

BMA

The changing face of medicine and the role of doctors in the future

Presidential project 2017



British Medical Association
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Foreword



There have been major movements in medicine and the role of doctors within the immediate past and the pace is accelerating. If this is a paradigm shift it is well under way and at a bewildering pace. Sociological and technological developments in the last 20 years have affected most aspects of life, especially in healthcare. These are having a profound impact on the art and science of medicine with palpable but as yet poorly understood outcomes for doctors themselves and their traditional relationship with patients and the public. The traditional role of doctors is under severe strain. Reports from many countries, particularly those with Western models of care, indicate stress and in some instances, crisis amongst the profession and in the delivery of healthcare.

My aim with this project, as part of my presidential year, was to open a dialogue about the role of doctors in a fast changing environment from an international perspective and how this will affect doctors' sense of vocation, professional values and their relationship with patients and the public. Whilst reflecting aspects of professionalism this project aimed to be distinct from the traditional definitions and understandings of 'professionalism' per se. 'Professionalism' implies a set of behaviours, skills and attributes amongst doctors. Some consider this to be a contributory component to the present sense of distress amongst doctors because of the discrepancy in the need to maintain professional standards and the inability to deliver them within their working environment.

Some of the recognisable factors in the changing role and remit of doctors are reflected in the wealth of comments and different perspectives we heard as part of the project including: a narrower divide between patients and doctors; the democratisation of information and knowledge and the impact of the internet; higher expectations from patients; the public and the media and the corporatisation of health care provision with potential conflicts with employers in professional values and priorities.

Medical advances need to be at the leading edge of discovery and innovation and cannot be held back. Doctors have traditionally been adaptable and have embraced positive developments. However, the current rate of change, particularly within the structures and environments in which doctors work has created difficulties for the profession. This is akin to a sliding zone where traditional training and professional expectations have not intersected happily with current demands and future trends. Amongst the 'symptoms' of this dissonance as reflected in the comments from participants are the high prevalence of disillusionment and burnout, withdrawal from professional commitments and early retirements, decreasing numbers entering into post graduate training programmes and a loss of joy in their role as doctors. It is unsurprising, therefore, that there is a high prevalence of mental health problems, substance and alcohol dependence and suicide amongst doctors and worryingly, more now in the younger aged group.

The evidence for these problems is reflected starkly in data from the UK Foundation Programme, Career Destinations Report 2016. These data relate to doctors who completed their basic post-graduate Foundation Programme and would normally have gone into further speciality training. Over the five years from 2011 the proportion of doctors proceeding into NHS speciality training fell from 72% to just 50.4% in 2016, a rate which is unlikely to sustain the NHS for its future needs. Of those not proceeding 13.1% took a career break, 12.7% left the UK and 21.7% elected to work in the UK health system elsewhere, including the military. Perhaps the most positive finding was that only 0.6% left the profession.ⁱ

i UK Foundation Programme (2016) Career Destination Report 2016. UK Foundation Programme Office. <http://www.foundationprogramme.nhs.uk/news/story/careers-destination-report-2016> (accessed 7 June 2017).

These findings are reflected equally starkly in GP data for the UK. A recent study confirmed the high rate of early retirements and a survey from south west England indicated that 40 per cent of GPs were planning to retire in the next five years, citing increasing workload and consultations as a reason. This is hardly surprising against a backdrop of increasing rates of consultation (340 million consultations annually in England alone, population 55 million) and it has been calculated that 5000 more GPs are needed. These data are put into further contrast when the traditional strength of general practice is considered – the ability to provide continuity of care. Despite confirmation of the value of continuity through reduced hospital admissions and overall care costs it seems unlikely that this can be delivered universally within current models of care.ⁱⁱ

Despite the technical advances and sociological changes the care of the patient is based on very human transactions. This often requires balancing strategies especially as medicine advances and systems of care evolve.

For example, the relative lack of doctors will almost certainly necessitate a different approach to the organisation and structures of care provision. Equally, threats to continuity of care for individual patients need to be balanced against patients' not unreasonable needs to receive personal care, at least in follow up and collaborative decision making. The term 'patient' may well be supplanted by 'consumer' and the consultation process with negotiation. There is a need to avoid medicalisation whilst recognising effective and useful possibilities and also the need to provide care versus the mere prolongation of life. These, and other situations, require a continuing dialogue in a collaborative relationship between the clinician and the care receiver, a treasured and long held tradition in medicine.

Whilst recognising the difficult circumstances at present we need, as clinicians, to think and prepare for the future. We have almost certainly reached the point from where a retreat to what was previously considered good is not possible, simply because the world has moved on. It is essential that we have a better appreciation of the environment in which we now function and the medical advances and social changes that are approaching.

The purpose of this presidential project was to acknowledge the present situation and to prepare for the inevitable future that confronts us. Commencing a dialogue is never easy – solutions do not pop out of the ether; neither can our predictions be guaranteed. We can, however, come to terms with what is happening with a view to adapting for the future. This series of meetings enabled a dialogue to commence about what is important and how things might look. This dialogue needs to continue into a more concrete acceptance of our situation and planning for adaptive strategies. Defining the role of a doctor has never been more important.



Professor Pali Hungin
BMA President

ii Barker I, Steventon A, Deeny SR (2017) Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. *BMJ* 2017;356:j84.

Project structure

Four roundtable discussions were held between January and March 2017. They focused on the changing nature of society and the effect on doctors and brought together professionals, both from the UK and overseas, together with lay people and patients. The format consisted of unstructured discussions held on a non-attributable basis and divided into two parts – an examination of the current situation and an exploration of wide-ranging factors causing the present day problems, followed by an exploration of potential future scenarios and predictions.

The key themes identified in these discussions helped to inform the agenda for a symposium held on 20 and 21 April 2017. This was attended by contributors from Canada, the CPME (Standing Committee of European Doctors), Israel, New Zealand, Spain, Sri Lanka, UK and the US and included doctors, as well as lay people – patients and patient representatives. The symposium combined presentations from individual speakers and a series of panel-based discussions. Delegates and speakers were invited following meetings and discussions the President had with stakeholders in the UK and abroad over the course of the year. The full list of participants in the roundtable discussions and the symposium is available at Appendix A. The symposium programme is available at Appendix B.

This document presents the themes and discussion points raised by participants from both the four group meetings and the April symposium. All the presentations from the symposium can be accessed on our website.

Project lead:

Professor Pali Hungin, BMA President

Advisors to the project:

Dr Richard Stevens, Thames Valley Professional Support

Professor Debbie Cohen, Cardiff University

Project team:

Dr Anthea Mowat, BMA representative body chair

Martin Davies, Senior policy advisor

Stella Dunn, Head of professionalism and guidance

Caroline Eason, Conference manager

Raj Jethwa, Director of policy

Susan Law, Strategic communications manager

Jane Lewis, Head of conference unit

Charlotte Phillips, Project researcher

International perspectives

Canada

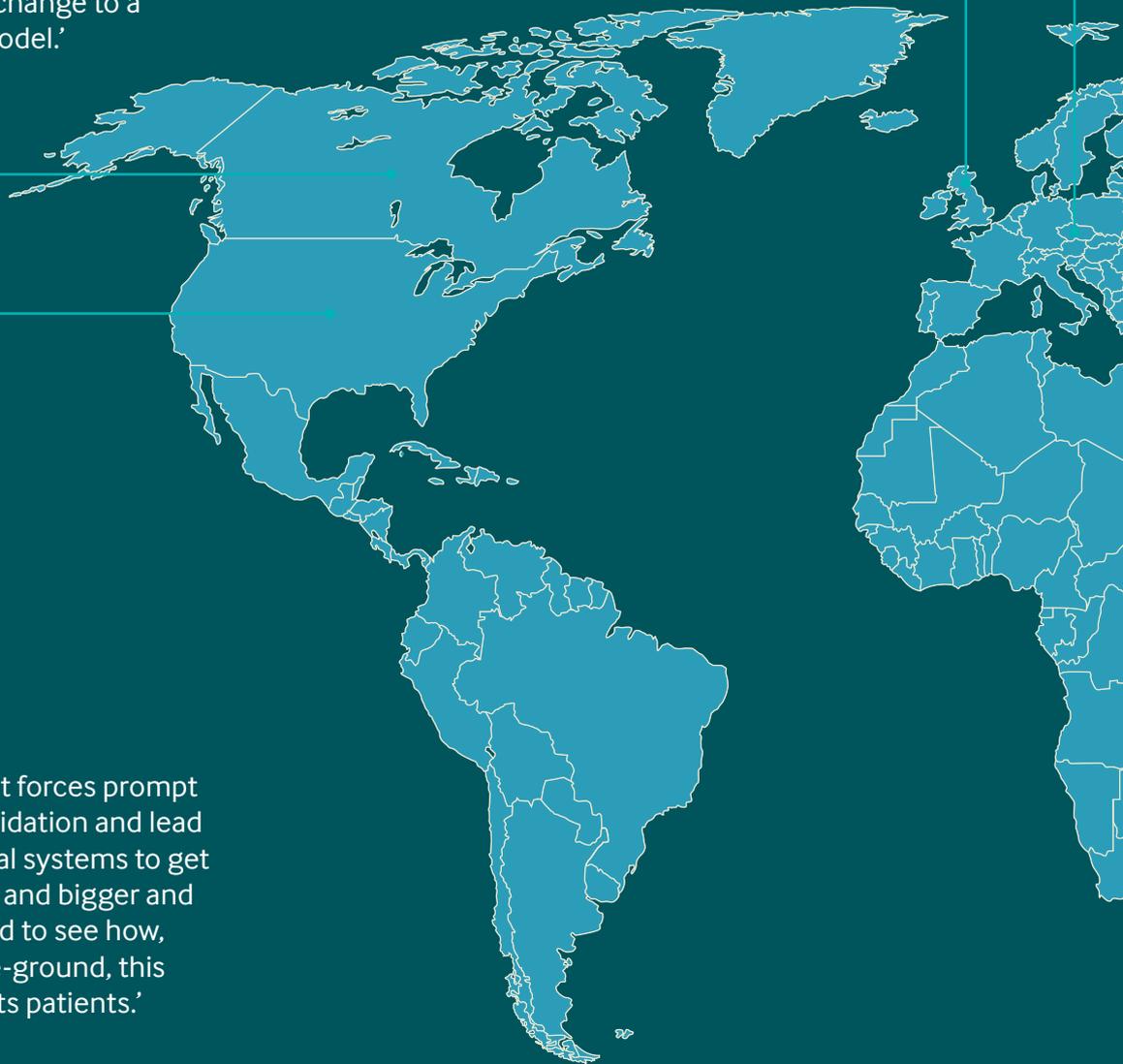
'I think the biggest thing is about collaborative decision-making. The way in which decisions are sometimes imposed top-down irritate doctors and nurses no end and it really needs to change to a collaborative model.'

UK #1

'It's not just this country – there's a world trend away from generalism...the system will collapse unless we have sufficient generalists and... it's been sort of starved of resources, starved of funds, particularly in the UK at the moment and its making it unattractive and it's a shame because it's a great job.'

USA

'Market forces prompt consolidation and lead hospital systems to get bigger and bigger and it's hard to see how, on-the-ground, this benefits patients.'



UK #2

'They're huge system-wide challenges, and I think for doctors getting their arms around those system-wide challenges is a huge challenge for them personally.'

Europe

'Better hospitals [are] needed, better publication of rules and policy is needed, but that's not going to change the system and that's not going to help colleagues feel better in 20 – 30 years, less burnt out or perplexed with their identity.'

New Zealand

'We've got restrained funding, we have diminishing workforces, we have increasing burdens of disease, ageing populations, and increasing expectations. And its how do you actually...preserve the value of the role of the doctor.'

Sri Lanka

'At the moment we have these areas that we face challenges in terms of cash limitations, fund limitations, as well as opportunities for education, particularly continuing medical education for the relatively underpaid doctor.'





Discussion points and themes

The doctor-patient relationship

Current factors

- Delegates felt that the ground is shifting in the relationship between doctors and patients. However, although the relationship is evolving delegates also stressed that doctors are still respected and held in high esteem.
- The democratisation of medical knowledge was seen to have benefits for patients and the healthcare system, but it also brings challenges. Questions were raised about how time-pressured clinicians can deal with the volume of unfiltered information, some irrelevant or misleading, that can now form the backdrop to any consultation. How does a doctor know if a self-diagnosing patient has omitted potentially vital information about their symptoms? A doctor's judgement was also increasingly weighed by patients alongside the 'wisdom of the many' including advice from other doctors, friends and from the internet.
- Participants highlighted a growing need to manage the expectations of patients who anticipate access to any treatments or who believe that 'everything would always go well': *'[Doctors] have to walk a fine line between being realistic with our patients, and destroying all their hope.'*
- We heard that much of the information that patients are given (or 'fed' as one delegate put it) from a variety of sources, strengthens this sense of expectation. This is exacerbated in those countries where advertising of prescription medicine to consumers is permitted, with doctors reporting increasing requests for new investigations as a result.
- However, where a patient arrives with internet print outs, for example, this *'is not a competition,'* explained a delegate, nor a signal that patients feel disillusioned or disengaged. On the contrary, there is a powerful – and easily overlooked – psychology at play between patient and doctor during a consultation: *'[Patients] go home happy with that interaction with a professional – reassurance – from whoever that may be.'*
- In many countries, there has been growing emphasis on shared care and the importance of the patient perspective in decision-making. Some delegates expressed positive views about this agenda while others have a more equivocal perspective, one patient group representative commented that: *'We have always moved towards a shared care agenda, where the patient is now seen as part of the healthcare team. [I am] not so sure about that; it might work for some but not for all.'*

Future considerations

- Participants felt that, whatever an individual's stage of life or state of health, the importance of the special relationship between doctors and patients will endure and needs to be recognised. The need for better dialogue and engagement between doctors and patients was also stressed though, together with the potential for a more collaborative relationship.
- One delegate felt there should be more emphasis placed on 'shared management' rather than 'self-care', with a greater acknowledgement that patients have expertise and experience of their own that can help inform a consultation.
- Even with a greater access to health information and data in the future, one roundtable participant explained, patients will *'still need someone who can interpret that information through the prism of experience and focus it.'*
- It was suggested that the doctor of the future will be an expert on people, compassionate and caring, with a holistic approach that incorporates the use of new technologies. There will be continued respect and acceptance for all patients whose expectations will continue to grow.
- However, patients also need to take greater responsibility for their own health in the future: *'They need to be aware of how to help themselves, for example by using their IT knowledge but without cutting the doctor off,'* said one delegate. This could also help to address the strains on health systems: *'We do have to drive initiatives that do empower patients to manage their disease more effectively – otherwise the workload will drown everybody.'*

- Delegates highlighted that society has great difficulty in coming to terms with the end of life and this is one of the most challenging aspects of medicine, echoing the findings of the BMA's own research on end of life care:ⁱⁱⁱ *'In the future, we must accept the concept of death, not prolonging the inevitable. The focus must be on quality not quantity.'* Again, reiterating the BMA's findings, there was a sense that the limited training in end of life care and exposure to the dying process in the current undergraduate curriculum should be improved.

The workforce, provision of care and the work environment

Current factors

- Delegates from different countries reported problems with recruitment and retention. In relation to the UK there is a trend for doctors who have not yet completed their specialist training, to seek jobs abroad.
- Problems with recruitment and retention were not unique to the UK. Delegates indicated a similar scenario in the US, where burnout and health problems exacerbated the situation.
- One delegate argued that if you give doctors more time and the right environment good care will follow. But there was a sense of something needing to change, as one participant noted, there is no 'infinite capacity.'
- Some specialisms are declining faster than others – notably GPs. In some countries, large numbers of doctors are approaching retirement age leaving gaps in the workforce.
- Many delegates emphasised the importance of the high-quality super specialists – *'we shouldn't retreat from excellent science'* – but also that generalists' diagnostic skills, continuity of care and integrated approach, and ability to *'turn their hand to anything,'* are not replicated elsewhere in the health system and needed greater recognition. It was noted though that, out of 28 European countries, only 17 recognise general practice as a speciality.
- One European delegate argued that the title of 'doctor' is disappearing from legal language, to be replaced by 'health professional' and 'healthcare workers' and needs to be brought back.
- For some participants, patients and doctors, continuity of care by a named GP remains important: *'We take continuity of care for granted but we do notice when there is unwanted discontinuity.'* Participants felt that everyone needs a good, well-informed GP who will share their expertise and judgement with patients and help them to make the right decision.
- Tensions were also identified where healthcare has a significant business focus, with conflicts emerging between the financial need to meet targets, which requires enough patients through the system to generate a return on investment, and the clinical imperative to ensure that only people in need are using the service.

Future considerations

- One participant suggested that tending to those who do not leave the country or profession by improving the quality of the working environment could help them make a positive decision to stay and could even convince others to come back – many do eventually return.
- Similarly, the decision by more doctors to take on a locum role or not proceed directly to specialist training should not be seen as necessarily undesirable or negative, as it allows clinicians to experience different settings and find a preferred role, potentially leading to highly trained doctors who can use their skills to help to develop or evolve departments.
- Collaboration and a meaningful, multi-disciplinary, and, where applicable, community-based approach was viewed to be a priority in the future. It was expressed by participants that doctors are a scarce and precious resource – we will need to use them in a smarter and better way.

iii For more information on our work on end of life care, see: <https://www.bma.org.uk/collective-voice/policy-and-research/ethics/end-of-life-care>.

- Changes to inter-professional working were seen by one participant as a necessary and positive development – doctors' future role would be one of partnership in a supportive environment that recognises that no one person can do it all.
- For one roundtable participant, in the future *'Doctors will be more agile, better able to signpost patients through the health and care system'* while another stated that *'We need to think in the future about different types of training, and also about not thinking about silos of who's doing the work, [whether it's] a doctor or healthcare professional, it's about who has the skill set to do the role.'*
- Delegates recognised that patients will not be a homogenous group and that service provision will need to reflect how different patients may want different interactions with doctors for different circumstances and ailments. This was seen as analogous to the shift to online versus physical transactions. Some customers want one or the other, others want both. Similarly, seeing a doctor one-on-one, face to face will be important if patients feel suddenly unwell. At other times, patients will be satisfied by an online consultation for an on-going condition. The key is flexibility: *'We need to adapt to what patients want and what we can actually provide, it's a dialogue we need to have.'*
- A need to engage more with patients in service design more was also expressed: *'...safety, access, efficiency, effectiveness, have tremendous weight behind them but patient experience still doesn't'*

Technological advancement

Current factors

- We heard a number of ways in which a range of technologies are being used to deliver or augment healthcare in different countries: e-health records, real-time counselling sessions, e-referrals discharge summaries, robotics and algorithms being increasingly used by GPs along with dynamic clinical decision-making tools. Although at the same time, there were often practical issues experienced by a number of countries, such as system compatibility between sectors, which could frustrate or hamper the provision of care.
- In many parts of the globe, IT is transforming practice, though not yet everywhere. In Sri Lanka, IT is used for medical education services but is in its infancy elsewhere. Concerns are directed more towards the loss of a need for compassion, though IT 'is still needed.'
- There was criticism expressed for the alleged failure of institutions to grasp that the 'future is curved' and that technology has already moved further forward than they can imagine, that technological capabilities already exist but are not used appropriately.

Future considerations

- The future health care provider, it was argued, will need to recognise the fast pace of change in genomics, robotics, information technology and data, and artificial intelligence (AI). These will have a role in maintaining continuity of care and communication, medical interventions and in personalised, precision treatments.
- Much of the focus was on assisted decision making: *'I think AI will be huge asset to doctors. Patient comes in with high blood pressure, you run the data and get a 20 per cent risk factor for a cardio vascular event in ten seconds, that's the model for what AI aids will give us – ever more precision.'*
- There was also reflection though on the need to ensure the fundamental values of medicine endure, that compassion and the human element remain at the centre of medical practice. In relation to AI, one roundtable participant highlighted that there *'seems to be a divide between AI and relationships, so how do we build a human future including AI and put in genomics, and how do we keep our relational [terms] in the face of huge mass of data we have? That's what we need to aim for – keeping human systems at the heart.'*
- Participants acknowledged the clear advances of precision medicine and more accurate diagnostic and clinical management strategies through AI. However they also highlighted the risks of scientific and technological advance leading to inappropriate medicalisation and over-treatment and the danger of over-inflating the importance of emerging technologies.

- Predictions for how technological advances will shape how care is provided ranged from positive to dystopian. For example one participant speculated about whether the rise of automation will lead to mass unemployment, with more demand placed on primary care, used as a model to deal with the resultant social distress.
- It was argued that the profession needed to become more involved in driving technological innovation; engaging with developers to help focus on technology where it can do most good: *'When it comes to AI and big data, that's going to happen no matter what. Question is whether medics are going to be involved or not.'*
- This includes how patients are using existing technologies and information sources – *'We don't have a good understanding of the way society now functions in an internet age ...so we've got to reflect much harder on that'* – and also the role that social media and online communities will continue to play: *'Partnership and peer support, is massively important to patients...people increasingly go to those big, disease-oriented communities to get information...doctors...are not engaged with it and the gap grows.'*

Physician well-being and morale

Current factors

- Everywhere, including apparently exemplary working environments, morale is at low levels and common themes emerge. We heard reports that doctors in a number of different countries are overworked, undervalued and struggling with sustainability and system-level issues that affect how they work.
- Other contributors highlighted the need to recognise the heavy emotional burden that doctors can carry, coupled with an inability to know when to lay down their professional responsibilities without feeling like they are letting people down if they do. Medical students, for example, embark on a long psychological voyage that starts on day one when they are expected to be mature, show empathy and touch bodies and this carries on from medical school into practice.
- Being overworked on its own need not be a trigger but it is when combined with other factors – not being heard, being pushed around, the loss autonomy or respect.
- Though wellbeing was widely recognised by delegates as a key issue many also feel strongly that not enough is yet done. Participants stressed that doctors' health and wellbeing can be substantially improved, but support remains limited and more practical interventions are needed.
- Evidence of bullying was also highlighted by participants from the UK and abroad. Some delegates posited that it was institutionalised in hierarchical healthcare systems and that a systemic lack of leadership effectively condones bullying by failing to condemn it.
- The focus on 'Resilience' and resilience training, was seen to be *'a sticking plaster only'* which, although relevant, *'doesn't solve the problem'*. As one roundtable participant argued, *'We need to be unbelievably cautious about resilience, because it's always about its environmental context...we have compulsory resilience training, train doctors to be resilient, put into toxic atmosphere, they break down and we say, 'it's your fault...''*

Future considerations

- Feedback illustrated a positive outlook for the future. There was widespread agreement for the need to challenge and change the culture, from doing more to understand the underlying causes to providing more safe spaces for talking and listening, support groups and physical space for doctors to talk freely about the traumatic experiences they experience. For example, an initiative in Wales is under way which focuses on talking about emotions and their impact on changing perspectives and on interactions with managers and career progression, and suggests that learning emotional intelligence can help doctors react to difficulties and bring back the joy of medicine.
- Participants across both events highlighted that civility is and will remain essential in healthcare. Restoring this relies on relationship change at an individual and system level. Bullying needs to be seen as unacceptable.

- Effecting change requires commitment from institutions to set new rules and guidance. It will only happen if there is a change at both individual and system level. Neither can happen without the other. The BMA, for example, has begun a major new project on bullying and harassment in the UK health system. It aims to review support for individuals experiencing bullying and harassment, seek better handling of how complaints are dealt with in the NHS, raise awareness of the issue across the medical profession, and to help drive the necessary culture change to prevent it happening.

Medical education and training

Current factors

- Medical schools and how future doctors should be trained formed a major theme during the events. Participants reflected on whether the current approach to medical school recruitment, which prioritises academic ability, needed to diversify and place greater emphasis on a broader range of attributes.
- There was wide acceptance by delegates of the importance of recognising the needs of the 'neurotic perfectionist' who is, in many countries, the traditional focus for recruitment. These bright overachievers are driven by the need to be the best and to not let people down. How can they be equipped with the medical skills, attitudes, motivation and values that will sustain them not just during training but into their future professional lives? The current system was said by one participant to bring in youthful people '*full of energy and compassion. Within a few months we have knocked it out of them...we need to harness the energy and compassion more in the future.*'
- Another question arose as to how doctors square their training in theoretical ethical scenarios which are predicated at an individual level – staying with or leaving a patient at the end of a shift; going over the head of a senior colleague in the event of a disagreement – when the realities of their actual responsibilities are to a range of people – themselves, colleagues, patients and wider society?
- Delegates heard about two different approaches to medical training. In Israel, founding a new medical school necessitated taking account of the fact that the medical students would be practising medicine in the future. Focus was placed on ambulatory care and on logical decision-making rather than disciplines and processes. In the US, Hofstra Northwell School of Medicine, whose first class graduated in 2011, was described as 'future-driven without the baggage of traditions' and focussed on how young doctors learn, with a new approach to the integration of clinical and basic science.

Future considerations

- A clearer vision of the future doctor, encompassing the realities of societal and technological change, will be needed to plan curricula at undergraduate and postgraduate levels. Getting this right, it was argued, holds the promise of a more fulfilled career and an enhanced, co-productive relationship with patients. If there is to be a near complete revolution of the role and remit of the doctors of the future this urgently needs to be reflected in the training provided now.
- Underpinning training, it was suggested, should be the importance of agreeing and establishing permanent values – humane practice and scientific, professional and responsible medicine – that inform all aspects of practice.
- The starting point was the recognition that more doctors must be recruited and questions were raised about recruitment and training priorities. Is kindness more important in medicine than science alone, and if so what are the implications for a system that focuses on what can be examined and measured? Could a new approach to medical education involve taking it out of the science building and placing more emphasis on the humanity aspects of practice?
- Delegates also reflected on how future doctors could best be supported, motivated and incentivised. A junior doctor participant, for example, stressed the importance of feeling valued, being treated like an individual and given opportunities through which they feel that are able to make a difference.

- Most delegates, for example, were firmly in favour of introducing a zero tolerance to the ‘back in my day’ approach that fetishises long hours and creates feelings of not being good enough.
- Delegates also suggested some relatively simple changes that could result in substantial improvements. In the UK, feedback from doctors suggests that recruitment of general practitioners, currently well below target levels, is hindered by limited exposure to general practice during training.

Medical Leadership

Current factors

- Many participants felt that current models of leadership and policy making needed to be challenged. A more robust approach is required from the profession, though there was praise for the way that representative bodies, such as the BMA, routinely challenge UK politicians.
- Others stressed that it is currently in the hands of others: administrators, financiers and politicians and is based on a traditional model of authority, with command controlled from the centre. Some delegates felt that this approach no longer worked and indeed, may never have worked.
- There is a pressing need for doctors and politicians to speak to each other, to ‘bring this messy world together, what it means, its uncertainty,’ as a delegate expressed it.
- While there are opportunities to engage with the wider political framework (including the role of National Guardian in the UK) these kinds of positions were often felt not to be designed for doctors, despite their remit.
- Top-down policy and management initiatives are seen as a threat to professional values and the relationship between doctors and patient
- Many delegates felt that doctors are also handicapped by an absence of tools, time, training and financial incentives to lead. One speaker talked of individual doctors working at ground level as akin to performers in a jazz band, an analogy that was referenced by many other delegates. Like musicians, doctors need the freedom and trust to perform to the highest possible levels. Unlike musicians, they do not get it. They may not see leadership as part of role, but unless they take it on, it was felt, nobody else will do it for them.

Future considerations

- Delegates talked about the need to enable doctors to reclaim leadership and take back control. Younger doctors in particular should be inspired and encouraged to think they can make a difference: that they are not ‘just a doctor’ but individuals with the ability to improve the health system. *‘The solution lies entirely within ourselves, we don’t need to look to policy makers’* stated one participant. Crucially though doctors who want to be involved at a national or region level will need training, time, financial incentive and support.
- Participants suggested that the new model for leadership will be collaborative and distributive. Leaders will have a diverse skill-set, be humble and facilitating, critical thinkers capable of exercising judgement, wisdom and compassion in the face of uncertainty. Leadership candidates should be *‘shown the levers and how to pull them’* and make the most of their role.
- Suggestions for ways to foster the next generation of doctor-leaders and awakening a more entrepreneurial spirit included: leadership featuring as part of the undergraduate curriculum, covered in medical humanities, ethics, and value systems; creating a career structure in which leadership is part of the job; joint training for doctors and nurses, to develop a shared knowledge base; and introducing a management fast stream for those who express an interest in leadership.
- It was suggested that the more that real conversations can be initiated rather than rhetoric, the better.

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TABLE
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Conclusion

Things are not right. Society and medicine are moving on and there is a need to consider the impact of this fast changing environment on the role and remit of doctors.

Across the four roundtables and the discussions at the symposium we heard a broad range of different and often contrasting viewpoints about the current factors affecting healthcare and the role of doctors and considerations for the future. Issues surrounding recruitment and retention of the workforce, service pressures, morale and wellbeing were all highlighted by participants.

While tackling the current difficulties remains the most pressing concern, which rightly dominates the efforts and attentions of doctors, it is important though to also look to the future. Medicine is always evolving in the face of the demographic, technological and societal changes and it is imperative to identify the potential challenges and opportunities that are on the horizon and which may shape the practice of medicine in the forthcoming years. What will the future of medicine, 'Era three' in Berwick's categorisation,^{iv} look like and will the role of the doctor change? How can we ensure that fundamental values such as kindness, care and compassion remain at the heart of medical practice?

The aim of this project was to not to provide definitive answers to these questions or to devise solutions to the various challenges facing medicine but to begin a dialogue, highlighting the views of doctors, medical students, patients and policy experts on the current factors which are affecting medical practice now and how the future of healthcare might change. The important issues raised by participants in these meetings merit urgent and more detailed consideration. Doctors and patients will play a pivotal role in these discussions, helping to shape workforce planning, leadership, recruitment and training, the adoption of new technologies, and the delivery of care in the future.

Appendix A

Participants and delegates

Roundtable discussions

Round table 1: Monday 23rd January 2017

Chair: Professor Pali Hungin, President, BMA

Attendees:

Professor Debbie Cohen	Cardiff University School of Medicine
Dr Antony Garelick	Consultant and director DocHealth
Dr Clare Gerada	Partner Hurley Group
Professor John Gillies	Senior advisor, Global Health Academy University of Edinburgh
Professor Sir Denis Pereira Gray	National Association for Patient Participation
Miss Claire Marx	President, Royal College of Surgeons
Dr Johann Malawana,	BMA, junior doctor
Dr Ellen McCourt	BMA junior doctor
Dr Andrew McCulloch	Picker Institute/University of Exeter
Dr Richard Stevens	Thames Valley Professional Support Unit

Round table 2: Wednesday 8th February 2017

Chair: Professor Pali Hungin, President, BMA

Attendees:

Dr Ruth Chambers	Clinical Chair & WMAHSN LTC Network Clinical Lead
Dr John Chisholm	Chair, BMA Medical Ethics Committee
Dr Jocelyn Cornwell	Chief executive officer The Point of Care Foundation
Ms Ceinwen Giles	Point of Care Foundation
Professor David Hunter	Durham University
Dr Terry Kemple	President, Royal College of General Practitioners
Mr Charlie Massey	Chief Executive, GMC
Professor Greg Rubin	Durham University
Dr Richard Stevens	Thames Valley Professional Support Unit

Round table 3: Wednesday 22nd February 2017

Chair: Professor Pali Hungin, President, BMA

Attendees:

Professor Debbie Cohen	Cardiff University School of Medicine
Ms Christine Douglass	Patient Liaison Group, BMA
Professor Michael Farthing	Vice Chancellor, Sussex University and previous Dean of Medicine
Dr James Morrow	Granta Medical Practices
Dr Richard Stevens	Thames Valley Professional Support Unit
Dr Simon Stockley	RCGP Clinical Lead for Sepsis
Dr Jeeves Wijesuriya	BMA JDC co-chair & council member BMA
Dr Patricia Wilkie	President and chairman National Association for Patient Participation

Round table 4: Tuesday 7th March 2017

Chair: Professor Pali Hungin, President, BMA

Attendees:

Ms Amanda Cool	Patient liaison group chair BMA
Professor Angela Coulter	Department of Population Health, Oxford
Dr Fiona Crosbie	Talbot Medical Centre
Ms Stella Dunn	Head of Professionalism and Guidance, BMA
Dr Jacques de Haller	President, CPME
Dr Iona Heath	Retired GP, past president of the RCGP, and medical writer
Dr Henrietta Hughes	National Guardian Freedom to Speak Up
Mrs Wendy Preston	Head of nursing practice Royal College of Nursing
Dr Tessa Richards	BMJ
Dr Richard Stevens	Thames Valley Professional Support Unit
Professor Chandrika N Wijeyaratne	President, the Sri Lanka Medical Association
Dr Guy Yeoman	Vice president Patient Centricity AstraZeneca

Symposium attendees

Thursday 20 and Friday 21 April 2017 BMA House, London

Dr Granger Avery	President, Canadian Medical Association
Dr Kate Baddock	Deputy chair, New Zealand Medical Association
Dr Charlie Bell	Medical students committee co-chair, BMA
Professor Rafael Bengoa	Director, Institute for Health and Strategy
Ms Cecile Bensimon	Director of ethics and professional affairs, CMA
Dr Ruth Chambers	GP and Stoke-on-Trent CCG chair West Midlands Academic Health Science Network
Dr John Chisholm	Medical ethics committee chair, BMA
Professor Debbie Cohen	Director, Medic Support and the Centre for Psychosocial Research, Occupational and Physician Health Cardiff University
Mr Stephen Colegrave	Giraffe
Miss Ellen Collard	Medical student, Cardiff University
Ms Amanda Cool	Patient liaison group chair, BMA
Dr Jocelyn Cornwell	Chief executive officer, The Point of Care Foundation
Dr Fiona Crosbie	GP, Talbot Medical Centre
Dr Arosha Dissanayake	Senior lecturer in medicine Faculty of Medicine, Galle
Professor Michael Farthing	GMC Council member
Dr Katrin Fjeldsted	Past president, CPME
Dr Antony Garelick	Consultant and director, DocHealth
Dr Clare Gerada	GP Partner, Hurley Group
Ms Ceinwen Giles	The Point of Care Foundation
Professor John Gillies	Senior advisor, Global Health Academy, University of Edinburgh
Dr Fiona Godlee	Editor-in-chief, BMJ
Dr Iona Heath	Retired GP, Royal College of General Practitioners, and medical writer
Dr Peter Holden	Council member, BMA
Dr Henrietta Hughes	National Guardian, Freedom to Speak Up
Professor Pali Hungin	President, BMA
Professor David Hunter	Professor of health policy and management, Durham University
Dr Dominic Johnson	Clinical sub-dean, School of medical education, Newcastle University
Professor Roger Jones	Editor, BJGP
Dr Terry Kemple	President, Royal College of General Practitioners

Ms Mary Jane Kornacki	Healthcare consultant, Amicus Inc
Dr Johann Malawana	Council member, BMA
Dr Ellen McCourt	Junior doctors committee, BMA
Dr Andrew McCulloch	Health and social care policy consultant
Professor Juan Mendive	Catalan Institute of Health, Spain
Sir Denis Pereira Gray	National Association for Patient Participation
Mrs Wendy Preston	Head of nursing practice, Royal College of Nursing
Dr Harshini Rajapakse	Senior lecturer in psychiatry Faculty of Medicine, Galle
Dr Jack Silversin	President, Amicus Inc
Dr Richard Stevens	Assistant director, Thames Valley Professional Support
Dr Judith Tweedie	Research fellow (health policy), Royal College of Physicians
Professor Michael Weingarten	Retired, Bar Ilan University
Dr Jeeves Wijesuriya	Junior doctors committee chair, BMA
Professor Chandrika Wijeyaratne	President, Sri Lanka Medical Association
Dr Patricia Wilkie	President and chairman, National Association for Patient Participation
Dr Guy Yeoman	Vice president, Patient Centricity, AstraZeneca

Appendix B

Symposium programme

The changing face of medicine and the role of the doctor in the future

Thursday 20 – Friday 21 April 2017
BMA House, London

Thursday 20 April 2017

- The current state of medicine and doctors within society
Professor Pali Hungin, BMA president
- Group work – The situation in my setting/country: challenges to medicine and healthcare
- Panel discussion
Facilitator: Professor Debbie Cohen, director, Medic Support and the Centre for Psychosocial Research, Occupational and Physician Health, Cardiff University School of Medicine, UK

Panellists:

Dr Granger Avery, president, Canadian Medical Association
Dr Kate Baddock, deputy chair, New Zealand Medical Association
Professor Juan Mendive, Catalan Institute of Health, Spain
Ms Mary Jane Kornacki, healthcare consultant, Amicus Inc, USA
Professor Michael Weingarten, Israel
Professor Chandrika Wijeyaratne, president, Sri Lanka Medical Association

- Healthcare, the doctor and the patient – the future
Professor Rafael Bengoa, director, Institute for Health and Health Strategy, Bilbao, Spain
- Panel discussion: What's important, what matters for the future? Opportunities and challenges
Facilitator: Professor Roger Jones, editor BJGP, Royal College of General Practitioners, UK

Panellists:

Dr Arosha Dissanayake, College of Physicians, Sri Lanka
Dr Clare Gerada, GP partner, Hurley Group, UK
Dr Fiona Godlee, editor in chief, BMJ, UK
Dr Dominic Johnson, clinical sub-dean, Newcastle University, UK
Dr Jeeves Wijesuriya, BMA junior doctors committee chair, UK
Dr Patricia Wilkie, president and chair, National Association for Patient Participation, UK

Friday 21 April 2017

- Health systems transformation: how responsive are organisations and policy to the future?
Professor David Hunter, professor of health policy and management, Durham University, UK

- Panel discussion: Healthcare in the future
Facilitator: Dr Richard Stevens, assistant director, Thames Valley Professional Support, UK

Panellists:

Dr Granger Avery, president, Canadian Medical Association

Dr Kate Baddock, deputy chair, New Zealand Medical Association

Dr Katrin Fjeldsted, past president, CPME

Professor Roger Jones, editor BJGP, UK

Ms Mary Jane Kornacki, healthcare consultant, Amicus Inc, USA

Dr Harshini Rajapakse, senior lecturer in psychiatry, Faculty of Medicine, Galle, Sri Lanka

- Panel: Future thinking
Facilitator: Stephen Colegrave, Giraffe

The impact of IT and AI. *Dr Guy Yeoman, vice-president – patient centricity, Astra Zeneca, UK*

Patient continuity. *Dr Terry Kemple, president, RCGP, UK*

Healthcare workers: evolving roles and relationships. *Ms Cecile Bensimon, CMA*

The 'escape' of medicine. *Dr Richard Stevens, Thames Valley Professional Support Unit, UK*

Preparing and strengthening doctors. *Professor Debbie Cohen, Cardiff University, UK*

- Doctors: the future. Reshaping medical training and the form of the new doctor
Ms Mary Jane Kornacki co-founder and president, Amicus Inc, Cambridge, Mass

- Patients, the public and doctors: the future
Dr Jocelyn Cornwell, chief executive, The Point of Care Foundation, UK

- Open panel discussion
Facilitator: Stephen Colegrave

Panellists:

Dr Charles Bell, BMA medical students committee co-chair, UK

Dr Ruth Chambers, GP, West Midlands Academic Health Science Network

Ms Ellen Collard, medical student, Cardiff University, UK

Ms Amanda Cool, BMA patient liaison group chair, UK

Dr Fiona Crosbie, GP, Talbot Medical Centre

Sir Denis Pereira Gray, National Association for Patient Participation

- Imagining medicine in 2040
Professor Michael Farthing
- Closing remarks
Professor Pali Hungin, BMA president

British Medical Association

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