medicine faced an identity crisis. What did it mean
6 to be a good doctor? Who dictated the terms? Such
7 questions are at the heart of what has become known as
8 professionalism, defined by 20th Century sociologists as
9 "the cognitive, moral and collegial attributes of
10 professionals".

11 I want to discuss what happened to the medical
12 professionalism from this point onwards and ask
13 particularly whether or not the response is sufficient to
14 carry us well into the 21st Century. But first we need a
15 bit more history. The Hippocratic Oath in the 5th Century
16 BC is widely regarded as the beginning of professional
17 ethics in medicine. It required of a new physician "to
18 swear upon the healing Gods that he will uphold a number
19 of professional ethical standards ascribing for the good,
20 never doing harm, keeping away from seduction, keeping
21 secrets" and so on.

22 In reality though, right up to the 19th Century,
23 doctors found professional distinction pretty difficult to
24 attain largely because the scientific basis of medical
25 practice was rudimentary and the treatments were often
26 harmful. Many doctors resorted to achieving status and
27 authority through public health initiatives rather than
28 clinical practice. This changed rapidly early in the 20th
29 Century as scientific and clinical evidence evolved. By
30 mastering this body of evidence, doctors became valuable
31 to the public. Bacteriology, germ theory, specific

1 disease-based treatments ushered in the biomedical model
2 of disease for doctors and scientists.

3 The new medical schools rode this wave that offered
4 cures instead of imprecise tinkerings of public health and
5 by the 1950s income, professional status and authority of
6 doctors far exceeded that of public health professionals.
7 These were the halcyon days of the medical profession.

8 Then things started to change again. In the latter
9 half of the 20th Century the science of epidemiology
10 demonstrated that most major illnesses were not random
11 occurrences and that people's overall health status
12 depended not only on their treatments but also on a whole
13 range of social and environmental factors. Business and
14 government became the principal purchasers of healthcare,
15 especially in North America. Disparities in health
16 status, unequal access to treatment, bearable quality of
17 care became apparent. Managed care designed principally
18 to control costs failed dismally to do so and by the late
19 1990s insurance premiums were rising at more than ten per
20 cent per year, 114 million Americans had medical debt
21 problems, 40 million were uninsured.

22 While Bristol happened on one side of the Atlantic.
23 On the other side there were plenty of high profile cases
24 of poor quality care. There were also some very public
25 examples of professional self interest, such as when the
26 cash strapped American Medical Association decided to
27 solve some of its woes by endorsing for a fee Sunbeam
28 healthcare products. By this time the public had grown
29 increasingly cynical about the medical profession's
30 ability to put aside its own interests and to self
31 regulate standards of importance.

1 Here is a slide showing the 35-year trend in the
2 proportion of respondents who expressed a great deal of
3 confidence in the health system and its leaders taken from
4 three large long running surveys. Bob Blendon, a Harvard
5 public opinion analyst said to me in 2002 over 30 years
6 American medicine had gone from being one of the most
7 trusted to being one of the least trusted social
8 institutions.

9 Any 20th Century sociologists such as Talcott
10 Parsons, All Star Terence Johnson took a keen interest in
11 the rise and fall of the American medical profession. But
12 the greatest impact on the profession itself was made by
13 the son of an immigrant Russian shoe salesman, Chicago-
14 based Eliot Freidson whose 1970 study "Profession of
15 Medicine" revealed how the medical profession tended to be
16 blind to its own shortcomings and who spent the next 30
17 years working to save and nourish professionalism.
18 Freidson distinguished professional work from other work
19 by the fact that it was complex, esoteric and
20 discretionary, requiring theoretical knowledge, skills and
21 judgment that ordinary people do not possess, might not
22 understand and can't readily evaluate.

23 Furthermore, he argued professional work is
24 especially important for the wellbeing of individuals or
25 society, having a value so special that money can't be its
26 only measure. For Freidson the character of professional
27 work underpinned two fundamental elements of
28 professionalism. The first relates to professional
29 identity. It arises because a relatively demanding period
30 of training is required to learn how to do complex and
31 esoteric work well. Training, he said, tends to create

1 commitment to knowledge and skill so that the
2 professional's work becomes essential life interest.

3 Professionals also develop intellectual interest in
4 their work where they are concerned with extending and
5 refining it. They believe in its value to society. They
6 do not merely exercise a complex skill and identify
7 themselves with it. Essentially, what professionals do is
8 not labour only for the income but for the pleasure of
9 something more.

10 The second element relates to professional duty, in
11 particular a fiduciary relationship with clients, because
12 although professional work is highly valued it is too
13 complex for clients to evaluate it accurately, therefore
14 they have no choice but to place more trust in
15 professionals than they do in others. Freidson argues
16 that professionals are expected to honour that trust
17 therefore the client's needs must take precedence over the
18 professional's needs to make a living.

19 Many such as Dick Crews, the former Dean of Medicine
20 at McGill, embraced the concept of a social contract.
21 Dick argued forcefully in his leadership of the American
22 Board of Internal Medicine's professionalism project that
23 the privileges physicians enjoy including monopoly, use of
24 knowledge, considerably autonomy in practice and being
25 allowed to self regulate, not to mention awards and social
26 standing. Consequent upon their commitment to competence,
27 integrity and morality the altruistic tend to promote the
28 public good. If professions fail to live up to
29 expectations, he argued, society will withdraw its trust
30 and the privilege it bestows.

31 In fact the social contract was not a new idea. The

1 last line of the Hippocratic Oath reads "If I keep this
2 oath faithfully may I enjoy my life and practise my art,
3 respected by all men and in all times but if I swerve from
4 it or violate it may the reverse be my lot". In the year
5 2000 this proposed contract had a new veracity, plenty of
6 examples where the profession was caught falling short of
7 its part of the deal.

8 The last decade has seen a spectacular and sustained
9 response to the medical profession. The catalyst was the
10 publication in February 2002 of a charter of medical
11 professionalism. It was a bold restatement of the
12 responsibilities of doctors as professionals, casually
13 referred to as "a modern Hippocratic Oath". The charter
14 had its critics, it reflected a particularly North
15 American view and arose mostly out of the discipline of
16 internal medicine. Nonetheless, it was given teeth by the
17 American Council of Graduate Medical Education and the
18 American Board of Medical Specialties Requirement that as
19 of July 2003 all American medical and specialist training
20 programs had to teach and assess professionalism as a core
21 competency.

22 The concept of professionalism rapidly gained
23 traction. The charter provided a roadmap. It defined
24 three fundamental principles: primacy of patient welfare,
25 patient autonomy and social justice. The first two were
26 uncontroversial. Social justice, however, and its implied
27 responsibilities for public roles that redress social
28 inequalities was greeted with some ambivalence and much
29 confusion; teasing this out became the topic of my Harvard
30 Fellowship year in 2002 and 2003. The charter described
31 end commitment: professional competence, honesty,

1 confidentiality, appropriate relationships, managing
2 conflicts of interest, improving care quality, improving
3 care access, to adjust distribution of resources,
4 increasing scientific knowledge and to maintain the
5 profession itself.

6 A plethora of codes of practice and professional
7 conduct emerged, many of which built upon the charter. I
8 am not in any way dismissive of their importance, it is
9 just that there is a lot of them. I have personally been
10 involved in drafting the codes of professional conduct of
11 both the American College of Surgeons and the Royal
12 Australasian College of Surgeons. Each has been a very
13 enjoyable gathering of experienced and thoughtful people
14 wanting to advance the cause of the profession, the
15 wellbeing of patients and to do something important that
16 will positively influence future generations and largely
17 they have succeeded. The codes of spawned teaching
18 materials, assessment tools, public statements enter the
19 topic of many worthwhile formal and informal discussion.
20 In a decade across the world doctors in training are
21 better versed about the non-technical aspects of their
22 work than ever before.

23 Yet in all of this activity I think there is
24 something missing, something not quite right. We reflect
25 on Freidson's fundamental elements: professional identity
26 and professional duty. The charter's principles and
27 commitments and those of all the codes that have followed
28 are very much concerned with the duty and little to do
29 with professional identity. It is not that different to
30 the Hippocratic Oath some 2500 years ago. They are rules
31 lauded down from all high, social contract just like the

1 last line of the Hippocratic Oath, it is the carrot and
2 stick assuring compliance.

3 I believe there are two problems with this in the
4 21st Century. Social contract is no longer and may never
5 have been a robust concept. The carrot and stick is not
6 the best way to motivate desired behaviour. The first
7 problem was with the social contract. It is not the
8 individual principles and commitments in the charter
9 itself that are the problem. Although they tend to be
10 abstract and devoid of context there is almost no one who
11 would disagree with any of them. We know this because we
12 have surveyed 1600 physicians across North America and
13 have over 94 per cent strong support for each of them.

14 The problem lies with the contractual arrangement
15 between society and the doctor. If there ever was a
16 direct quid pro quo between good behaviour and the
17 public's bestowing of privilege it has been diluted and
18 separated by multiple degrees through increased complexity
19 of clinical care, increased numbers and types of
20 stakeholders in the process, commercialisation of the
21 healthcare endeavour, government regulation and control.

22 While the old-fashioned notion of the trusted doctor
23 and his patient still holds true, in the intimate
24 environment of the consulting room or the focused
25 environment of the operating theatre it breaks down as
26 soon as the patient goes out the door. Others become
27 responsible for parts of the care, multiple intermediaries
28 involved in service provision, patient obtains a deluge of
29 information with the media or the internet. More than
30 ever before patients have access to information about
31 their condition and what to expect from their care. They

1 are not all as well informed but they don't know that. No
2 longer can we assume that a fiduciary relationship must
3 exist because patients can't evaluate the quality of care
4 accurately.

5 In fact the courts in the United States upheld this
6 view. Goldfarb v. Virginia State Bar in 1975 even, the
7 court unanimously ruled that the professions of law and
8 medicine were subject to the rules of the marketplace and
9 were not exempt from anti-trust regulation. They were
10 considered ordinary purveyors of commerce - no different
11 from any other business.

12 In Pegram v. Herdrich in 2000, the Supreme Court
13 ruled that under the Employee Retirement Security Act of
14 1974 physicians do not have a fiduciary relationship with
15 their patients. According to common law, a fiduciary
16 relationship is the highest duty owed by a professional to
17 a client. The court issued a new definition of the
18 physician/patient relationship wherein physicians act not
19 only on behalf of patients but also on behalf of health
20 maintenance organisations. If it ever existed, social
21 contract is no longer what it used to be. However, it
22 also leads me to the other problem, that is about the lack
23 of attention to professional identity, the best means of
24 motivating doctors to behave professionally.

25 It is here that I think we turn to another type of
26 sociology. It is the sociology portrayed in the latest
27 blockbuster film "The Social Network". For those of you
28 who have seen it, I am sure you will agree it is a
29 wonderful film. It chronicles the evolution of Facebook,
30 an idea at Harvard College that dawns in 2003, the year
31 that I was at Harvard blissfully studied professionalism

1 in health policy, to become an entity that is now valued
2 at over 60 billion dollars. Facebook's success is based
3 on its ability to capitalise on two fundamental human
4 desires: the need to be part of a community; the need to
5 be personally successful.

6 On Facebook the community was the "in" crowd, the
7 markers of success of scoring with the most attractive of
8 the opposite sex, but the message is the same for
9 anything: if your enterprise hooks into motivators that
10 are deeply situated you can get lasting success. Edison
11 and I am sure law still attracts the best and brightest
12 and they are generally motivated by high ideals. I see
13 this in plenty of our residents and students.

14 But as Haile Debas, Dean of Medicine at UCSF said to
15 me "If we take the most idealistic creatures on the planet
16 in four years we can turn them into ordinary folks with
17 ordinary motives". We have not found through all the
18 exhortation of principles in carrots and sticks a way to
19 reliably sustain their ideals through all the other things
20 that happen in their lives and influence their behaviour.

21 Of course this is also Generation Y. We all know
22 them. As a group they have been characterised as being
23 unwilling to sacrifice personal life to succeed in their
24 work. They tend not to value title status or experience
25 and, importantly, they demand flexible environments and
26 benefits. Their adult life has been characterised by an
27 expanding job market and a shrinking workforce and this
28 has significantly impacted on their view of the world and
29 their career outlook. They are ambitious, confident,
30 demanding and impatient. They are highly educated, debt
31 ridden, digitally and internet immersed. Often they are

1 described as narcissistic, little understanding or regard
2 for corporate behaviour.

3 A 2007 questionnaire conducted by the Association of
4 American Medical Colleges more than half of the graduating
5 medical students agreed that a physician's work interferes
6 too much with family relations and other interesting
7 pursuits. This generation are less likely rather than
8 more likely to be influenced by principles exulted from
9 the high altar of professional society who they are just
10 as likely to regard as old-fashioned.

11 A neat little book titled "Drive - Surprising Truth
12 about what Motivates us" Daniel Pink offers an
13 alternative. He reveals that while carrots and sticks may
14 be useful for mundane tasks they are ineffective in many
15 situations and can stifle high level creative exceptional
16 abilities, rush intrinsic motivation, diminish performance
17 and foster short-term thinking. Complex or creative
18 pursuits in medicine must fall into that category. Pink
19 argues the secret to high performance is not our reward
20 and punishment drive, it is our deep-seated desire to
21 direct our own lives, to extend and expand our abilities
22 to live a life of purpose.

23 This sounds to me quite unlike principles and
24 commitments of professionalism. Just as it sounds unlike
25 principle-based ethics of beneficence, non-maleficence,
26 autonomy and justice. I personally do not think those
27 principles speak to our deeply held values.

28 Miles Little, a surgeon and founder of the Centre
29 for Ethics, Values in the Law and Medicine at the
30 University of Sydney made similar observations about
31 surgical ethics. As Miles Little said, principle-based

1 ethics failed to capture the extreme nature of the
2 surgical experience, the vulnerability that it entails and
3 what that means for the way the surgeon understands
4 himself and the surgeon/patient relationship.

5 Based on his ethnographic research in cancer
6 survivors he defined five characteristics of a surgical
7 ethic. Patients perceive need for rescue from something
8 so serious that it warrants surgery; proximity of the
9 surgeon to parts of the patient that not even the patient
10 knows about; an operation and its aftermath as ordeals to
11 be endured and the reassurance provided by the surgeon's
12 presence in the course of surgery and during recovery.

13 Instead, I think Pink's message echoes the flavour
14 of Freidson's first element of professionalism: the
15 importance of a robust professional identity. Secrets to
16 motivating professional behaviour may now be to have a
17 clear view of what constitutes professional behaviour and
18 to bolster professional identity. We must have good role
19 models. Build on the long history of thoughtful work that
20 I have described to show us what service to patients,
21 integrity and accountability, pursuit of excellence and
22 fairness.

23 We must celebrate our autonomy, to make important
24 decisions within the clinical relationship. We can foster
25 mastery of our craft in the pursuit of excellence. I see
26 this in the sheer joy that colleagues get when they
27 discover how to do something better. We can recognise and
28 embrace without carrots and sticks the fundamental purpose
29 for which we strive. Steve Bolson showed us there could
30 be no more important justice and wellbeing.

31 DR FRENCH: Professor Gruen said he is happy to take some

1 questions, so we have got a microphone if anyone wants to
2 start.

3 QUESTION: Thank you, Russell. One of the privileges of being
4 a professional, as you mentioned, is autonomy, the
5 privilege of making decisions about your patient. If you
6 look at it ethically the highest level is to make a
7 decision which is in the patient's best interest. Are you
8 concerned by the fact that hospital administrators are
9 taking these sorts of decisions to the courts: decisions
10 such as removing nasogastric tubes, pegs and
11 tracheostomies and that this is in fact undermining
12 professional autonomy.

13 PROFESSOR GRUEN: Thanks for the question. I am going to
14 answer it a little bit obliquely in that I am often
15 dealing with slightly tricky decisions: conflicts between
16 clinicians, obvious cases of quality failures, our quality
17 improvement committee where we really have to deal with
18 problem cases. Sometimes differences of opinion between
19 management and patients and sometimes patients that have
20 gone to the courts and are fronting to us with legal
21 representation.

22 Fundamentally, the way to handle those situations
23 and those dilemmas are in the patient's interests, the
24 moral compass where true north is always what is best for
25 the patient. It does not need to dismiss the importance
26 of all the other drivers of the billion dollar healthcare
27 endeavour that we are all part of, but it does remind
28 everybody that fundamentally you are on strong ground if
29 you are arguing what is in the best interests of the
30 patients and people have a much weaker argument and if
31 they are arguing for something else they need to be able

1 to very much substantiate and argue forcefully in a way
2 that can overcome the importance and significance of what
3 is in the patient's best interests.

4 So, keeping that as true north on the compass is a
5 tool that I and my colleagues use for resolution of
6 difficult situations.

7 QUESTION: Thank you for your informative talk. I just wonder
8 whether you can comment on the fact that in the past year
9 or so there has been a lot happening from a parliamentary
10 position where legislation has come in to regulate health
11 professions and there is obviously now a lot that has been
12 discussed to do with the way that this is operating,
13 particularly to do with the operations of APRA. Do you
14 believe that the new regulations and the way that it has
15 been handled will improve the sorts of things that you
16 have been talking about?

17 PROFESSOR GRUEN: I am an optimist. I think we are still
18 seeing the way that is evolving and what APRA's mandate
19 will really be and how it is going to change (if anything)
20 the way we all work. I think there is going to be
21 substantial money behind it and it is probably going to
22 therefore be able to offer plenty of carrots and have a
23 number of sticks up its sleeve to change things and we are
24 going to have to wait and see how that pans out. I still
25 fall back to the position that I think most of us in this
26 room and most of the people who I work with are innately
27 good people who wanted to do well and do the right thing
28 and there have been a lot of insults and assaults over the
29 last century through which doctors and lawyers have
30 endured, have adapted and have continued to promote the
31 fundamental cause for which they work. So, I do not think

1 that any, say, transient Federal Government legislation
2 about regulation is going to fundamentally change what we
3 do but it might make it a little uncomfortable at the
4 edges.

5 MS CUE: My name is Kerry Cue, I am not a doctor or a lawyer, I
6 am a journalist and therefore I am free and I think this
7 is a good forum to ask this question. If doctors are
8 forced by fear of litigation to adopt check box or tick
9 box diagnoses or performance, how can they exercise their
10 complex skills that you were talking about?

11 PROFESSOR GRUEN: You started that question - - -

12 MS CUE: Do you want me to say it again?

13 PROFESSOR GRUEN: No, you started the question with "if".

14 MS CUE: Yes, I did, I started with "if". I would say they are
15 being forced to follow tick box diagnoses and performance.

16 PROFESSOR GRUEN: I think there are a number of complex aspects
17 to that question. One is yes, we live in an era of
18 evidence-based medicine where it is probably much clearer
19 what many standards of care are and there is an agreement
20 both within the profession and in the broader medico-
21 scientific community on what they are.

22 Secondly, there is increased ability to understand
23 and know what doctors are doing through tracking their
24 prescribing habits, through understanding their operation
25 that they perform, through measuring their outcomes,
26 through monitoring hospital discharge/readmission rates,
27 unplanned returns to theatre, surgical side infections,
28 all those sorts of standards of care.

29 Thirdly, as I mentioned in the presentation, there
30 is an increasingly demanding public who is more informed
31 about what they expect out of their healthcare who often

1 come brandishing the printout from the internet that says
2 "I want you to do this because this is what I read on
3 mybowelproblem.com. Within all of that we still have as
4 individuals autonomy to make some decisions. We need to
5 do with that with the patient who comes brandishing the
6 report in the context and within the boundaries defined by
7 the administrator who runs our hospital within a society
8 that is measuring and monitoring what we do and in
9 Australia that is far less than what it is in the United
10 States or the UK, mind you. We have only had kind of the
11 threat of public reporting of performance made by the
12 prime minister last year. We have not seen any moves
13 towards that actually happening, whereas in the UK your
14 name is there on a lead table of your complication rate
15 from cardiac surgery or bowel surgery or whatever and your
16 hospital is there amongst the other hospitals on a lead
17 table and the public can see exactly what your rate is and
18 compare it to the others. There is a serious threat to
19 individual sort of autonomy in that, but it has not
20 translated in the UK to be the complete dismantling of
21 professional practice nor is it thought to be in the
22 future. So, I am an optimist. These are real world
23 constraints. Medicine is an expensive business. It is an
24 important business. It should not be allowed to just
25 shoot blindly with the treatments that we have at our
26 disposal.

27 DR PRAGA: Shirley Praga. Thank you for your lecture. I
28 notice you were talking a fair bit about the USA and about
29 health maintenance organisations and over the last I guess
30 30 years in various organisations such as the AMA and the
31 Australian Doctors' Fund, I have been involved with many

1 others in fighting the introduction of US style managed
2 care into Australia and to some extent successfully in the
3 private sector. I wondered what you thought about the
4 importance of these organisations in maintaining the
5 ethical practice of medicine and the law.

6 PROFESSOR GRUEN: First I want to congratulate you for a
7 successful defence of our shores. Dr Lilian Kow, who is a
8 guest of ours from University of Texas and incoming
9 President of the Academy of Academic Surgeons, and I were
10 talking today about the problems of the managed care
11 environment. Managed care as of the sort of '70s/80s/90s
12 was an ogre and has been widely perceived to be the cause
13 of many ills.

14 In reality, it was just the marketplace operating in
15 a system that allowed it to operate. It did not have a
16 fundamental platform of universal access to healthcare, a
17 society that said everybody is going to get a basic level
18 of healthcare regardless of market forces and it did not
19 really offer any protection therefore managed care
20 flourished.

21 As I said, it was designed to control costs. It
22 failed dismally in part because of profit, managed care
23 organisations as well as not for profit managed care
24 organisations, a duplication of the administrative
25 function was far more inefficient than Medicare or
26 Medicaide (as the national organisation is in the US) and
27 of course our Medicare system. And for a variety of
28 reasons, including the fact that healthcare rights are
29 being attached to work privileges was a consequence of
30 post-war America where one of the ways that employers had
31 of attracting a scarce workforce in the mid '40s was to

1 say "We will give you free healthcare if you come and work
2 for us".

3 This idea took off and all of a sudden you have got
4 a very large section of the population who have healthcare
5 while they are full-time employees of big companies and as
6 soon as they get self-employed, casual or stop to have
7 babies or anything of those things they lose their
8 healthcare. It takes a whole system reform which Hilary
9 Clinton failed to bring in, which Obama has not yet
10 successfully brought in and which seems to be able to be
11 torpedoed by rockets of conservative elements of the
12 American medical marketplace and very successfully. So,
13 congratulations to you. I think it has been a fight well
14 worth fighting and Australia is certainly the better for
15 it. Thank you.

16 DR FRENCH: Thank you very much, Professor Gruen, and some good
17 questions and I would just like to ask Dr Raphael Kuhn our
18 medical secretary to give a vote of thanks.

19 DR KUHN: Professor Gruen, on behalf of the Society I would
20 really like to thank you for a truly illuminating and
21 insightful presentation on medical professionalism on
22 ethical professionalism in medicine. It has been every
23 thought provoking and makes the medical profession realise
24 just how many challenges we have to face especially the
25 one of professional identity. I would like you to accept
26 a small token of our appreciation for an absolutely superb
27 presentation.

28 - - -