1. The College welcomes the opportunity to respond to the questions posed by the Royal College of Physicians’ Future Doctor Working Party on the Role of the Future Doctor. We have asked our members to respond to questions 1 to 3 from the perspective of a general practitioner and to question 4 from the general perspective of a doctor. We have also provided a general introduction which we hope the working party will find helpful.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the ‘voice’ of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 36,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. To try and predict how the role of the doctor will change over the next 20 years, we need to examine current patterns, trends and expectations and consider how these might interact with wider societal and global developments.

Drivers of change

4. There are several identifiable drivers of change and underlying trends in health and the delivery of healthcare which can be identified. People are living longer, meaning that the provision of care for patients, especially those with co-morbidities, will become increasingly complex. Whilst some evidence would suggest that the health inequalities gap is declining, there are still unhealthy trends, such as smoking and obesity, which continue to disproportionately affect lower socio-economic groups. Often these groups are not vocal about their healthcare needs and do not engage in the system. On the other hand, there are sections of the population who are increasingly vocal about their healthcare needs and demand high quality services which fit around their lifestyle. The RCGP has responded to great expectations around choice and quality of treatment by leading on the development of CPD systems, the revalidation of GPs and the accreditation of practices through the Primary Care Provider Accreditation Scheme. We want quality improvements in general practice to benefit all sections of the population.

5. We anticipate that the current trend of services moving closer to patients’ homes will continue. This will be facilitated by the continuing integration of services between primary, secondary and social care. There will be an increasing need for healthcare groupings which give primary and personal care while providing rapid testing diagnostics and ambulatory management. We believe that testing in a community setting will allow
GPs to confirm diagnoses without referral to specialist centres. The RCGP’s Federated model\(^1\) brings GP practices and the wider primary care team together in an association to provide care in a community setting as well as offer some of the services which have previously been provided through secondary care, including diagnostics. Consequently, it will be necessary for generalists and specialists to collaborate to ensure that care is delivered safely and effectively. This is illustrated in Teams without Walls\(^2\), a document jointly produced by the RCGP, the Royal College of Physicians (RCP) and the Royal College of Paediatricians & Child Health (RCPCH) which describes an integrated model of care, where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local clinicians. We also believe that technological advances will move care closer to patients by allowing them to monitor their own long-term illnesses and adjust their treatments.

6. Resource pressures will continue and the government will have to seek the most cost-effective way of delivering high quality healthcare. Evidence suggests that investment in primary care is the most cost-effective way of keeping a population healthy. We need to concentrate on doing the basics through primary care rather than focusing on secondary care. Primary care should play a key role in prevention and health promotion. A holistic, joined-up approach to care is essential.

7. We must also consider wider patterns of change. Globalisation will impact upon workforce and will serve to create wider health economies, where patients may opt to travel to other countries to receive treatment, which perhaps may be funded by their own health system. Global warming will introduce diseases, such as malaria, to new areas and present challenges not experienced before. Immigration will continue to present us with populations who have specific health needs as well as cultural barriers which will need to be overcome.

**How will the role of the GP change?**

8. The role of the generalist will become increasingly important. The changing demography of the population will increase the complexity of treatment as more and more patients experience co-morbidity. The College believes that both continuity of care and the close therapeutic relationship between doctor and patient will be essential to deliver the holistic and high standard of care that these patients will require. The future GP will need to be well equipped to deal with ageing populations as well as increased ethnic diversity. As well as needing more time to carry out consultations, they will need the confidence and skills base to deal with the complexity of care which they will be required to deliver. It is for this reason that the RCGP argues that the length of GP training should be extended from 3 years to 5 years, to put it on parity with other specialties and GP training requirements in other countries.

9. We anticipate that GPs will become the lynchpin of Federations. We anticipate that GPs will increasingly take on a commissioning role through Federations and they will use their local knowledge to commission patient-centred, locally appropriate services. We hope that GPs will be able help tackle health inequalities through the commissioning of services which are appropriate for particular sections of the population. We also hope that GPs take back the commissioning role for Out-of-Hours (OOH) care, which we feel has not been carried out effectively in recent years. GPs will need to increase their skills

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\(^1\) Primary Care Federations – putting patients first - published by The Royal College of General Practitioners (June 2008)

\(^2\) Teams Without Walls – the value of medical innovation and leadership - jointly published by The Royal College of General Practitioners, The Royal College of Physicians & The Royal College of Paediatrics & Child Health (April 2008)
in community level planning and commissioning, whilst simultaneously retaining a focus on the needs of patients and their families.

10. GPs will increasingly work in partnership with patients. Patients’ expectations of their involvement in their healthcare will increase and the idea that ‘doctor knows best’ will continue to be challenged. GPs will have to work hard to preserve the respect of their patients and GPs and patients will need to work together in a 1:1 relationship based on mutual respect and trust.

11. To provide high quality joined-up care, we believe that boundaries which hinder effective collaboration between health professionals must be removed. As outlined in Teams Without Walls, we believe that hospital and community teams should merge to ensure that “patients see the right person, at the right time, in the right setting.” We also advocate a jointly commissioned model of integrated health services provided by primary and secondary care working together.

12. We envisage that GPs will increasingly assist patient navigate through a care pathway that has been specifically tailored to them. We also believe that the evolution of technology and greater public health awareness will allow patients, especially those with long-term conditions such as diabetes, to manage their own conditions, with appropriate support from health professionals.

13. The move of emphasis to prevention will continue and GPs will increasingly play a key role in health promotion and screening. They will become increasingly active in terms of identifying ‘at risk’ groups and responding appropriately, quite possibly through their commissioning function.

14. We believe that GPs and other medical professionals will develop specialist interests in clinical areas, which will serve to diversify expertise within the professions. We also anticipate that GPs will take on more acute emergency roles, such as that which may be required in a flu pandemic, an environmental disaster or a major security threat.

Answers to specific questions in the document:

**Section 1: How is society set to change over the next 20 years?**

*What will health needs be?*

15. We anticipate that there is likely to be an increase in mental health problems, obesity, diabetes, alcohol-related illness, sexually transmitted disease, illness related to substance misuse and illnesses relating to stress.

16. There will be better and earlier detection of some chronic illnesses, such as diabetes and chronic kidney disease and therefore increased healthcare needs for this patients.

17. There is likely to be an increase in the prison population from between 83,300 and 85,100 in 2009 to between 83,400 and 95,800 in 2015. There is therefore likely to be an absolute increase of the following illnesses in that population: mental health problems, substance misuse problems and illnesses associated with drug misuse, e.g. mental health issues, Deep Vein Thrombosis (DVT), Hepatitis C (HCV), Hepatitis B (HBV) and HIV. The quality of healthcare in prisons remains an issue, and the RCGP

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has two groups dedicated to improving healthcare in prisons: The Secure Environments Standing Group and the Substance Misuse Standing Group.

18. Reduced levels of exercise and poor diet will lead to increased rates of both obesity and diabetes. We therefore, as a society, need to encourage more exercise and make it more widely available on prescription.

19. Health care needs will reflect demographic changes. An ageing population will present more complex health needs as many patients will suffer from co-morbidity, the presence of several conditions simultaneously. To provide effective treatment for these patients we must make sure that the close long-term therapeutic partnership between GP and patient is preserved and that a range of services are available close to home in a community setting. It is important that GPs will be able to provide holistic care, particularly for those with co-morbidities. We must therefore ensure that measurement tools, such as the Quality and Outcomes Framework (QOF) are modified to take account of all aspects of patient health, and do not focus exclusively on single-disease states. We must ensure that risk and uncertainty in patients are managed appropriately, and ‘tick box’ and ‘protocol’ medicine do not result in unnecessary intervention and treatment, resulting in side effects and complications.

20. There will be greater demand for information for patients, available verbally, through Patient Information Leaflets (PILs) and on the web. Information in languages other than English will need to be available on the web and in surgeries where there is a high ethnic minority population.

21. The RCGP curriculum and the extension of GP training from three to five years will help to prepare GPs for the increasing complexity of illness that they will face. GPs will have to work hard on their Continuing Professional Development (CPD) to keep pace in society and we foresee that there will be greater specialisation in primary care. GPs will play a greater role in prevention, and health promotion will become a more prominent aspect of their day-to-day activities.

22. New technologies will be available such as genetic information and nanotechnology. Whilst providing new ways to treat, manage and prevent disease, they will also serve to create new needs and increase public expectations. Governments will be under pressure to manage resources in the face of these new demands. We fear that this may result in less and less treatment being available on the NHS.

What will change?

23. The population will live for longer. This will present a significant shift in health needs, as described above in paragraph 19. More care will have to be delivered in a community setting, particularly because significant sections of the population are likely to become less mobile and less reliant on private car ownership. Primary Care Federations will serve to ensure that a variety of services are available to patients close to their homes.

24. Evidence suggests that the gap between rich and poor in Britain narrowed between 2000 and 2005\(^4\). However, the country remains one of the most unequal in the world and further action is required to tackle wealth inequality, particularly because this impacts upon the health of the population. Whilst consumerism is likely to continue, we anticipate that, unless coordinated action is taken to address the situation, the divide between the “haves” and “have nots” in terms of health outcomes will persist.

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25. More effective medicines and treatments will become available. These will be required by more and more patients, resulting in increasing cost to health systems. Rationing of healthcare is a possibility. We believe that this should be avoided but, if it were to occur, there would have to be a national debate and patients would have to be involved in drawing up the basic criteria. Such a situation could lead to an increase in the use of private healthcare by the more affluent sections of the population. The government will have to manage expectations appropriately, and politicians will have to be open and realistic with the public about the finite nature of resources. Pressure on health services might be increased by population growth – however, a higher population might also generate more economic resources to spend on healthcare.

26. There is likely to be an increase in ethnic minority populations. Primary care will have to adapt to meet the specific health needs of these populations and ensure that services are accessible and that barriers, such as language, are minimised.

27. We might experience changes due to climate change, which could result in the migration of malaria and the introduction of other new diseases.

28. Genetic screening will become increasingly available, possibly even from birth. It might become compulsory and impact upon housing, insurance and employment. In addition to the increased demand on services that screening may generate, it is also likely to bring considerable ethical challenges as well as uncertainty for patients. Genetic screening will not be the answer to all our health needs – as one commentator has suggested, all types of screening can show up “good spots, false positives and false negatives.”

29. We might witness increasing government control on lifestyle change. This has occurred recently with the smoking ban in pubs and restaurants, and it could extend to areas such as sexual health.

30. One or two commentators anticipate an increase in government control on the GP profession. Whilst the College believes that QOF and Revalidation will improve patient care, a minority believe that they simply amount to government protocol. The College believes measures to improve health care should be professionally led rather than dictated from Whitehall.

31. Doctors are likely to find that their profession is increasingly influenced by European Government. The European Working Time Directive (EWTD) is a recent example of how workforce patterns may be affected by legislation made outside of the UK.

32. We predict that there will be more nurse practitioners and physicians assistants.

What will stay the same?

33. Patients will continue to expect to be able to consult a GP about any symptom they are worried about. They will expect their GP to respond to any problem that impacts on their health and provide life-long care for the whole family. We also believe that the medical profession, including GPs, specialists and other health professionals, will remain determined to deliver care humanely and equitably.

What will the science be that underpins medicine in 20 year’s time?

34. We expect to see more evidence-based medicine; more genetic medicine; more qualitative as well as quantitative research; more awareness of consulting skills
research, including research into models of consultation which lead to more patient- 
centred care; more use of Information Management and Technology (IM + T) in the 
delivery of health care; potentially more template or “tick box” based medicine, which will 
ensure that chronic diseases are monitored effectively, but may not successfully 
enshadow all aspects of patient care.

35. The limits of science may become more apparent. For example, more emphasis may be 
placed on the importance of communication and empathy, particularly in the context of a 
patient consultation.

36. We must ensure that all research protects the dignity of human life. There is likely to be 
intense debate about whether some types of research do so.

What will be the significance of globalisation?

37. We are likely to see more patients from more ethnic groups and an increase in cultural 
variation. This will present language barriers and there will be differences in healthcare-
seeking behaviour. We may see a wider variety of conditions, including infections 
aquired abroad. We need to prepare for this, with enhancements to infrastructure and 
proved knowledge of ethnic variations in incidence/prevalence, of likely response to 
rious treatment modalities and of cultural traditions (e.g. vitamin D deficiency is very 
common in Somali patients who wear head coverings).

38. We might also see a world market in health professionals, driven by prosperity and 
demand. This could potentially have negative consequences for less well-off countries, 
or those which try to ensure that health is delivered on an equitable basis.

What impact will an ageing, dependent population have?

39. We should be positive in the sense that we are going to be living longer. However, an 
aging population will have an enormous impact and we need to prepare now. We 
require the following: improved professional awareness; more timely diagnosis of 
dementia; Advanced Care Planning (ACP); more safeguarding measures to prevent the 
use of adults; and more effective management of co-morbidity in the primary care of 
older people. GPs will need to develop Care of the Elderly and Palliative Care expertise 
and be prepared to undertake more home visits. There will be an increased demand on 
Out-Of-Hours services and more joined up working will be required between primary and 
secondary care, social services and community organisations. We should consider 
whether there should be government funding for organisations such as Age Concern 
which provide a lot of the infrastructure to support the ageing population.

40. To effectively manage co-morbidities, GPs will have to move away from disease and 
medically orientated models of care and embrace traditional, holistic models of care. 
Some commentators fear that future GPs run the risk of losing these skills in a target or 
disease focussed model of primary care.

41. A nightmare scenario would be a utilitarian approach to the care where elderly life will be 
seen as dispensable and euthanasia encouraged.

What impact will immigration and changing cultural norms have?

42. See paragraph 37. We need to emphasise how patients and their values impact on the 
consultation. As explained in the RCGP curriculum, high quality patient-centred care
requires the need to understand a patient within the context of their own culture but also to see that person as an individual, rather than simply a product of their culture.

43. We are likely to see patients with different health-seeking behaviour, health beliefs and language barriers. There might be restrictions on certain therapies due to cultural beliefs, such as care in prescribing non-steroidal anti-inflammatory drugs (NSAIDs) to patients fasting during Ramadan.

**What will the role of the doctor be as an agent of government?**

44. GPs will have to continue to comply with government policy but must be very vocal when that policy could potentially harm patient care. The RCGP has expressed its views recently on issues such as “polyclinics”, the Choose and Book system and the security of the NHS data spine.

**What will be the relationship between medicine and elements of knowledge – ‘medicine is more than the sum of its parts’**

45. Hopefully medicine will not become too reductionist and the less tangible or “artistic” sides of medicine will continue to be recognised: consulting skills, caring, compassion, interpersonal skills, a non-judgemental and non-prescriptive approach and sensitivity to cultural differences. It is important that policy makers are made aware of the importance of the consultation, and that training GPs are exposed to the experience they need to enable them to develop the clinical wisdom needed for practice.

**Section 2: How are patients’ expectations likely to change over this period?**

**How would you describe the spectrum of patients’ needs and expectations?**

46. An ageing, multicultural population will mean the need to provide health services nearer to peoples’ homes, and the RCGP Federated model is well placed to provide this. There should be improved public transport infrastructure and services that are friendly for patients from ethnic minorities to use, including interpretation services on site as well as over the telephone, advice on one site in the health centre (with interpretation facilities) on benefits, support in asylum applications etc. Car parking needs to improve at some health centres and a wider range of services, e.g. simple radiology, Out-of-Hours services, should be provided nearer to patients’ homes, perhaps in “Darzi” centres. However, the way in which Darzi centres are being established in every PCT without careful planning or assessment of need risks destabilising some local practices, often small ones. This is cause for profound concern, especially given the changes in society anticipated above and the need for healthcare to be provided nearer to patients’ homes, especially the elderly.

47. There will need to be longer appointment times for all patients, especially for increasing numbers of patients with language difficulties and with complex medical problems. The President of the RCGP, Professor David Haslam, called last year for consultation times to be extended so that the patient’s agenda and the QOF can both be dealt with comprehensively. This would obviously have enormous implications for staffing levels, the recruitment of extra GPs and the financial resources needed. However, this would be no bad thing, since there are a very large number of young GPs entering the profession who currently have no work.

**What do we do when the medical profession in unable to provide the care that people require?**
48. We need to act as advocates. The needs of many patients are often social and they lack a support network, including family and friends to care and support them. There needs to be better signposting to other services that can help. GPs need to be better educated about other statutory and voluntary services in their locality, as well as self-help groups, web-based support, suitable reading etc. There particularly needs to be better support for people with that misnomer condition “minor” mental illness. This is, in reality, a devastating problem, which impacts so much on every aspect of people’s lives and health, yet resources are far outstripped by demand. This is a priority area for improvement.

How does patient access to knowledge and technology impact on the role of the doctor?

49. Patients have increased access to information, although the information that they do have access to is not necessarily accurate. Greater patient access to reliable information supports shared decision making, which as a College we support. We believe, however, that at present health literacy is currently lacking and that the popular media could do more to disseminate accurate health information.

What will the impact of personal behaviour be on health?

50. There is likely to be an increase in the following illnesses related to personal behaviour: obesity (and hence diabetes) due to lack of exercise, alcohol-related illness, sexually-transmitted disease and illness related to substance misuse. In turn, many of these may cause mental health problems.

51. Unfortunately it must be recognised that even the best informed patient may still choose behaviour with adverse affects. We need to think carefully about what directs behaviour and use health literacy and/or social marketing techniques to empower people to consider the relationship between certain types of behaviour and the long-term consequences. There are, of course, ethical considerations with regards to how much power society should have over certain aspects of an individual’s behaviour.

What is the role of the doctor in this circumstance?

52. The GP should do their best to listen to the patient, offer the best treatment available and offer advice in a non-judgemental manner. They should work with the patient to change the behaviour concerned, either by stopping it or minimising its harm. However, while the consultation is very important, public health plays perhaps a more significant role in information giving, education giving and supporting population change.

What are the relationships between healthcare and society?

53. The relationship is profound. In addition to societal activities impacting on health (as detailed below), a health care system is an exemplar for and an expression of society’s values in relation to caring and equity.

54. Work stress (partly through overwork, antisocial working hours and the effects of employment legislation), crime levels, poverty, an aging population, more people from ethnic minorities, drug misuse, sexual behaviour, drinking habits, over-eating, lack of exercise, sedentary occupations and sedentary leisure time, the media and other sources of social pressures (for example to be slim and regarding sexual activity) have a very profound effect on health and on the healthcare needs of the population. Action by government to bring greater awareness to the public of the dangers of some of these social changes needs to keep pace with those changes. Poverty has a devastating effect on health and Government needs to do even more to tackle the evils of poverty at all
ages, not just in childhood and the elderly. GPs who profess to provide holistic care must be very concerned about the social problems discussed at the beginning of these comments, all of which impact profoundly on health, and we must speak out about the need for change.

*What do we expect of our healers?*

55. We expect our doctors to be acting primarily in the interests of the patient rather than to maximise income. They should be compassionate, clinically competent, and have good listening and empathy skills. We expect appointment times that are adequate to deal properly with all issues that impact on the health of the patient (and not just those that are strictly medical), and the ability to see the doctor of choice as far as is reasonably possible. We expect real continuity of patient-centred, holistic care for the whole family, as well as emotional support, respect for confidentiality and advice on all health-related matters. We expect our doctors to be advocates in all matters relating to health.

*Who is going to be the voice of patients?*

56. We believe that doctors should work in collaboration with patient representative groups including, for example, the RCGP’s Patient Partnership Group, to be the voice of patients.

**Section 3: Where is the medical profession now (and what are the trends before deciding where we want to go)?**

*What form of profession would best accommodate to a changing society?*

57. We believe that primary care will play an ever greater role in responding to challenges of the future. To address the health needs of population effectively, we believe that GPs must reaffirm their traditions and values (compassion, integrity, patient-centred care etc), particularly in the face of recent media criticism. GPs need to firmly re-establish themselves as the ‘caring profession’, so that they are well placed to deal with the increasing demands of an ageing and multi-ethnic population. The GP workforce will need to be much larger than at present, with probably increased numbers working part-time (especially young women who want families) and with longer consultation times. The issues of a growing number of salaried GPs will need to be addressed and unless fulfilling and rewarding work is found for all these doctors, they will go and work for private companies or go abroad.

58. GPs must adapt to changing needs and focus their Continuing Professional Development accordingly. Organisations, such as the RCGP, must continue to support GPs expand their knowledge and enhance their skills base.

*What is the room for manoeuvre for determining the future role of the doctor?*

59. GPs and others in the medical profession must continue to guide government policy.

*What levers of change do we have?*

60. One of the most critical levers of change that we have is the knowledge that patients have of the value of traditional models of care delivery.

*Will the role of the doctor impact on inequalities or will inequalities impact on the role of the doctor?*
61. Tackling health inequalities also requires strategic planning and change at societal or community level and the medical profession must be fully engaged with this process. As explained in the RCGP’s Addressing Health Inequalities publication, GPs can use their knowledge of their patients and the local area to influence service delivery in order to reduce health inequalities, particularly through their commissioning role. We hope that this will become commonplace when increasing numbers of practices join Federations, which will use their commissioning role to identify local need and commission services which are appropriate to the local population.

**What are the boundaries of the medical profession?**

62. Doctors should be prepared to help in any matter that affects health, including making representations to government. Doctors should operate within legal and ethical boundaries, as stipulated by the General Medical Council, and not use patients for the gain of either themselves or others. As historical events have demonstrated (the Holocaust) doctors have sometimes crossed the boundary of seeing one person’s life as being of less value than another’s.

**Who will be the doctors in 20 years’ time?**

63. The doctors in 20 year’s time must be people who can demonstrate the combination of sound clinical knowledge and skills with caring, compassion and patient advocacy.

64. We might have more overseas doctors.

**What will they expect?**

65. They should expect a good remuneration for a highly skilled and demanding job, to be treated fairly by government and colleagues, to have fair contracts, terms and conditions of service and to have adequate paid and protected time for study and other work-related activities. They should expect the respect of the public whom they serve.

**Section 4: What are the implications for the role of the doctor?**

**What will the relationship/overlap be with surgical/physician assistants?**

66. Physician assistants should not be seen as substitute doctors. There should be boundaries based on the complexity of the tasks undertaken and the level of accountability of the two roles.

**What will the specific nature of the different roles within the team be?**

67. The rise of the nurse practitioner and the many courses for them increasing their areas of competency, are welcome. However, they should be seen as supplementing, rather than substituting for, doctors. They certainly have a very valuable role to play in triage, treating minor illness and running health promotion and chronic disease management clinics. We are likely to see nurse practitioners seeing a wide range of minor illnesses that were previously dealt with by GPs, and the workload of the GP is likely to become more complex.

**In 20 year’s time will doctors still be the leaders of the health care system/team?**

68. Yes, but only if they work hard to maintain and deserve that position of respect.

**What will the implications be for education and training?**
69. Education in dealing with different ethnic groups and their cultural norms and in elderly care will need to be prioritised in the curriculum. Education and training in the management of chronic disease (especially diabetes), terminal care, sexual health, substance misuse, mental health disorders, and obesity will need to occupy a larger percentage of the curriculum than has been the case so far.

What distinguishes a doctor from others professionals working in healthcare?

70. All members of a clinical team are essential to deliver high quality patient care. However, a doctor is expected to attain a higher level of skill through more difficult and prolonged training, involving the study of all aspects of human anatomy, biochemistry, physiology, pharmacology and morbidity. The role of the doctor is that of accurate diagnosis and effective management, whereas clinical assistants have a different skills set in order to carry out triage and operational follow-up. Doctors are expected to manage a greater level of complexity and uncertainty as well as handle more knowledge and apply this in the interests of patients. Doctors are also required to retain core attitudes and values despite, in some cases, pressure to put them aside.

Dr Maureen Baker
Honorary Secretary of Council