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Shaping a Vision for 2040

Academy of
Medical Royal
Colleges

**+HE
CHANGING
FACE OF
MEDICINE**

Introduction

This report is the result of a series of public webinars with clinicians in late 2021. The CFM initiative is a Commission hosted by the Academy of Medical Royal Medical Colleges and this is the second report following a conference at King's Fund in 2020.

The Changing Face of Medicine webinars have taken place with the backdrop of the COP26 summit in Glasgow and rising cases of Covid-19. The context of these discussions cannot be ignored; we are living through unprecedented times. The Changing Face of Medicine Project has sought to cast an eye over the current landscape, asking how we can best prepare ourselves for the next wave of change.

We have found ourselves confronted with difficult questions over the course of this project. Could it be the case, for example, that the elements of our healthcare service we hold dear today are impeding progress? Is our preference for continuity

and the human touch preventing the patient being treated in the most expedient and effective manner by the most suitable healthcare professional? The concept of continuity with a single GP, coupled with the delays in the current system, means we must be prepared to challenge existing models of care. Yet continuity of care has proven benefits to patient recovery. How can we balance today's consumerist demands for speed of access and efficacy, while continuing to support those who have complex health needs, such as the elderly and who rely on their familiar GP for help? Or those who require support with their mental health, where the relationship with their mental health practitioner is key to their recovery? It seems clear that for the time being, there will continue to be occasions when the human touch is more than desirable - it is essential.

As technology advances ahead of society's understanding, how can we reconcile this widening disconnect? Already we can see the effects of our culture lagging

behind the science in today's right-wing media coverage of the remote consultation. Yet pre-pandemic, these were lauded as a boon to convenience, freeing up doctors' time and reaching hard-to-access patient groups. If we do not seek to partner with patients and provide a collaborating role in creating the future of healthcare, we are likely to continue to meet resistance to change.

Considering patient/doctor parity, however, there seems to me to be an inherent imbalance, particularly when we take into consideration the knowledge and experience of the clinician and the sometimes misplaced or overstated expectations of the public.

The question is, whilst co-production is a fine ideal, is it conducive to a genuine equal partnership? Many doctors are either exhausted or burnt out because they perceive the emotional pressures on them from the people that they are trying to serve. Patients on the other hand are dependent on their

clinicians for receiving treatment. Is this a balanced situation and can we create an equal partnership?

Those clinicians who find themselves in the firing line are the general practitioners, mental health practitioners and others where communication and time is important, not just with the person in front of them but also carers. These are jobs that today's doctors are increasingly reluctant to take on because of pressures and strictures. Whilst the moves towards integrated care and social prescribing offer new possibilities, we do need to build care delivery models with high levels of professional and personal satisfaction for the clinician.

Constructing a robust healthcare service able to meet the needs of our future population will require fundamental change, beginning with how we educate our next generation of doctors and how we select for the role in the first place. Encouraging a cohort that reflects the actual British population could require us to adjust our entry requirements, as well as the form our medical training takes. Apprenticeships, for example, with

early exposure in real settings, might better prepare the doctor for the long term.

And finally, what responsibility should patients have? If patients are to be empowered for the years to come, we must entrust them with their own health information, making available data that enables them to participate better in decision making - perhaps a new compact with the public. Meeting challenges for the future with the changing face of medicine means changing the way we see the future.

**Professor Pali Hungin OBE
Chair, CFM Commission**



Foreword

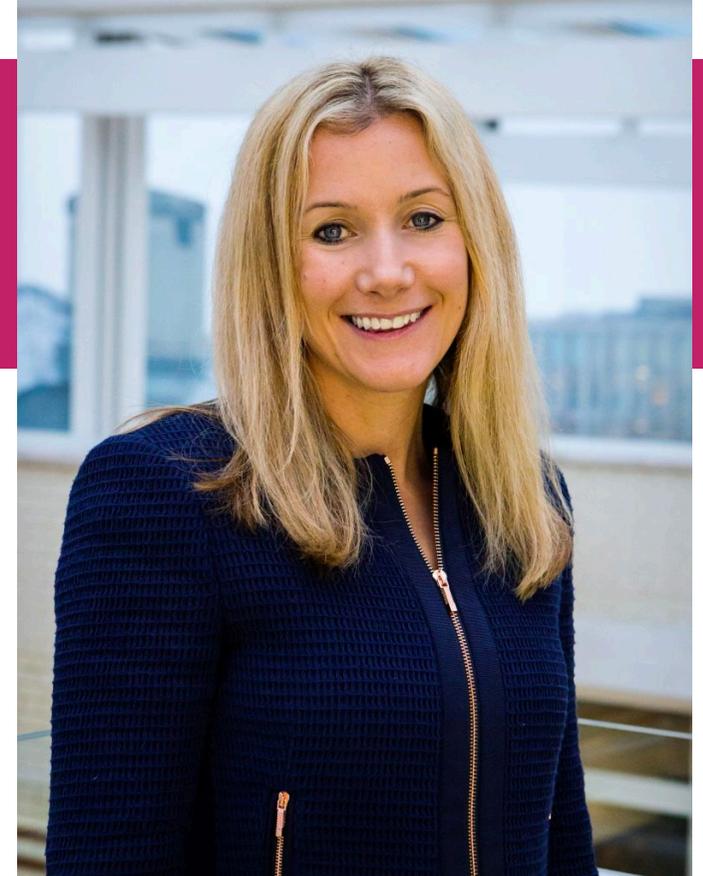
Dr Lily Lamb

Dr Lily Lamb is a General Practitioner in Northumberland and NIHR-funded fellow, based at the School of Medical Education at Newcastle University. She chairs the leadership strand of the Changing Face of Medicine Project and is also chair of the RCGP in the Northeast of England.

It's going to take more than tech, AI and big data to move our healthcare service into the next paradigm. We need to lay the foundations for change from within, starting with our culture and society at large. Asking, how do patients perceive their doctor? What do we mean by patient/doctor parity? And what is the healthcare service actually for?

The COVID pandemic has highlighted mankind's flexibility and resourcefulness at a time of crisis, yet it has left a deep scar upon the healthcare profession. We need to start addressing issues like burn-out and poor mental health in order to make a career in medicine sustainable and an attractive option for future doctors. How can we work together to make the NHS a better place to work? And how can we better support the valuable resource that is our healthcare professionals?

While we don't have all the answers yet, there's a clear need for education and a desire to move towards a better future. Bringing together both experts and lay people, the Changing Face of Medicine project has focussed on exploring the space inhabited by British patients, doctors and the NHS at large, asking: how can we all coexist in it together?



Executive Summary

Changing Face of Medicine Webinar #1: Clinician's Wellbeing - What Does The Future Hold?

Resilience has been held as a hallmark of doctors. However, the impact of stress and emotional challenge on clinicians has been underestimated, particularly where they have direct interactions with patients, such as in general practice and in situations where there are no easy solutions for difficult-to-resolve patients' problems in a resource-limited environment.

- **The current system does not support doctors to remain healthy within the profession resulting in many choosing to work part-time or leave the profession.**
- **Ingrained medical culture is resulting in doctors working unsustainable hours to their own detriment and ultimately not seeking help until it is too late.**
- **Cultural change, beginning in the way doctors are trained at university, is key.**
- **Patient education is also needed to help them understand that healthcare professionals are human beings too.**
- **Should patient care be secondary to clinician care? How can we ensure a healthy workforce able to meet the healthcare needs of the UK?**

"We cannot expect patients to start looking after their doctors, but we have to be empowered to recognise that we are human first. We need the right kind of role models teaching the future workforce." – Dr Lily Lamb

Changing Face of Medicine Webinar #2: Medical Education - What Does The Future Hold?

Constructing a robust healthcare service able to meet the needs of our future population will require fundamental change, beginning with how we educate our next generation of doctors and how we select for the role in the first place. Encouraging a cohort that reflects the actual British population could require us to adjust our entry requirements, as well as the form our medical training takes.

- **Medical education needs to adapt and become more flexible to train a workforce able meet the unpredictable unknowns of the future.**
- **The pandemic and an increase in the use of technology has led universities to collaborate regarding the production of teaching materials – this could benefit doctors and educators going forward.**
- **Many students leave their training unprepared for the day-to-day of healthcare. Could apprenticeship programmes and clinical placements be expanded to allow greater contact with patients and real-life experience?**
- **Attracting a more diverse student body to study medicine will benefit a heterogenous patient group.**
- **Current academic entry requirements to study medicine are repelling students from certain backgrounds and with certain health conditions who could become excellent doctors.**

"During the pandemic, a lot of students were able to have different jobs within their NHS hospital, whether it was taking bloods or being a clinical assistant. I found this valuable - being on the wards, knowing my role and knowing how I can contribute. Feeling needed and useful makes a difference." – Dr Olamide Dada

Executive Summary

Changing Face of Medicine Webinar #3: Technology, Informatics and AI in Medicine - What Does The Future Hold?

In this age of fast-moving technology, fast-moving diagnostic decisions and fast-moving new treatments, is our preference for continuity and the human touch preventing the patient from being treated in the most effective manner by the most suitable healthcare professional? As technology advances ahead of society's understanding, how can we educate patients on the advantages of remote consultations, for example, that free up doctors' time and reach hard-to-access patient groups?

- **The pandemic has pushed the healthcare service to take big leaps forward in its use of technology. As a result, we have certain changes – including remote consultations, triage and point-of-care testing – that are here to stay.**
- **Patient education has not moved at the same pace, resulting in a lack of understanding towards the use of technology in the NHS.**
- **Although studies have revealed that both patients and doctors feel concerned about AI's potential within healthcare, the fear that AI will replace doctors is unjustified. AI will always be an adjunct, not a replacement, for clinicians.**
- **Increased use of technology can help the healthcare service reach hard-to-access communities. There are environmental benefits and benefits to clinician wellbeing.**
- **The NHS has a way to go in terms of partnering with other brands when it comes to monitoring patient health. There is huge potential to work alongside tech companies to design and build technology that could be integrated into the healthcare service.**
- **Despite the benefits of technology, patients overwhelmingly prefer human contact when receiving care.**

“The role of AI and technology will be to help free up doctors from some of the tyranny of how they spend their time, to look at more imaginative ways of connecting with their communities and getting into the deeper issues of what makes people and communities tick. Until we do that, I think we do stand that risk of widening inequalities.” – Prof David Hunter

Changing Face of Medicine Webinar #4: The Future Doctor and The Future Patient - A True Partnership?

While we understand that co-production is desirable, it will remain impossible as long as we continue to support a paternalistic relationship in the consultation room, one that infantilises the patient and casts the doctor as a godlike figure with no margin for error and devoid of human feeling. If we are to empower patients, we must entrust them with their own information, making available data such as cost of medication, correspondence and records specific to the patient. Only once we elevate the patient can we begin to collaborate on a healthcare service that proactively confronts issues and ultimately works for everyone.

- **NHS models encouraging choice and competition turn patients into passive consumers. Studies have shown patients want reliable and accessible local services above all else.**
- **Co-producing a working healthcare system going forward would be beneficial to doctors and patients. This requires creating an environment of openness and honesty about patient need and responsibility and the actual role of both doctors and the system at large.**
- **Forging a social contract between heterogenous patients and the healthcare system is difficult to navigate and could exacerbate existing inequalities. Ultimately, the aim is to empower patients to co-produce a healthcare system alongside doctors that works for everyone.**
- **AI and technology will free up doctors to give them time to forge beneficial relationships with patients.**
- **Social prescribing, which addresses lifestyle factors to improving overall wellbeing, is the future of healthcare.**
- **There will never be true equality between two groups who approach the healthcare service from different angles. Yet, co-producing healthcare does not necessarily have to mean equality.**

“As a patient, I bring expertise about my own condition or conditions. However, I do not have the expertise that a medical professional has about 101 other illnesses, so that is their special speciality and their responsibility. My responsibility and knowledge is about my conditions. I think this is often ignored: the medical profession does not respect patients for what they know.” – Dr Patricia Wilkie

The Webinar Series

Clinicians' Wellbeing - What does the future hold?

Moderated by: Professor Pali Hungin
Key Presenters: Dr Lily Lamb & Dr Richard Stevens
Panel: Professor Dinesh Bhugra, Professor Debbie Cohen & Dr Gregory Dollman

Medical Education - What does the future hold?

Moderated by: Professor Michael Farthing
Key Presenters: Dr Charlie Bell & Dr Emma Peters
Panel: Dr Olamide Dada, Professor Sheona MacLeod & Professor John McLachlan

Technology, Informatics and AI – What does the future hold?

Moderated by: Professor Pali Hungin
Key Presenters: Dr Sarah Hallett & Dr Jeeves Wijesuriya
Panel: Professor Michael Farthing & Dr Gursh Johal

The Future Doctor and the Future Patient – a true partnership?

Moderated by: Dr Lily Lamb
Key Presenters: Dr Charlie Bell & Professor David Hunter
Panel: Dr Sunny Raju, Dame Professor Helen Stokes-Lampard & Dr Patricia Wilkie

Biographies



Professor Pali Hungin

Professor Pali Hungin OBE is the Lead of the Changing Face of Medicine Commission at the Academy of Medical Royal Colleges. He is Emeritus Professor of Primary Care and General Practice at Newcastle University and was formerly the Dean of Medicine at Durham University and the President of the BMA.

Chair of the Changing Face of Medicine Project and past President of the BMA



Dr Sarah Hallett

Dr Sarah Hallett is a South London paediatric registrar and is also currently the Chair of the BMAs Junior Doctors Committee.



Dr Jeeves Wijesuriya

Dr Jeeves Wijesuriya is a GP serving in Hackney and a Council Member of The British Medical Association. He was the Chair of the BMAs Junior Doctor Committee between 2016 – 2019.



Dr Gursharan Johal

Dr Gursharan Johal is currently an NIHR Academic Clinical Fellow in Psychiatry, based at the Centre for Suicide Prevention at The University of Manchester. She is also currently Chair of the British Medical Association's Junior Doctor Conference and a medical examiner at The University of Manchester.



Dr Patricia Wilkie

Dr Patricia Wilkie OBE is President of the National Association for Patient Participation. She has a long history as a pioneer and champion for patient involvement, founding patient liaison groups for several medical royal colleges and chairing the lay committees of the AOMRC, the Royal College of Radiologists and RCGPs.



Dame Professor Helen Stokes-Lampard

Dame Professor Helen Stokes-Lampard is current chair of the Academy of Medical Royal Colleges. She is also a GP in Lichfield and Professor of GP Education at the University of Birmingham. She was Chair of the RCGP until 2019 and is current Chair of the Nation Academy for Social Prescribing.



Dr Sunny Raju

Dr Sunny Raju is a trainee in gastroenterology, an Academic Clinical Fellow in Gastroenterology at The University of Sheffield and a member of the Changing Face of Medicine Faculty. He is also current chair of the trainee section of the British Society of Gastroenterology.



Professor David Hunter

Professor David Hunter's academic career spans over forty years researching health systems with a focus on how policy is formed and implemented. He was director of the Centre for Public Policy and Health at Durham University until 2017 and he's now emeritus professor at Newcastle University. He is a special advisor to the World Health Organisation.



Dr Richard Stevens

Dr Richard Stevens studied Psychology and Physiology at Oxford before his medical degree. He was a GP principal in Oxford for thirty years and was a trainer and tutor. He is currently a coach and the Associate Director for the Thames Valley Professional Support Unit.

Biographies



Professor Dinesh Bhugra

Professor Dinesh Bhugra CBE is professor of mental health and cultural diversity at the Institute of Psychiatry, King's College London. He is an honorary consultant psychiatrist at the South London and Maudsley NHS Foundation Trust and is former president of the Royal College of Psychiatrists.



Dr Lily Lamb

Dr Lily Lamb is a General Practitioner in Northumberland and NIHR-funded fellow, based at the School of Medical Education at Newcastle University. She chairs the leadership strand of the Changing Face of Medicine Project and is also chair of the RCGP in the Northeast of England.



Dr Gregory Dollman

Dr Greg Dollman is a senior medico-legal advisor for MDDUS. He has specialist experience in psychiatry and care of older people and completed a Masters in Medical Ethics and Law in 2015.



Professor Debbie Cohen

Professor Debbie Cohen OBE is the Director of the Centre for Psychosocial Research Occupational and Physician Health and the Director of Student Support at the School of Medicine in Cardiff.



Professor Michael Farthing

Professor Michael Farthing was the vice-chancellor of the University of Sussex (2007–2016). His academic career was in medicine, specialising in gastroenterology when he was President of the BSG and Editor of Cut from 1996 to 2002.



Dr Charlie Bell

Dr Charlie Bell is a member of the Changing Face of Medicine Faculty and a psychiatry trainee. He is a John Marks Fellow in Medicine and Praelector at Girton College, Cambridge and an Academic Clinical Fellow at King's College, London. Until recently, he held the role of National Medical Director's Clinical Fellow at the Health and Social Care Committee.



Dr Emma Peters

Dr Emma Peters is a doctor in training, currently working at Croydon Hospital. Emma trained at Newcastle University.



Dr Olamide Dada

Dr Olamide Dada is an award-winning junior doctor who recently graduated in the summer of 2021. She is the founder of Melanin Medics, a registered charity that is home to the largest intergenerational network of African and Caribbean doctors of past and present.



Professor Sheona Macleod

Professor Sheona MacLeod is Health Education England's Deputy Medical Director for Medical Education Reform, Chair of Health Education England's Deans and Chair of the UK Conference of Postgraduate Medical Deans (COPMED). She is an Honorary Professor of the University of Nottingham and the University of Leicester.



Professor John McLachlan

Professor John McLachlan is currently Professor of Medical Education and Assessment Lead at the University of Central Lancashire and former Associate Dean of Medicine at Durham University and Director of Phase 1 at Peninsula Medical School. He has specialised in health care education delivery and research over the last 18 years.



“A physician is obliged to consider more than the diseased organ, more even than the whole man, he must view the man in his world.”

- *William Osler*

“To cure sometimes, to relieve often and to comfort always.”

- *Harvey Cushing*

Utopia vs. Dystopia?

A great many GPs take the sentiments of Harvey Cushing and William Osler as key to their practice, placing the patient and their wellbeing first above all else. Yet, it is this very ethos that would have GPs and other healthcare professionals working to their own detriment, sacrificing their own health as a result. While it is clear that Cushing and Osler's principles are important to today's doctors as well as those of the future – certainly the patients themselves believe that doctors providing holistic treatment and comfort is key – the important question is, how can this be achieved in a way that does not ultimately harm the clinician?

Our current healthcare scenario is a dystopian one that shows little compassion for its clinicians, despite the well-known cost of not treating burnout, notably a decrease in productivity, increased clinical costs, increased complaints and an increased turnover of staff. There is a global shortage of healthcare staff yet, in medicine, instead of being valued and treated as rare commodities, the units of production are disregarded and allowed to run on fumes. Current thinking places the patient as first concern but perhaps we need to move away from this and have doctors put their own oxygen mask on before the plane starts to crash.

“Looking after the doctor of the future will result in better productivity, better clinical outcomes, reduced costs and a better patient experience. There doesn't seem to be a single answer – apart from history – as to why we aren't doing that now, let alone 10 or 20 years into the future.”

- **Dr Richard Stevens**

Time For a Paradigm Shift?

The “no pain, no glory” culture in medicine is outdated. It is also clearly not a good environment to encourage caring, sympathetic, curious, intelligent and alert doctors. Moving forward, how can we create a supportive culture in which goodwill is recognised and a work-life balance actively encouraged? Full-time working, particularly in general practice, is clearly very hard at the moment and many are choosing to work part-time. However, we need doctors to be able to work full-time. How can full-time working become sustainable? We need 50% of medical graduates to become generalists. So, how can careers in general practice become desirable?

Role models play an important part in forging this new world. Medical students and junior doctors cite their relationship with their line manager as being one of the most important contributing

factors to wellbeing. It is for this reason we need to cultivate leaders who value their teams and recognise when individuals are struggling and let them have the space they need. Moving away from the idea that doctors come to work regardless of how they are feeling, we need to empower people to take time off when they need to. These leaders, through role modelling compassionate leadership, shape the next generation of role models and contribute to changing the culture around wellbeing

Problematically, research has shown that doctors in particular are very reluctant to seek help, meaning many turn to self-prescription with drugs and alcohol to deal with their burnout. This needs to be addressed on an institutional level as well as on an individual level to make sure doctors get help when they need it. Opportunities for debrief,



reflection and psychological support are clearly important as doctors face stressful events.

We would like to see a future where doctors have some control over their working day and they are not just at the mercy of demand. Self-awareness, flexibility and recognition that doctors are humans first and foremost are all concepts that need to be built into medical culture going forward. The future of the clinician must begin at medical school where the fundamentals of wellbeing can be instilled into culture and education from day one of the student's journey.

And perhaps we need to look even further back to ask, who are tomorrow's doctors? Our current selection process is such that those with high academic achievements, sporting prowess or parents who can arrange work experience for them, are the ones who are selected for medical school. But are they the “right” people for the future of medicine? Could it be that exposure to challenge, adversity and a less-than-conventional background may help lay the foundations for a healthier perspective? Could we create a culture in which life experience amongst the cohort is actively encouraged, thereby helping our future doctors remain “well” in their career for longer?

The Patient-Doctor Parity Dilemma...



The patient that has not Googled their condition before speaking with their GP is becoming rarer. But what are the repercussions of this? We are experiencing the effect of information – and especially misinformation – and the power it can have on changing the public debate. One example of this can be observed at play in the media campaign to vilify virtual GP appointments. Yet pre-pandemic, patients were being charged a premium (by private

healthcare providers) for their remote consultations.

What we are seeing are conflicting and not entirely rational expectations from the modern patient. On the one hand, we see a consumerist desire to access healthcare in the same way they would order a pizza online at any time of the day or night, while at the same time demanding to be “held” by their doctor in a manner more suited to the paternalistic patient-doctor legacy of the past. And while the patient’s historic projection of an idealised authority and wisdom over the doctor can in some ways work to the clinician’s advantage, it is also the reason we struggle to find a parity that would acknowledge humanity on both sides.

Part of the problem with the dialogue is around the NHS being free – it is not. It is free at the point of use and yet it is taxpayer funded. Medics continue to have an aura of being the experts, not just about the condition but about the healthcare service as well. Perhaps there are some questions that need to be answered about how open and honest doctors are with patients, about how they can

help and what they can actually offer.

For so many who work in healthcare, the interaction between doctor and patient is what gives purpose and it is this relationship that should remain the focus going forward. The good news is that with technology, machine learning and AI able to take much of the burden off the GP, a lot of knowledge will be instantly available during the consultation and we are going to see an increase in generalist skills. Patients already have more fixed ideas of what they want from their consultation and the physician’s job will be to take these ideas and meld them with the science, the technology and the medicine and work together to make a plan – which has always been the intention of general practice. There is so much potential for technology to free up clinician time that in the future hopefully we can rely more on what makes us human.

Several medical students said that they liked the idea of simulated consultations but they struggled to generate feelings of empathy when faced with a paid actor presenting with certain

complaints. How could they reconcile this disconnect? It is the double bind that of being a good doctor - being empathic on the one hand and being professional and keeping your distance on the other. In medical school, doctors are taught to create a step between themselves and their patients. Although we are trying to move away from these paternalistic models in medicine to make patient health more of a co-decision making process, nonetheless it continues in the teaching of medicine because the student sees patients and then their supervisor and it is therefore still seen as a transactional experience.

The way we were trained 40 years ago no longer works. There are different societal pressures. We need to take generational changes into account in the planning, delivery and development of services too. Changing the dialogue between society, patients and doctors is impingent on a strong foundation of medical training. How we teach the next generation is of utmost importance.

What Kind of Crucial Strategies Will We Need in The Future to Care For Our Future Clinicians?

We need to be thinking on three levels:

1. On a national level and what the system expects of doctors.
2. On an organisational level and what the institution can, should and must do for their clinicians. This means providing both fundamentals: hot food and sleeping facilities and treating staff like human beings.
3. On an individual level and what clinicians should be doing to look after their own physical health and mental wellbeing.

Feeling valued and respected are the two clearest components of wellbeing and yet how these manifest is slightly different for everyone. Implementing system-wide culture change is about diligently attending to each link in the chain, explaining exactly what we expect for example, from our education or from our line managers. Looking beyond medicine for inspiration could yield results. Take agriculture's response to the environmental emergency for example and how they are adjusting to working in a more holistic fashion across the industry – should we be treating the current healthcare emergency in the same way?

Over the course of the pandemic, we have seen a process of converting from clinical and medical leadership to senior management, empowering instruction rather than consultation and discussion. At a time of crisis when decisions need to be made

quickly, there is less space for discursive decision-making. Yet, to improve service interaction, leadership styles need to change from more directional and a “tick box” exercise to more interactional. One of the big challenges is the need for different leadership styles for different things – it is not “one size fits all.” The past year has highlighted the strengths and weaknesses within the medical profession and the question coming out of pandemic is, how do we build on these experiences?

Medical education is often seen as the “poor relation” to clinical research in medical schools and it is very challenging to secure funding to undertake high quality research in medical education. Problematically, within the institution researchers are expected to be both educators and clinicians and this can result in a tension that places education and

teaching as the lowest priority. For us to learn from the current wellbeing crisis, perhaps our expectations of academia and what is important needs to change, with medical education given more credence within the institution.

Changing Face of Medicine Webinar #2: Medical Education - What Does The Future Hold?

Evolution vs. Revolution?

The pandemic has enforced a reactive change on us all. Suddenly doctors were not able to work as before and this drove many to think about how things could be done differently. This radical change is only going to continue over the next 30 years: what patients want, what doctors want, what other healthcare professionals want and what the medical service wants are going to dramatically evolve and currently, we are not in a place where we are able to respond with any kind of agility.

It is impossible to predict the huge number of changes that will come to pass over the next few decades:

there are too many unknown unknowns as well as the known unknowns. How then do we provide an education system that is able to produce medical students that are adaptive and able to navigate the unknown unknowns of the future? Are we getting it right in terms of knowledge versus clinical skills? Or are there areas that we continue to teach simply because we have always taught them instead of looking at what we want as our final product and then working backwards? Do we spend enough time looking at what the workforce needs or indeed, what the rounded doctors of the future look like?

Selection - Have We Got it Right?

Why is it that widening participation matters? Social representation at medical schools is skewed and sadly many from deprived settings do not meet the grade requirements at the age of eighteen. Perhaps they would make remarkably good doctors but they are excluded from the programme at the first entry hurdle. When considering the role of secondary education and issues such as predicted grades, certain ethnic minority groups are more likely to have their grades underpredicted. To be shortlisted for consideration into medical school, the student must meet entry requirements. At undergraduate level, when students are applying for medical school, one of the first challenges they face is finding clinical work experience. Many miss

out on these opportunities due to their socioeconomic background. One solution could be for university hospitals to offer insight and work experience so that all potential applicants have equal opportunity and access to information and training.

We need to facilitate widening access even more than at present, not only from the profession's perspective, but also so that doctors are more representative of the population they serve.

Medical students are instilled with the toxic belief that they need to work incalculable hours and this continues into the profession itself, meaning anything that could be seen as a weakness is stamped

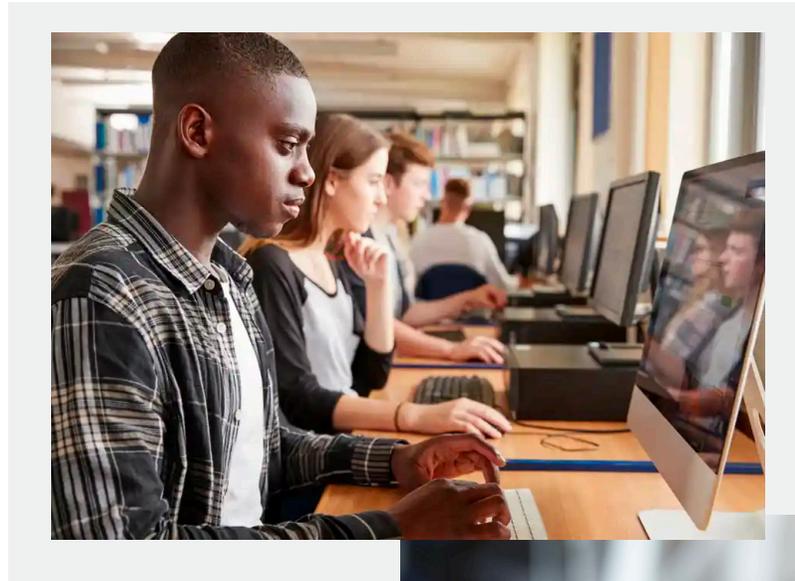
out. It is part of a culture which either results in people leaving medicine or doing themselves psychological damage. Building a workforce that is reflective not only of wider societies but also of our patient groups means reassessing both the selection of and the culture we instil into our students.

It is time to challenge ourselves about what is actually needed for a career in medicine and ask whether we are “weeding out” people too early who might, in fact, be great in some fields because of their differences. There are few doctors who have declared disabilities for example, yet they are working within an environment where a huge number of their patients have disabilities or a medical condition. We need to recognise that we are still, consciously or unconsciously, discriminating against clinicians who themselves are patients with long-term conditions and who could therefore be of huge benefit to patients.

In Scotland, there is a scheme called HCP Med where healthcare practitioners can work part-time and earn money while studying,

emerging as qualified doctors at the end of the programme. Similarly, The University of Central Lancashire is looking at an “earn-as-you-learn” programme. These types of programmes can facilitate access to education for those who might not be able to do so otherwise. Bringing in qualified healthcare deliverers from the armed forces, for instance, enables people with practical experience to become capable doctors. We could do the same for those at a later stage in their career who have been working within different medical sectors.

Looking at it from the postgraduate sphere, selection was based on what we thought doctors needed to be good at – academic excellence. What is desirable in a clinician is the ability to relate to patients, to be an advocate, to be able to engage with communities and be adaptable. Our current selection models need to look at these.



What Should Medical Education Look Like?

One question now is whether we need all of our medical schools to be offering the same thing. Whilst we have relatively similar curricula across institutions, each medical school is setting the way they do their own teaching. But do we want to open that up further? Do we want to be even more flexible? And what is it we want as our common standard? What is it we want at the end of medical school? Do we want to be producing a doctor that has a tried and tested set of knowledge? Or do we want to be producing individuals who are able to utilise skills and understanding in order to learn more?

Historically, we have seen medical schools developing materials with enormous redundancy. Yet, during the pandemic, many universities worked together to build an educational toolkit. This practice of cooperation, if it continued, could be powerful and efficient. We must remember, after all, that not everybody is a good teacher but there are some wonderful teachers out there and if we could bring their enthusiasm and their insight into all medical schools, not just their

own, then this could be extremely beneficial. Virtual learning has created a lot of economy of effort too. In introductory skills classes for example, it is now possible to pre-record material which can be watched in advance, therefore eradicating the need for educators to repeat the same content. This is more time efficient, resulting in valuable face-to-face time with patients or even virtual patient time being maximised.

While many students struggled with receiving education online last year, there is a lot of potential with the technology. Educators must consider how to best include their cohort, helping them to feel involved instead of passively receiving instruction, knowing when to exploit online formats and when teaching works better in person. Today, medical imaging is much more important than anatomy and this is just one of several areas that the pandemic helped to move forward by forcing universities to consider virtual reality and online methodologies.

Do We Need More Clinical Placements And Apprenticeships?

We often talk about people needing to have done their placements in a nursing home or similar to get into medical school. Problematically, this can feel somewhat like a “tick box” exercise – the young student has shown an ability to be empathetic and caring and gained an understanding of what medicine is like and that is enough. Yet, perhaps we should think about integrating this kind of caring into medical education. Could students begin working as healthcare assistants from the very start?

When the pandemic hit in 2020, a lot of teaching fellows were redeployed back into clinical work. Many students in their final year graduated a few months early and went into “interim foundation training”. Although a large proportion reportedly felt apprehensive and many suffered from imposter syndrome having not yet completed

their finals, upon reflection these students went on to say that they felt better prepared for their foundation training.

Working in paid placements or apprenticeship-type roles shifted the focus for many new doctors. Instead of being in education for their own benefit, they were suddenly there for their patients. This marked a key difference in emphasis and gave many students the extra drive and feeling of responsibility to see decisions through from start to finish and think about their treatment plans more carefully.

What can we take from this experience going forward? Students clearly benefit from this type of learning. Medical education is theory-heavy, yet students are reporting that they feel ill-prepared for the day-to-day of being a doctor by the time they graduate.

On Teaching As An F1

Case Study

For F1s, teaching can be a challenge as it is undertaken very soon after their own qualification, when they are new to the job themselves and pressure is high. This is made harder by the fact that students under their ward could be from an array of skillsets and curricula. In this position, it is difficult to see how the F1 can help by giving the students the best experience possible, while also keeping their own head above water.

To this end, it can be useful to consider Maslow's hierarchy of needs and how to provide students

with these basic needs so that they can build a strong foundation on which to grow their own educational experience and achieve their full potential. Before an educator begins educating, they should consider fundamentals like introductions, orientation and goal setting. If a student knows who people are, where they are and what they want from their day, then they can begin to construct a plan going forward, feeling safe in the knowledge that they know who to ask for help and where they can find the bathroom!



Should We Reconsider The University Model?

Is a university degree the only way to provide medical education? We base ourselves on the model of the university without questioning whether this model is fit for purpose in terms of shaping our future doctors. There are a lot of areas of possibility that remain completely untouched because we are so committed to the university model rather than the clinical medical opportunities that we provide people. One of the big changes as we move forward will be flexibility, both in terms of the course provision and also the working environment. Some people may want to have a portfolio career or move between different specialities - how do we best enable that, not just in post-medical school training, but also during

medical training itself and indeed, beforehand? How do we make sure that flexibility, if we believe it to be a positive, is front and centre of our medical education programmes?

There are big questions about whether seeing medical education as simply another longer university degree is the right way forward. Health Education England are exploring a medical apprenticeship model, which will mean working with NHS employers, continuing to work and following an apprenticeship route. Could this new way of studying attract a different cohort of people? It is a radical change but maybe a necessary one if we are going to change what we want from doctors.

Changing Face of Medicine Webinar #3: Technology, Informatics and AI in Medicine - What Does The Future Hold?

The NHS website defines “health informatics” as “the intelligent use of information and technology to provide better care for patients”. It is a term that encapsulates the interdisciplinary study of data, information and computer technology in regard to human health conditions. As such, it is something that should resonate with all NHS clinicians and even more so as we move further into the next paradigm of healthcare provision.

While some of us may not consider ourselves to be technology experts, there is no avoiding the fact that technology will be inextricably linked to the profession and patient interaction going forward. It is in all of our interests to consider how we can engage with technology better and how its incorporation into the healthcare system will change the face of medicine in the coming years.

When considering health informatics, the following areas should be included:

The provision, storage and sharing of data. Taking into consideration how information is shared between hospitals, between primary and secondary care and within social care settings also includes considering the security of such data. One of the common problems currently faced by clinicians is the incompatibility of different systems within different settings and their incapability to communicate with one another, rendering coordinated patient care extremely challenging.

Administration. The transcription of clinical notes or letters through to the administrative elements of a healthcare professional's employment, for example payroll or onboarding when starting at a new trust. Currently junior staff transcribe decisions in MDT meetings when technology could easily perform this task instead.

Diagnostics. One example of this is diagnostic imaging. AI technology can pick up findings on chest X-Rays and thus augment clinician analysis and interpretation. AI can also interpret large

pieces of data quickly, effectively and use algorithms and evidence-based methods to identify risk for patients.

Monitoring. We often talk about using software at the patient's home to carry out tasks like point-of-care testing, blood pressure monitoring and continuous monitoring of glucose in diabetes et cetera. It is interesting to consider how this might look with increasing commercial availability of software created by brands like Apple to monitor pulse, saturation of oxygen, blood pressure et cetera and how this could interface with the way we deliver healthcare.

Interface. We often forget the interface element, not just for clinicians in terms of how we interface with technology within our systems, but also patient-facing interface - how patients access clinicians, make appointments and how they speak to specialists in secondary care or general practitioners coordinating care in the community.



Technology Within The NHS: Past, Present And Future...

When thinking about the future of technology, it is worth acknowledging that we have not got the basics right yet. We need to preface any discussion with a recognition that there is difficulties with our basic IT and this causes huge issues for patients and clinicians, for example the time it takes to order tests. These simple tasks should take a couple of minutes. A challenge for the system as we move forward is how we ensure that these basics are in place for the coming years.

One of the main issues for clinicians are internal systems and in particular, the lack of connected infrastructure, working printers and systems that do not “talk” to each other. The working of our internal tech is not something that the patient is aware of - until it breaks down. The perspective of groups like the Kings Fund have been that there is much scope within patient-facing technology, giving patients the ability to access systems and to see their own tests and results. This is patchy at present. The demand

for this type of access increased during the recent period of COVID and we saw thousands downloading the NHS app. Patient experience and input is essential in future developments.

Touching on artificial intelligence, something of a buzzword now, it can feel like a separate category of medicine when, in fact, it is simply an extension of our current use of technology. A YouGov online survey in which 1,000 NHS staff and 4,000 of the UK public were surveyed gave a mixed

response to AI. Both groups raised concerns around a lack of human interaction, a worry which is reflected more generally in the media with coverage of remote consultations. Those surveyed also reported fears about the potential for medical error due to programming issues and having an AI-only approach to medicine.

In reality, technology is being brought in to support healthcare workers, making certain elements of healthcare more efficient. AI is almost never used in isolation or



to replace healthcare workers.

COVID has had a huge impact on technology and its use within the NHS. We have seen a monumental shift in the way that technology has been used in almost every element of healthcare. What has been interesting to observe is how many myths around what could be done and what was possible were dispelled by need. Under pressure, our use of technology evolved in an incredibly short period of time and bureaucratic barriers were removed to facilitate that. We saw NHS X funding projects like the “Attend Anywhere” platform for outpatient clinics in secondary care. We saw the further use of Accurx to allow the texting of documents and video and telephone consultation used in virtually every practice in the country. Indeed, the move to an almost exclusive use of remote technology as an initial triage process before allowing a face-to-face assessment has been a huge shift and one that has forced primary and secondary care to adapt very quickly to something that they have been quite resistant to in the past.

The reality is that many of the technological improvements from the pandemic are here to stay and

are a fundamental reform of the way that we will be delivering healthcare. And while the revolution has already happened, perhaps it should have been co-produced and co-created with patients.

Going forward, these shifts benefit the NHS by enabling increased access to remote working, something that was previously relatively uncommon, particularly for clinicians. Remote working allows scarce hospital space to be used in different and more flexible ways and is of huge benefit to those who have caring responsibilities or for those who need flexibility in their life commitments. This may in turn have a positive impact on the gender pay gap, enabling women who are currently statistically the main caregivers, to remain working. Teams have been able to meet without having to travel, thus improving multidisciplinary working and efficiency across sites. It can also potentially improve care delivered in remote and rural areas or understaffed areas. While there are some doctors who have raised concerns about a switch towards what is been described as “call centre medicine,” a BMA GP survey has indicated that, in fact, 88% of GPs wanted to retain remote consulting.

It is also worth mentioning that there has been a positive environmental impact. Pre-pandemic and pre-remote triage, 5% of all road traffic was due to patients travelling to NHS appointments in this country. Today, especially in light of the recent fuel crisis, we need to consider how a changed approach to both outpatient and general practice appointments can make a significant environmental difference.

Potential issues going forward include recognising that for many patients, the use of technology has felt like a barrier rather than an augmentation or enhancement of the skills that clinicians are able to use. While there are many patient populations that struggle with technology, we also need to consider that data shows that people with a disability are nearly twice as likely to use technology solutions and online health services. Considering current increased patient demand, there is a need for a levelling up of infrastructure that must accompany these changes.

Yet, ultimately, it is patient awareness and confidence that is so crucial to the success of this technological paradigm shift. Coming out of the

pandemic, we need to ensure we are co-creating the healthcare for the next generation of patients, recognising differences between the patient groups and their different needs. Much of the technology used at home, for example, is developed by non-NHS technology companies and integration into NHS systems can be difficult. We need to think about common standards and how these services can be commissioned in the most effective way, for both clinicians and patients.

There are challenges about confidentiality and how we manage data in a more digital world. There needs to be a consideration of how we assess and set targets for technology across the NHS, which will then potentially make it easier for NICE to assess and recommend the services. Procurement Services need to be looking at what is the best value in terms of benefits to the health system rather than purely financial value.



Technology vs. The Human Touch Within Psychiatry

Looking at the pros: technology can facilitate accessibility to care through remote consultations, which are cheaper and easier to run and resource. It also reduces stigma. Unfortunately, there is still a stigma in accessing mental health services and facilities. Many patients can be more forthcoming in the comfort of their own homes.

Research into AI in online CBT shows promising results in patients who experience depression and anxiety, but unfortunately not in other conditions. In 2017, The University of Central Lancashire developed Avatar VR therapy for patients who had schizophrenia with auditory symptoms – and it worked. Psychiatry is an extremely stretched area of the NHS, but perhaps precision medicine, artificial intelligence and digital health could go some way to repair parity of esteem issues. In an ideal world technology would take us further still, enabling psychiatry to care for a patient population that has always been on the backfoot when it comes to advances in healthcare.

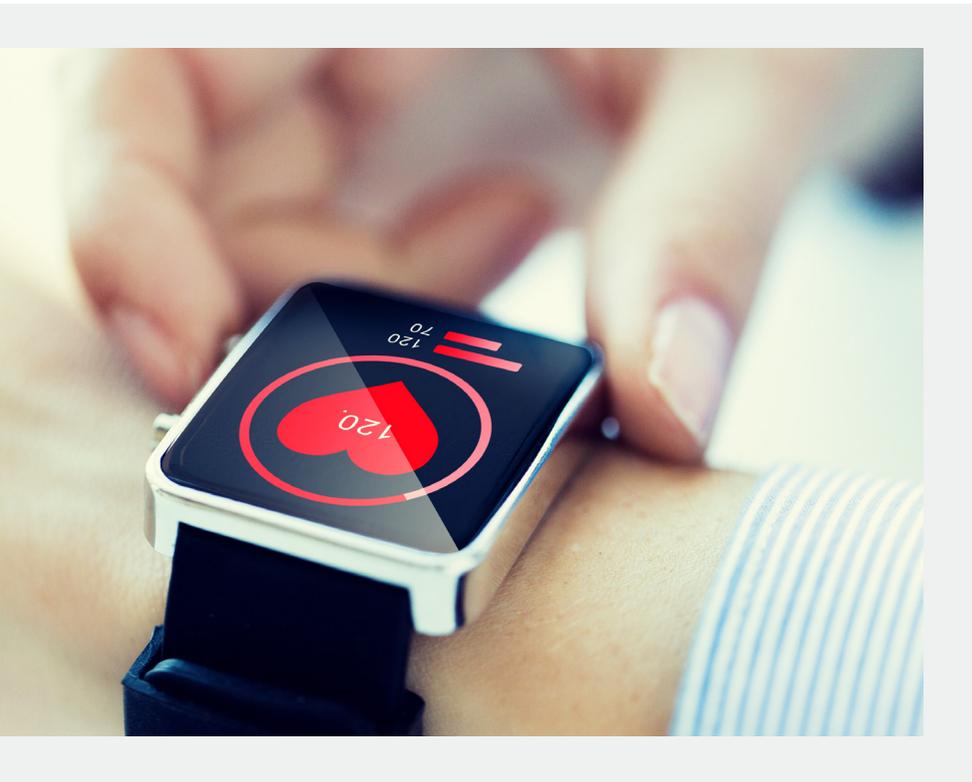
But of course, there are cons too. Research shows us conclusively that patients, no matter how remotely scattered they are, do want that face-to-face interaction. It seems no matter how good artificial intelligence is currently, it does not quite capture nuances and subtleties. Technology cannot match the human understanding of dynamic psychodynamic processes for example, or relations between the clinician and the patient, which are so important not just in the mental state examination, but in more vital procedures like assessing risk. And even though humans are not always right when it comes to this, few of us are willing to pass this huge responsibility on to AI.

Within general practice, it is when seeing a new patient that the human factor matters most. Should that patient come into the practice regarding a particular condition, the GP can take a global, holistic health approach. Incidental findings linking with other conditions often requires a face-to-face consultation. How do



we compensate for this in a remote consultation? There is a risk that we can become complacent in a virtual consultation and miss other key factors.

Data, POC Testing And Partnering With Tech Beyond The NHS



Creating an open dialogue is, as always, key to technology's successful integration within the NHS. The ideal situation would be that the facilities would be in place for patients to use, but that this would be developed with a patient-centred approach. What we are not doing currently is capitalising on the opportunity to use technology that sits outside the NHS. Point-of-care testing for example, will dramatically change the way that our patients engage with us. Patients are requesting GP appointments on the basis that their Apple watch has indicated that their heart rate is high. Such technology could be a real asset to us in future years.

The nature of the NHS is such that it is possible to reach a large number of patients and conduct high-quality clinical trials. This can enable us to form partnerships between the NHS, the technology and biomedical sectors. AI too requires large data sets in order to create a functioning clinical prediction model. Unimaginable unified efforts will be required to make sure that the data sets used are unbiased and without error, truly representative and are regularly

updated as patient group patterns and data change over time. Without this, AI may not only be useless but also harmful.

Some computer-based cognitive-based therapies are now often formatted as smartphone apps with on-screen prompts, collecting of points, background music, comforting and engaging graphics et cetera like social media apps and computer games. Is this responsible healthcare or is it manipulating patients? We have yet to see the impact and successes of gamification on health.

Changing Face of Medicine Webinar #4: *The Future Doctor and The Future Patient - A True Partnership?*

“There are many different kinds of relationship going on between the patient and the doctor and some of these are going to be inherently unbalanced, particularly when we take into consideration the knowledge and experience of the clinician. The question is, whilst co-production is a fine ideal, is it actually part of a genuine equal partnership? Many doctors are either exhausted or burnt out because they perceive the emotional pressures on them from the people that they are trying to serve. Patients on the other hand are dependent on their clinicians for receiving treatment. Is this a balanced situation? Taking this into consideration, can we ever create an equal partnership?”

- Dr Patricia Wilkie OBE,
President of the National
Association for Patient
Participation

Four C-Words...

As we give greater priority to population health and tackling health inequalities going forward in our healthcare system and especially in the context of what has happened with the pandemic, (but not exclusively so, as the 2019 NHS Long Term Plan demonstrates) we need to include the public and the places they inhabit when forging any true partnership between doctors and patients.

Over the years, there has been considerable talk of public and patient involvement in health, much of which has amounted to symbolic gestures with little, if any, evidence of a genuine shift in the power

imbalance between the medical profession and the patients. Such hubristic activity has been termed “engagement camouflage” for decisions largely taken elsewhere. The American political scientist Robert Alford, in the classic study almost 50 years ago, referred to patients and the public as “repressed interests” while doctors remained the “dominant interests”. Arguably, not much has changed over the years although, with the arrival of managerialism in the 1970s, doctors may feel themselves to be less dominant than they once were.

Since the 1990s until very

recently, the focus in the NHS in the UK has been on choice and competition as proxies for creating a true partnership. Indeed choice and competition were central planks in successive English governments’ health reforms despite the contested nature of their alleged virtues. Surveys have shown most patients do not really want or call for choice. Rather, they want accessible, quality local services which are safe and they can trust. In fact, the focus on choice and competition has only served to reinforce the idea of patients being consumers and largely passive ones at that.

Now we are entering a new era of health reform that will take us forward at least 10 years and probably beyond and this is marked by another C-word: collaboration. The move towards integrated care systems in England offers a fresh opportunity to foster a true partnership between the public, patients and doctors, summed up by yet

another C-word: co-production. In this healthcare model, there is no place for outdated notions of professional dominance or paternalism.

It is clear that choice and competition have not worked for patients. Neither has it worked for doctors and other groups in the health system. Going forward, collaboration and co-production offer hope for a new compact or social contract between patients and doctors. But this will only succeed if we implement both cultural and structural change and cultural change takes a long time to be embedded. Doctors need to be at the forefront of efforts to empower citizens and patients as co-producers of their health. Only by working together can doctors and patients navigate their way through the complex challenges we face and fashion solutions that work, all of which are beyond the scope of any single group or individual to devise and implement.

Removing The Enemy From The Room

Often the doctor/patient relationship is cast in terms of two sides: the doctor versus the patient. This view is based on historical understandings of the doctor's role in contrast to more modern understandings of what the patient requires. One of the key things that would be helpful as we move forward is to remove the "enemy" from the room in that neither doctor nor patient are the enemy, but often they are both set against a system which itself does not enable either to be able to achieve or gain what they need.

This raises a question about what we do in terms of doctors. Do we deliver to patients or with patients or alongside patients? What do they prefer? Some patients will be extremely well-versed in their condition and they might understand much more than some healthcare professionals. Others will want to be much more widely guided by the medical profession. As doctors, we must consider how to hold the tension of delivering to and delivering

with together, recognising that patients are by no means a homogenous group, just as doctors are not a homogenous group.

Some patients will know exactly what they want while others will not know or are unable to say, for example, those who lack the capacity or those for whom the medical world or their own body is alien and they would much prefer more engagement from doctors. How do we hold the model together where we do not provide a paternalistic role, but neither do we leave patients on their own when they would much rather have more guidance from doctors than they might be getting?

The challenge is therefore extricating the relationship with the doctor from the relationship of patients with the system itself. How we can encourage and enable doctors to become patient advocates themselves and how can we enable and encourage patients to be doctor advocates;

all being on the same side. How do we empower doctors within the system to make the changes that patients need and want so that when the system becomes problematic - patient difficulties booking scans, to get access to medical treatment or indeed, just booking a medical consultation - doctors can advocate for their patients.

It is also important to be honest about the challenges of delivering joint-working and be more open as a profession to recognising that joint-working is often what is preferred, even if that contradicts with our initial intuition. Often patients may prefer and ask for collaboration more than they want our expertise. Furthermore, certain things are outside the sphere of what doctors can deliver and therefore we must focus on other healthcare professionals as well when we think about patient and doctor engagement. Patient service engagement is one thing, but we need to work

out exactly what it is the patients want from doctors specifically, not just what patients want generally and could gain from the service more widely.



Reaching Into The Dark And Tender Places Of Peoples' Lives...



As doctors, we need to better value what has made medicine so powerful and important in the past and that is the relationships behind it. It is the trusted bond, allowing for deep conversation that means we can tackle difficult things together. While AI and robotics will never be able to replace the most powerful part of that doctor/patient relationship, its role in the future of medicine will be to free up the clinician or healthcare professional so that they are able to “reach into the dark and tender places of people’s lives,” taking time to connect with and understand their patient.

Making the best use of clinicians’ time is important. The amount of time doctors spend analysing and looking at results, requesting investigations, correspondence chasing and sorting are not necessarily the best use of skills. By 2040, we will hopefully see technology as an enabler and friend, freeing

up doctors’ time they can then use working alongside their patients.

Moving forward, finding the balance between accessibility and speed of treatment, which AI and technology can facilitate, versus human contact for patients is crucial. As the last year has demonstrated, some patients will prefer a quick phone call and a quick prescription while others will need to be guided by their GP with face-to-face contact. Similarly, some patients come very well-prepared to their consultations, particularly those who have long-term conditions, who probably know more than their doctor. How do we enable and empower patients in that relationship? How do we redefine that relationship between doctors and patients so that we do not patronise but we nonetheless hold expertise that can benefit the patient?

It is also important to mention

the negative and still little-understood impact of social media in terms of influencing public perception. One example of this can be seen in the response to the COVID vaccine. While in real terms there is little data against vaccines, nevertheless data is getting side-lined by the social media presence. Moving forward, we need to think about how social media is used. For example, Facebook and Twitter have a fact-checking system in place now and yet still misinformation gets through. Perhaps in the future we will have more control over the accuracy of data and its ability to inform or misinform.

Creating A Social Contract Without Widening Health Inequalities

Do patients have a particular responsibility, either to the system or even to the medical profession? We talk a lot about doctors having responsibility for patients and the need to provide for patients, but should there be some kind of social contract between the public and patients, the system and the doctor? How can this fit in with the wider social determinants of health and social justice?

We need to empower patients with the responsibility to co-produce the kind of health system they want. Politicians often fall behind when it comes to bringing the public into the discussions

and it is then left to doctors and other healthcare professionals who feel antagonised about the problems with the healthcare system. Increased transparency about the struggles facing the NHS could make clinicians' lives easier by allowing patients into that discussion - that adult conversation - rather than expecting doctors to be god-like figures with total responsibility. For example, many patients still think doctors will cure them but it is not as simple as that and we will not move past that kind of relationship unless we bring patients into that discussion in a way that will vary locally.

Treating patients as experts on their own health is the first step towards a more equal partnership. This could include any of the following:

- Making patients aware of the costs associated with their treatments. Would this help them to understand the value of their medication? Or would it induce guilt when receiving expensive treatments? One problem is that the cost is not always related to efficacy or quality and is more often related to how long a drug has been licenced for or the complexity of the drug generation.
- In other countries, patients have full access to their medical records online. This means they do not need to chase for their results but only need to contact when they are unsure. Could this openness further empower the patient group or would it cause further confusion and unnecessary worry?
- By 2040, it should be normal that communication between patients and clinicians includes other clinicians copied in for information that may highlight the need for additional action. This shift will naturally allow the "plain language" agenda to be better addressed, increasing accessibility.
- Being open with patients about what a doctor can and cannot do, what the system does and does not enable them to do and what a doctors' boundaries are in terms of our abilities, knowledge and time.
- Allowing the patient to take responsibility for organising their repeat tests prior to their appointment.

While it is agreed that treating patients as individuals is important, how can this be navigated without widening inequalities? The educated patient with access to the resources and a better ability to navigate the system will always have the edge over those on the margins of society. Does this mean that the poor are to be content with a paternalistic service, while waiting for society to tackle housing, the language, the digital divide et cetera in the meantime?

COVID cruelly exposed weaknesses in our health system which, although not new, were perhaps not widely appreciated or not thought to be so detrimental in terms of their impact on deprived communities. We now know differently; the pandemic showed how critical public health is and how impoverished it has become.

The consequence of this has been a reduction in life expectancy in many parts of the country. It has shown us that a new way of working is called for that does not place all power in the hands of hospitals and advanced specialties but instead, those active in primary care, public health and local government need to be at the

centre of integrated care. The focus here is on place and communities, which the pandemic has shown to be pivotal and fashioning an effective response to the impact on people's physical and mental health. Such a focus requires doctors to be less reactive and to ask what their community's most important health needs are and then to tackle them in conjunction with patients through co-production. The priority for future doctors is their relationship with the community, not just the one between doctor and patient.



Social prescribing gives a name to something that doctors have always done. Social prescribing is everything that takes place outside the consulting room and the NHS, whether that is physical exercise, green spaces, advice and guidance; these are the extra activities that enrich us and our lives. A few years ago, the NHS in England took a bold move to commit to introducing social prescribing link workers to general practice. As a result, these have been rolled out around England with similar schemes happening in the other UK nations. The UK has probably led the world in terms of the social prescribing space and we have global alliances on this now.

By 2040, we would like to see social prescribing as part of the normal fabric of health and care. This means that when people think about their wellbeing, they will be thinking not only about where the health service fits in but also where everything else fits in. For example, I am feeling lonely or isolated - how do I connect with people? I want to do more physical exercise - how do I get started? And for those who need help, link workers will be a normal part of the healthcare system, enabling those connections to be made. GPs right now spend a lot of time doing exactly this.



“The title of the project is the Changing Face of Medicine. But medicine is not only about doctors. In the webinars there were some discussions about the part that other professions/occupations may play in the future shaping of the changing face of medicine and in particular the role that many patients and their organisations currently do, want to and can play in the future of medicine. Interestingly the NHS is at last acknowledging the importance of real patient involvement as are some of the professions including many GPs who embrace the help from their patient groups. Doctors cannot improve health care and carve a better future for medicine on their own. Neither can other health care professionals nor managers nor patients. We all need to work together respecting each other's skills and knowledge.”

- Dr Patricia Wilkie OBE, President of the National Association for Patient Participation

March 15th 2022

Social prescribing: a utopian vision for the future?

Acknowledgements

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