

**THE
CHANGING
FACE OF
MEDICINE**

Doctor, who?

Shaping a Vision for 2040

A report from The Changing Face of Medicine
Commission under the auspices of
The Academy of Medical Royal Colleges



Academy of
Medical Royal
Colleges



October 2020

THE CHANGING FACE OF MEDICINE

‘Doctor, who?’ - Shaping a Vision for 2040

Introduction

Preparing for the future and watching it happen...

The Changing Face of Medicine (CFM) project was born out of the necessity to scan the horizon in a fast-moving health world. The future has arrived faster than we envisaged.

The COVID-19 crisis has seen spectacular shifts – staff repurposed virtually instantly, facilities and services reconfigured, additional hospitals created within days and the worlds of biomedicine and engineering driven to results with unprecedented velocity.

General Practices adapted within days, switching to electronic consultations and minimal face-to-face appointments. The public, too, changed their healthcare-seeking behaviour. There has been a sharp reduction in emergency attendances and an acceptance, at least temporarily, of a new health world order underpinned by new-found stoicism and willingness to postpone what was previously perceived as urgent.

Several things stood out beyond the change in consultation behaviour: the acceptance by clinicians of the need to work outside established roles; the requirement to deliver with limited resources, and the re-awakening of a sense of vocational commitment, with so many risking their lives. Combined, these may represent a pivotal point in the evolution of healthcare. Despite the demands of a high-stress environment and the imperative to deploy the latest technologies, many doctors may well have rediscovered what originally made them go into medicine.

The impetus for the CFM initiative stems from the 2017 British Medical Association Presidential project [1] that sought to visualise the future, prepare better for it and provide a sense of direction for so many who are disillusioned and feel concreted within their professional roles and environments

As part of a commission within the Academy of Medical Royal Colleges, the project, which began in 2018, has developed into a significant think tank of clinicians and lay people, providing a space for a thought exercise in response to the changing world.

The CFM national conference at the King’s Fund – held, as it happened, only a few days before the COVID-19 lockdown – focused on the interim outcomes from our key themes: the fast moving technological advances; the shifting role of the doctor in professional, patient and societal interactions; public expectations of health provision and providers; the need for visionary medical leadership; and the wellbeing of clinicians themselves.

Recent reports from both the AoMRC, ‘Answering the Call for Action’ and Health Education England, ‘The Future Doctor Programme’, reinforce the need for a forward-thinking, visionary approach. The deliberations of the CFM Commission include contributions from all the home nations who face the same issues, despite differing structures. Indeed, our outcomes almost certainly reflect the situation world-wide.

It was remarkable how perspicaciously and powerfully the previous 18 months of work, and the discussions on the day, anticipated aspects of the situation that evolved immediately afterwards. Like an idea whose time has come, this envisioning and preparation seems imperative now. Not only should it continue, but there is an urgent need to accelerate its aims.

As current events show, the future does not wait. It is essential that this dialogue is widened and strengthened so that clinicians and the public become aware of impending shifts which will so profoundly affect the healthcare of their own generation and of those to come. The establishment of a formal, resourced permanent Commission with this single-minded focus will ensure that this happens.



Professor Pali Hungin
OBE MD FRCP FRCGP FRSA
Lead, Changing Face of Medicine Commission
President, British Medical Association 2017



Foreword

The Chair, Academy of Medical Royal Colleges

We all know that the future is notoriously hard to predict, and the COVID-19 crisis has powerfully illustrated that change can be forced upon us suddenly.

The medical profession has done remarkable work across all sectors where it was already agile and supported and it has been able to respond swiftly and effectively.

Some sudden changes are a necessary response to crises. Most, however, should occur in parallel with clinical, technological, and societal shifts. Having an awareness of developments around our profession and importantly, being prepared to respond to them, is an essential requisite for us as clinicians.

The CFM Commission sets out to consider what the future might hold for clinicians and the public they serve, in a way that tries to free us from our current preoccupations.

It is crucial that this dialogue be continued and for it to become a normal element in our ongoing professional conversations, enabling us to lift our gaze from today's problems to encompass the great opportunities and profound challenges of the future. Preparation for the future, including inevitable paradigm shifts, has to be an active part of managing today.

The Academy of Medical Royal Colleges, which hosts the CFM project, welcomes this report as an important contribution to these crucial debates about the future.



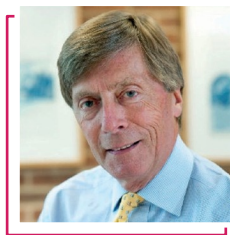
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The Changing Face of Medicine Project Team



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The Changing Face of Medicine calls to action

Technology, Informatics and Artificial Intelligence (AI)

- Ground-breaking technology and discoveries from non-medical fields and industries will be explored and adapted to the healthcare environment to expand beyond the limits of what is currently possible
- Technological advances may appear unpalatable and have the potential to challenge the doctor-patient relationship. Decision-makers within health systems need to assess their ethical, medical, financial and relationship implications
- Developments must be compatible across NHS platforms and silos, and enable better communication throughout all providers
- Whilst the immediate impact of technological advances in medicine may have been overplayed, the speed of adaptation can be startling, as the COVID-19 crisis has illustrated
- The long-term impact of technological advances in communication, scientific discovery, research and clinical and social management and planning need to be embraced

Patients, the Public and Doctors

- Continuity of care and human contact will remain highly valued in the ever-changing balance of the doctor-patient relationship. As the use of digital technology and artificial intelligence (AI) become more commonplace, the inevitable shifts to this balance will need to be understood and carefully managed
- Connection, communication and the validation of engaging at a human level is vital. Changing values need to be reviewed as the 'where' 'how' and 'when' of speaking to a clinician starts to matter more
- Patients will need to be involved and engaged effectively in future NHS planning to ensure it is fit for purpose especially in the face of accelerating societal and technological shifts which impact on the way care is delivered and received

Clinician Wellbeing

- Doctors will need to feel their job matters and has meaning to perform optimally.
- Future developments must support physician wellbeing
- Prioritising clinician wellbeing will maximise efficiency, reduce the chances of mistakes, reputational damage and expensive litigation, and should result in a more satisfactory patient journey
- Those responsible for structural and organisational changes must resist the temptation to use technology merely to compel doctors to see more patients, with detrimental effects on patient outcomes and doctors' wellbeing

Visionary Leadership

- New, devolved leadership models will be required that empower individual leaders to take responsibility for effecting change
- Recruitment of future leaders will need to target those who are willing to seek greater autonomy and embrace the additional challenges and higher levels of risk for the greater good of the public
- These visionary leaders will need to have the ability to embrace change, show us the path towards adoption and evolution, resist hierarchies, have diverse rather than narrow skill sets and be responsive to the need for greater job satisfaction
- Current models of leadership, often geared towards effective management, do not facilitate imaginative global strategies for the future and a different approach to visionary leadership will be required
- A major effort is required to engage with younger clinicians, reflecting diversity, to develop and capitalise on the already demanding qualities and attributes required to enter a medical career
- Changing regulation and assessment will need to be amended to incorporate more qualitative and long term measurements
- We will need to improve our understanding of healthcare within a wider global context e.g. environmental issues at all training levels

Medical Education

- Doctors must be trained in a wider portfolio of skills, including compassion, communication and adaptability to the future that increase their sense of humanity and improve communication
- Medical school selection needs review to develop a more diverse and reflective workforce. Medical careers must be accessible to a wider range of promising candidates, including those with diverse academic and technical backgrounds not allied to health, as well as part-time students.
- Training will need to be adaptive to advances, allowing flexibility in duration, encompassing competencies in an evolving environment.
- Transferable skills and generalism in careers will be a valuable attribute of clinicians.

The next steps

There is:

- an urgent and essential need to widen and strengthen these discussions and dialogue with healthcare providers, clinicians and the public to create a greater sense of preparedness for the future
- an imperative for the establishment of a formally resourced continuing commission whose role - critically exploring likely future developments and directions – will inform policy makers, health providers, clinicians and the public and help to shape thinking and decision-making



The CFM Commission: background, aims and structure

‘Looking into a vision for the future, not solutions to today’s challenges’

The *Changing Face of Medicine* (CFM) project is a commission under the auspices of the Academy of Medical Royal Colleges (AoMRC). The CFM looks to develop a vision for the future rather than solutions to today’s challenges.

As President of the British Medical Association in 2017, Professor Pali Hungin convened a series of meetings with stakeholders, including the medical Royal Colleges, senior doctors and nurses, junior doctors, patients and patient representatives. A resulting international conference identified themes for future determination and the imperative, for doctors in particular, to prepare for the future in our fast evolving medical and societal settings. <https://www.bma.org.uk/media/2067/bma-the-changing-face-of-medicine-june-2017.pdf>

The CFM continues to play a pivotal role in taking this forwards. The project’s driving force is the work and visionary thinking being undertaken by five Theme Groups, each encompassing a vital future area.

The Theme Groups report to The Faculty Group, made up of representatives from medicine and related disciplines and lay people, and chaired by Professor Michael Farthing. Members of the Faculty Group guide progress and set the direction of travel. The scope of the five Theme Groups’ work addresses the key dilemmas, threats and opportunities that will define the way doctors are identified, recruited, motivated, supported and above all led in the years and decades to come.

A priority has been to ensure that Theme Group leaders and members span the age range. The project leaders sought, particularly, to involve young doctors who have a vested interest in planning for the future and the ability, vision and fearlessness to challenge the established order, with recruitment of disruptors and thought leaders continuing throughout the project’s evolution.

Whilst separate, the Theme Groups retained a real sense of shared purpose, strengthened over time, underpinned by regular meetings and information sharing. We endeavoured to avoid the silo thinking that often besets healthcare and ensured that factors common to each group - notably technology - were addressed in a cross-cutting way.

Liberated from the hierarchical constrictions that are all too common in the medical profession and encouraged to think independently, each dedicated team has the potential to act as a powerful catalyst for change and improve awareness amongst clinicians.

Where we are now - an evolving and dynamic process

The five CFM Theme Groups are as follows.

Patients, the public and doctors: addressing the future evolution of the complex, often challenging but essential relationship between doctors and patients

Technology, informatics and artificial intelligence: exploring the profound impact of technology, destructive and beneficial, on aspects of medicine

Clinician wellbeing: confronting future challenges to clinicians’ physical and mental wellbeing

Visionary leadership: inspiring, educating and supporting a new generation of leaders

Medical education: looking at how to equip the future population with the future doctor they need and how medical education and training might need to be configured

Each group considered these questions:

What health-related societal and technological developments can be anticipated?

What likely scenarios will exist in the future?

How can we prepare the profession for these changes?

Initial outputs from the five Theme Groups became a focal point for the 2020 CFM conference.

The impact of Technology, Informatics and Artificial Intelligence (AI)

'Achieving radical change without harming people's fundamental need to be connected.'

Whilst the COVID-19 crisis has accelerated the role of IT in communication and consultations, the promise of technology within medicine itself is only just starting to have an impact. Technology within the health field has developed fast and we need to allow ground-breaking innovations from unexpected directions. Like renewable energy, technology "has the potential to radically change healthcare efficiency and balance the demands of a more expectant population," stresses Professor Mark Wilson, Convenor of the CFM Technology Theme Group and Consultant Neurosurgeon at Imperial College.

• Benefits

There are unfathomably large opportunities for healthcare to benefit from technology and to improve its efficiency beyond what was considered possible from when the NHS was founded and, indeed, from the present time. Future diagnostics and interventions, alongside genomic advances, will be used earlier. Genome sequencing and targeted treatments will lead to better use of healthcare resources as well as improved outcomes for patients. Technology and data, noted Professor Sir Mark Caulfield (Chief Scientist for Genomics England), will help to move the NHS away from being a "national disease service" towards a true health service. Nonetheless, we must be careful not to rely solely on biomedical information and data because lifestyle factors will always have a significant influence on outcomes, reinforcing the human and societal elements in personal and societal health.

Technology must maximise benefits, minimise harm and, crucially, work across all systems and platforms. Professor Derek Alderson (President of the Royal College of Surgeons) explored the possibility that this could enable technology to optimise patients' health ahead of surgery, improving outcomes and enabling a faster return home. This also underlines the importance of well set up social care which, if functioning effectively, represents a system of care that is truly collaborative and integrated. Thus without associated social improvements, tech innovations alone will have a limited impact. The new technologies already offer significant opportunities for remote surgical advice, which have a large impact in hard to reach communities or where patients, such as those with COVID-19, need to be isolated.



• Challenges

People have a fundamental need to be connected and the use of technology must not harm the face-to-face, patient-clinician relationship. It will also be important to ensure that access to technology does not become exclusive or disadvantageous for certain groups and unintentionally increase health inequalities. Robust monitoring of the impact of the emerging technologies will be essential, to leverage its potential benefits while ensuring that groups of individuals are not left marginalised and their wellbeing jeopardised.



Collaboration will be vital as new technologies are introduced; for example, clinicians will need to communicate with engineers and the roles of a variety of non-clinicians will be enhanced as they contribute to aspects of care and the development of medical products, including software. Similarly, thinking from outside medicine is already providing the impetus for massive imaginative leaps in medical thinking through big data, healthcare planning and individual treatments as well as in research and scenario modelling. Astrophysicists and mathematicians are closer now to healthcare than might have been imagined some years ago because of their expertise in very large, complex and hard to understand data and settings. Medicine will become an even more complex field particularly in the basic sciences and their application to healthcare.



Patients must continue to have the right to informed choice around the use of their data. Public trust in technology and AI will be eroded quickly if there is a failure to protect data or to use it in a responsible and transparent way. This will require a new compact between the health services, patients and the public.

Patients, the Public and Doctors

'An equal partnership even within the bounds of differential expertise on both sides'

The relationship between patients and doctors, and also the public and their healthcare, is constantly shifting but doctors are still held in high esteem. The increasing democratisation of medical information and greater awareness on the part of patients brings benefits and challenges.

• The patient–doctor relationship

In 2040, people will still get sick, need a diagnosis, treatment and help and reassurance in understanding the implications of their illnesses and living with a problem. The question is who will be delivering their care?

The human relationship between doctors and patients has traditionally been at the heart of medicine. This relationship will continue to be at its centre, with a high value attached to continuity of care with an individual or team.



We must acknowledge this as an equal partnership even within the bounds of differential expertise on both sides. A competitive or hierarchical relationship will not be conducive to excellent care and is likely to hinder clinical outcomes and the good use of healthcare resources. Patients, as co-producers of their care, will have an increased level of participation in decisions about their care and clinicians will need to continue to enhance their skills in communication as well as in clinical care.

Patients need to be involved and engaged effectively in future planning. Their views should be actively sought, for example by the BMA, the General Medical Council (GMC) and the medical Royal Colleges and fed into overall policymaking to shape the design of medical education. Representation should be automatic on expert panels reviewing NHS staff training and the education of healthcare professionals.

A reoccurring theme throughout the project, as Professor Whitty, Chief Medical Officer for England, phrased it, was that “communicating with people has been, and always will be, at the centre of medicine”.



• Challenges

Patient involvement and engagement may vary between those with different understandings, education and personal preferences and it will be vital not to make assumptions about their capabilities. It may be hard to build a relationship where issues such as language barriers have an impact on patient experience. Accessibility to services can be a problem, as people increasingly face a 'three-bus journey' in rural or deprived communities. Cultural barriers may also delay a patient seeking medical advice and will have a future impact as well. If a patient has a poor experience, they are significantly less likely to return to see their doctor.



In some specialities, a breakdown in the doctor-patient relationship can lead to mistakes being made and may compromise patient safety, for example, in psychiatry where a the substitution of a different clinician, however good, 'is never quite good enough'. There is also the impact of shorter appointments, overrunning clinics, long waiting lists for procedures and investigations that all test the patient's trust of their healthcare professional, the healthcare system, and the continuity and quality of care.

COVID-19 challenged fundamental aspects of communication between doctor and patient, replacing face-to-face contact with video and telecommunication. The lasting impact of this will need to be carefully evaluated. With limited knowledge and treatments we had to be honest and open with patients, do our best to treat them with warmth and empathy, despite the impact of masks and shields and the reality of patients dying in side rooms with only an iPad to say goodbye to relatives.

Trust is the most important aspect of the doctor-patient relationship but must be earned. Transparency is therefore crucial. Many patients, if given reassurance about appropriate safeguards, will trust their healthcare provider and be willing to get involved in health system improvements or share data. However, there are increasing ethical and moral issues associated with the rise of wearable technology, driven by the private sector, and a consequent lack of trust about how data is being used. Computer-led decisions about patient care will increasingly be made with less reliance on clinical experience. As this doctor-patient relationship relies on trust, it is hard to see how it will ever be possible for an intuitive doctor to be replaced by a sophisticated algorithm.



Clinician Wellbeing

'Casualty rates amongst clinicians are high and public and patient expectations become a burden and are compromised'

Improving the wellbeing of the workforce is crucial to the high rates of burnout, early retirements and challenges with recruitment and retention in many specialities. Wellbeing can be notoriously hard to define and measure, making evaluation of interventions challenging. Nevertheless, there is an ethical, economic and patient safety argument to maximising clinician wellbeing.

• Current wellbeing

The current NHS culture adds pressure to clinicians' wellbeing and there is a large and significant gap between image and reality. Working environments and conditions are not conducive to wellbeing. At a technological level, gaps in the availability of data about patients which is often of questionable quality, essentially caused by a lack of connectivity across different parts of the health service, lead to fragmentation and poorer delivery of patient care. The desire to offer a better service while thwarted by system-level factors leads to anxiety and frustration amongst clinicians. From the human viewpoint, the commodification of health workers as a resource has compromised the human element. You cannot deliver caring and effective care if you are compromised yourself. The essential tenets of compassion, empathy and meaningful face-to-face contact can become a burden.

Unmanageable and uncontrollable workload can lead to pathological levels of stress and anxiety – learning to be resilient is hardly a long-term solution. Many clinicians question the value of their vocation.



Added to these factors are financial pressures. Many doctors have chosen less than full time careers, some in an attempt to improve the life-work balance. Those working as locums or in part time or intermittent roles have the additional pressures of financial security, so clearly demonstrated by the COVID-19 crisis when locums found it difficult to retain jobs. A changing pattern in sickness and unemployment cover has exacerbated the situation, with the major cause of morbidity being mental ill health. Interventions often aim to improve personal resilience. This is inappropriate when environmental and systemic factors are impacting wellbeing.

• Future wellbeing

If current trends continue, more clinicians will experience burnout, with negative impacts for themselves, their patients and society. Optimising clinician wellbeing would therefore optimise the health system. There is a strong economic case [2] for ameliorating burnout. The cost of treating it is lower than the cost to the system of continuing to ignore it. In the immediate future simple solutions such as filling rota gaps and ensuring safe staffing levels must be implemented now to improve clinician wellbeing significantly.



To ensure improved clinician wellbeing in the future, health systems will need to align with the increasingly prominent role of technology. Future interventions will be successful only if clinicians are involved in their integration. By optimising teamwork and the impact of other healthcare professionals on the role of the doctor, more cohesive and efficient teams will be better able to deliver for their patients. Moving from reactive to preventative and predictive medicine, in equal partnership with patients, is likely to have a positive impact on job satisfaction.

Emotional wellbeing attracts much attention, but physical wellbeing is equally important, and can be enhanced through technological advances. Technology that is more ergonomically designed can reduce pain or discomfort, be clinically more precise and therefore improve both patient outcomes and the surgeon's wellbeing. Technology that improves efficiency is vital, yet we must avoid the temptation to use it to save time and compel doctors to see more patients, which would have detrimental effects on patient outcomes and doctors' wellbeing.

If current trends continue, more clinicians will experience burnout, with negative impacts for themselves, their patients and society. Optimising clinician wellbeing would therefore optimise the health system. There is a strong economic case [2] for ameliorating burnout. The cost of treating it is lower than the cost to the system of continuing to ignore it. In the immediate future simple solutions such as filling rota gaps and ensuring safe staffing levels must be implemented now to improve clinician wellbeing significantly.



Visionary Leadership

The question for leaders must not be 'what could be better?' but 'what is ideal?'

Leadership during times of change is crucially important. We need visionary role models, exemplary individuals - not only managers - who can effect change collaboratively to be most effective in delivering real improvements. We need to be able to scan the horizon and visualise the future rather than be held back by short term goals which are often a barrier to long term success.

• Current perceptions of leadership

Disillusion and dissatisfaction with current health leaders strongly suggests the need for a new paradigm with an emerging, younger group of leaders. To date the working environment has been underfunded and understaffed against a backdrop of hard-to-manage patient and public expectations. This toxic combination has not contributed to a supportive environment. Junior doctors at the CFM conference highlighted that the workforce is so focused on now that a future vision can be disempowering. Indeed, the fact that currently needed changes are not being implemented is a clear sign of leadership failure. The focus on immediate goals loses sight of long-term value. Target-focused leadership can fail to recognise the value of qualitative elements around workforce management and patient care - 'the humanity in the machine'.



• Challenges

Leaders need to motivate for change and enable others, but system changes are also required to make real improvements. The NHS silo structure and stereotypical thinking prevails with discriminatory and disrespectful cultures and narratives, a reduced emphasis on clinical generalism and medical units maintaining their own 'isms'. It is crucial that we address the controversial issues of defensive medicine and the cost of billions of pounds in clinical negligence and loss of workforce, as well as its impact on collaborative thinking and working. Revalidation procedures, complaints management and a lack of individualised opportunities in professional progress are seen as obstacles when they were not intended to be. There is a sense that the individual is merely a small cog in a system with many moving parts, and that roles and the sense of 'team' is being lost. This will need to change in the future.

Excellent managers, including clinicians, are not necessarily good leaders. The desire to create leaders of the future exists, but engagement by clinicians in innovative, wide scanning thinking is lacking, possibly due to the pressure to prioritise patient care. A new, risk-taking form of leadership is needed, with mentoring and support, replacing the more iconoclastic approaches that can so easily hamper innovation and constructive 'disruptive' thinking. We need to have the support and courage to focus on how to create a culture and approach that fosters long term success rather than short term goals. Instead of 'what could be better?' the question should be 'what is ideal?'. This would help to ensure that resources and processes are used to optimal effect.

• What should future leaders look like?

To prepare for the future, we need to train and foster visionary leadership now, at all levels. Early opportunities for this, including at medical student level, should be utilised to initiate this. Divisional leadership roles in major hospitals are currently determined by trust priorities, such as efficiencies, reorganisations and reactivity, rather than being focused on devising solutions for imminent problems. Future leaders will need to have a different mindset and find ways of capturing the energy of local leadership. We will need to create space for constructive criticism and meet difficulties in new ways, placing greater emphasis on mentorship roles and demonstrating this through examples and feedback around change. This must be achieved without losing the advantages of the economies of scale, the sharing of best practice and reduction in duplication that come with central command and control.

From a public health perspective, it is vital that we become better at teaching medical students about how to have the biggest impact on lifelong health, from maternal and child health to preventative behaviours. If implemented, doctors could play a significant leadership role in changing the environment to reduce the burden of illness. If it does not happen, the risk is that overall health outcomes and inequalities will worsen. As part of this process, we must recreate the sense that students and doctors are part of something bigger - their role is about much more than the service requirements immediately in front of them.

Future leaders should be visionary, reflect the full diversity of the society they serve and colleagues they work with, and comfortable with allowing managed risk and challenges to the hierarchy. They will need to work collaboratively with patients, bringing in expertise from social care, allied health professions and experts outside medicine in order to deliver joined up care. Significant changes to leadership require an effective underlying infrastructure that supports a new way of working. Visionary leaders need legal frameworks, financial resources and the physical spaces to bring about real improvements.



Medical education

'Medical schools' entry criteria should not homogenise future students and doctors...medical education is about so much more than educating in medicine.'

Medical education must evolve and adapt to develop the workforce of the future. With uncertainty around such issues as what the doctors of the future will be doing and how their training needs to equip them for this, the current structure and duration of the curricula, essentially based on a long-standing model, may not be appropriate. Instead, different models of medical education and visionary curricula will be needed to meet these challenges.

• Future vision

Medical education and keeping up to date continue throughout a doctor's career. In the future, training needs will have to be adaptive and not necessarily follow the present duration of years it takes for a doctor to qualify, during which there might have been significant medical advances. The importance of recognising and having insight into individual learning styles will need to be highlighted, as well as the need to adapt to individual and personalised styles of learning. Flexibility will be key and competency-based training must be adaptable and foster a mindset for transferrable skills with a greater emphasis on generalist skills as well as specialisms.

The traditional model of full time learning may need to change to offer greater flexibility in completing a medical qualification, opening the way for previously untapped sources of talent. Encouraging part-time study would enable students to maintain carer responsibilities, work to support their studies or even start-up businesses, which might complement the perspectives they gain through the medical biosphere.

To broaden mindsets and to improve basic medical school training it will be essential to include patients in planning training, providing students with direct insights into the lived experiences of the people they will work with. Intercalation in seemingly unrelated fields such as enterprise and entrepreneurship offer the opportunity to engage future doctors in wider fields to benefit health.

The importance of training people where they are needed will remain an important target and strategies for attracting clinicians to specialities and localities where there are currently shortages will need to be vigorously enhanced.



• Challenges

Some of the challenges with preparing the next generation of doctors come from current pressures on the system. This means that there is often less time for supervision, something that used to be more akin to mentorship and an active part of learning, leading to better team working. Many of the junior doctors at the CFM conference repeatedly brought up the value of mentorship, suggesting it will be a vitally important component with protected time, in the future.

The medical profession itself needs to reflect the population it serves and improve diversity. Entry criteria should shift from a homogenous approach to selection with an open approach based on professional and societal requirements. The timing is right for an open discussion to define the attributes, characteristics, skills, competencies and knowledge that will be required for future doctors even whilst holding on to what we value now.



Concluding points



The Changing Face of Medicine initiative is a part of a wider campaign that engages in open, meaningful dialogue with fellow clinicians and society as a whole.

Thinking about the future is hard and particularly so because the tools we have for thinking are rooted in the present. Our immediate tendency is to try to solve today's tangible problems rather than attempting the far more challenging task of conjuring up the 'ghost of medicine yet to come' that might lie ahead 10 years down the line.

Change may be inevitable but the consequences are not. While there may be comparatively fewer doctors, using their diagnostic and clinical skills appropriately and spending more time with patients may make them less inclined to leave the profession early. Patients, too, will need to adjust to a new way of working with healthcare providers and be actively involved in these changes, together with users and payers of the service.

Interrelated fields such as highly targeted bioengineering for pharmaceuticals will increase in importance. Developments in areas such as genomics are set to have a major impact on the way diseases and disorders are detected early and in the ways they are managed. The emphasis on the individual person is likely to be of significance not only in human terms but in the way medical approaches are more precisely personalised.

In just a few short months, the pandemic has forced acceleration upon us. It has displaced many previous systems and offered a unique opportunity to seize the opportunity to revolutionise how our health system operates. The creativity, new thinking and hierarchical disruption it provides is a platform from which to build boldly. Before this window closes it would seem worthwhile to consider urgently the future of medicine and healthcare, and the future role of clinicians to work out where restructuring and fresh thinking is needed. There has been a paucity of such initiatives in the past.

It is clear that if we continue to operate in the same way, with so much dissatisfaction and so many doctors leaving the profession, we are heading for a crisis. By establishing a formal thinking process for the future, we could avoid being continually caught out by issues that are determined largely by the external environment. The time to act is now – to visualise the future and to prepare for it.

The next steps

There is:

- an urgent and essential need to widen and strengthen these discussions and dialogue with healthcare providers, clinicians and the public to create a greater sense of preparedness for the future
- an imperative for the establishment of a formally resourced continuing commission whose role - critically exploring likely future developments and directions – will inform policy makers, health providers, clinicians and the public and help to shape thinking and decision-making

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Answering the call for action: Academy of Medical Royal Colleges and partners statement, July 2020

The joint Supporting the Workforce statement from the Academy of Medical Royal Colleges and partner organisations reinforces the need for a public commitment to tackling the problems faced by the NHS and care workforce as we move into the next phase of managing the COVID-19 pandemic.

The key issues that it highlights are:

- Ensuring the wellbeing of the workforce through a sustained and coordinated approach if staff are to be retained and remain engaged
 - Increasing the supply of workforce to meet the demand for additional staff
 - Flexible working arrangements and at work facilities to ensure that staff are valued and healthcare careers are seen as attractive and rewarding
 - Building on the innovative ways of working and delivering care so that we are demonstrably effective in tackling COVID-19
 - Recognising the crucial importance of strong, diverse and compassionate leadership at all levels and its importance in creating an inclusive, person-centred culture.
 - Tackling these workforce issues is the best recognition of the hard work and dedication of the NHS during the pandemic and also will be essential if the NHS is to deliver for its patients in the months and years ahead.

Source:

https://www.aomrc.org.uk/wp-content/uploads/2020/07/200703_Supporting_the_workforce_joint_statement.pdf

The CFM conference

The conference, held on February 27th 2020, brought together the Theme Groups and leading clinical, public health experts and lay people to consider how the medical future might evolve.

Guest speakers included:



Professor Chris Whitty
Chief Medical Officer for England



Professor Sir Mark Caulfield
Chief Scientist for Genomics England



Dr Jocelyn Cornwell
Founder of The Point of Care Foundation



Professor Derek Alderson
President of the Royal College of Surgeons



Professor Sheona MacLeod
Health Education England (HEE)

Presentations were also made by the Theme Group leaders:



Dr Charlie Bell
Medical Education
Theme Group



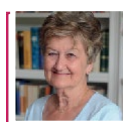
Dr Joseph Butler
Clinician Wellbeing
Theme Group



Dr Sunny Raju
Leadership
Theme Group



Dr Lily Lamb
Leadership
Theme Group



Dr Patricia Wilkie
Patient/Public-Doctor
Theme Group



Dr Gursharan Johal
Patient/Public-Doctor
Theme Group



Professor Mark Wilson
Technology
Theme Group

Programme: The Changing Face of Medicine Conference, 27th February 2020, held at The King's Fund, London.

Morning session

Introduction: Professor Pali Hungin, Lead, the CFM Commission

Chair: Professor Michael Farthing, Honorary Professor of Medicine, UCL

Presentations:

'Surgeons and surgery: a vision for the future.' Professor Derek Alderson, President, Royal College of Surgeons

'Medical education – what's in the pipeline?' Professor Sheona MacLeod, Health Education England (HEE)

Deputy Medical Director for Medical Education Reform.

'The work of the Medical Education Theme Group.' Dr Charlie Bell, Fellow, Girton College

'Patients, the public and medicine: a vision of the future.' Dr Jocelyn Cornwell, Founder, The Point of Care Foundation

'The work of the Patient/Public-Doctor Theme Group.' Dr Patricia Wilkie, President, National Association for Patient Participation (NAPP) and Dr Gursharan Johal, NIHR Academic Clinical Fellow in Psychiatry, University of Manchester

Afternoon session

Chairs: Professor Debbie Cohen and Professor Pali Hungin

Presentations:

'Genomics, medicine and the public – a vision for the future.' Sir Mark Caulfield, Chief Scientist Genomics England

'The work of the Clinician Wellbeing Theme Group.' Dr Joseph Butler, Junior Doctor in Psychiatry and Dr Richard Stevens, Co-convenor, The CFM

'The work of the Technology Theme Group.' Professor Mark Wilson, Consultant Neurosurgeon and Pre-Hospital Care Specialist, Imperial College.

'The Wesleyan's perspective.' Mr Peter Laycock, Wesleyan Financial Services.

'The work of the Leadership Theme Group.' Dr Sunny Raju, Academic Clinical Fellow in Research and Dr Lily Lamb, NIHR In Practice Fellow, Newcastle University, Chair RCGP, NE England.

'A future vision of health and the role of doctors.' Professor Chris Whitty, Chief Medical Officer for England.

Conference participants

Ms Erika Aldridge
Dr Miriam Armstrong
Dr Granger Avery
Dr Shehla Baig
Dr Charlie Bell
Professor Dinesh Bhugra
Dr Pallavi Bradshaw
Dr Daniele Bryden
Dr Michael Burdon
Andy Burgen
Dr Joseph Butler
Dr Rachel Chall
Dr John Chisholm
Dr Rachna Chowla
Mr Barry Clare
Professor Debbie Cohen
Mary Cooke
Dr Simon Cooper
Dr Jocelyn Cornwell

Mr Steve Crone
Dr Richard Cruttenden
Dr Amy Dehn Lunn
Dr Mike Dilkes
Dr Arosha Dissanake
Ms Kathy Evans
Professor Michael Farthing
Professor Dean Fathers
Ms Alison Firth
Dr Simon Fleming
Mr Rob Fleming
Mr Paul Forder
Dr Antony Garelick
Ms Emma Georgiou
Professor John Gillies
Mr Ed Godber
Mr Richard Gold
Professor Anne Greenough
Dr Claire Greszczuk

Dr Sarah Hallett
Dr Adam Harvey-Sullivan
Professor Pali Hungin
Mrs Barbara Hungin
Professor David Hunter
Dr Rose Jarvis
Dr Gursharan Johal
Professor Roger Jones
Dr Stania Kamara
Ms Pauline Kent
Professor Mayur Lakhani
Dr Lily Lamb
Mr Peter Laycock
Professor Sheona MacLeod
Dr Alison Moulds
Dr Anthea Mowat
Dr Sarah Muldoon
Ms Helene Mulholland
Dr Chaand Nagpaul

Dr Zaid al-Najjar
Dr Lisa Newton
Ms Emma Peters
Ms Charlotte Phillips
Dr Suneil Raju
Dr Charlotte Refsum
Dr Shivan Sivakumar
Mr Sandy Starr
Dr Richard Stevens
Dr Simon Stockley
Dr Caroline Walker
Ms Henrietta Wallace
Professor Valerie Wass
Dr Jeeves Wijesuriya
Dr Patricia Wilkie
Mr Andy Wilkins
Ms Victoria Woods
Ms Sabrina Tambini

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Dr Bea Bakshi
Dr Charlie Bell
Professor Dinesh Bhugra
Dr Pallavi Bradshaw
Dr Joseph Butler
Dr Robert Carter
Dr Rachel Chall
Dr John Chisholm
Professor Debbie Cohen
Mr David Cole
Dr Simon Cooper
Dr Jocelyn Cornwell
Ms Olamide Dada
Dr Paul Darragh
Professor Michael Farthing
Professor Dean Fathers
Professor John Gillies
Mr Ed Godber

Dr Fiona Godlee
Mr Richard Gold
Ms Sandra Gower
Dr Claire Greszczuk
Dr Sarah Hallett
Mr Alastair Henderson
Dr Gary Howsam
Professor Pali Hungin
Professor David J. Hunter
Ms Gemma Jackson
Dr Gursharan Johal
Dr Dominic Johnson
Mr Alan Karthikesalingam
Ms Olivia King
Professor Mayur Lakhani
Dr Lily Lamb
Mr Peter Lees
Mr Phil Martin
Professor Jane Metcalf

Dr Anthea Mowat
Dr Zaid al-Najjar
Dr Zoe Norris
Ms Emma Peters
Dr Katie Petty-Saphon
Dr Suneil Raju
Mr Gurdas Singh
Dr Richard Stevens
Dr Judith Tweedie
Dr Caroline Walker
Mr Chris Walker
Ms Henrietta Wallace
Mr Dan Wellings
Dr Chandu Wickramarachchi
Dr Jeeves Wijesuriya
Dr Patricia Wilkie
Mr Andy Wilkins
Professor Mark Wilson
Dr Guy Yeoman

Acknowledgements

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