The Global Role of the Doctor in Healthcare

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Abstract
Medical care is deficient in many parts of the world, while in richer countries the costs and complexities of health care are rising unsustainably. Thus, societies need to understand what it is that only doctors can do and what can or should be done by other members of the healthcare team. The duty of doctors to examine their accountability to society as a whole is critical, in order not to continue blindly to do what has always been done. We argue that doctors may not need, in the future, to undertake all their traditional roles, while other new roles may emerge instead. A synthesis of these elements is necessary to propose a policy and philosophy for the future global role of the doctor. Only when we have defined this, is the stage set for medical education to produce a person equipped to fulfil that role.

Keywords: global health, internationalization, medical practice, medical education, professionalism, society, social accountability, healthcare

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Introduction

Medical sciences, and our knowledge of the practice of medicine, are advancing at an ever-increasing rate. However, medical care in many parts of the world is deficient; nothing (not even biomedical science) can continue to grow without limit; resources to support medical care are always finite; and we have to plan for a world that will be socially and environmentally very different from the world we know now. This requires an examination of what doctors are for and what doctors will do in the future.

Background: What is the Need for Redefinition of the Global Role of the Doctor?

Political Pressure and the Changes in Medicine

The changing political and social setting in which medicine is practised, and changes in healthcare systems around the world, create pressure for the work of doctors to be reviewed. In developed countries, the costs and complexities of health care are rising unsustainably, with a breakdown in provision of universal health care, even in some of the world’s richest countries.¹

The nature of medicine—medical knowledge and medical technology—has changed in such a way that tasks that were previously complicated or unpredictable, and required unusual skill from a doctor, can now be done by the less medically skilled, or even better by other members of the healthcare team with more adequate competence. Equally, new knowledge and techniques are developing that require ever higher levels of sophisticated expertise. Professional groups other than doctors are interested in doing more than they have in the past.

The role of the doctor has changed from being the only healthcare professional involved in decisions concerning diagnostic and therapeutic procedures in the individual patient, based on face-to-face meetings between doctor and patient. Today such decisions are made by several members of the healthcare team, often supervised by the physician, normally together with the patient. The nature of this shared role for the doctor in the healthcare team depends on the number of doctors available in the specific

society or region, the relative wealth or poverty of that society, and the main healthcare problems that are to be found there.

The Social and Economic Role—and Social Accountability—of Doctors

Societies need to understand what it is that doctors (and, primarily, only doctors) can do, and what can or should be done by other members of the healthcare team. Is there a real shortage of manpower in the healthcare system? In particular, is there a shortage of doctors, as we generally understand this role? What are different members of the healthcare team doing and what people do you need? How should the health workforce be planned (if such planning is ever possible) and what can be afforded?

The duty of doctors to examine their accountability to society as a whole is important, because without such an autoanalysis the profession may blindly continue to do what it believes has always been done. This analysis particularly includes the cost (both financial and other costs) of medical actions and interventions. Medical interventions that prolong life may have profound repercussions not only for the patient but also on the patient's family and on society at large. Do doctors adequately examine the effects of the costly treatments they use on the total resources available for health care?

Doctors have often been resistant to change. For example, when the U.K. National Health Service (NHS) introduced universal health care, free at the point of delivery, in the United Kingdom in 1948, many doctors were among the strongest opponents of the change: when, decades later, the NHS was perceived as being at risk, doctors collectively had become one of its strongest champions. Although reform of the healthcare system was clearly necessary in the Czech Republic in the early 1990s, and doctors were among the strongest supporters of reform, doctors were also one of the most vocal groups opposing reform once specific reforms were proposed.

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2 For a review of the main part of this literature on role substitution, see Laurant, M. et al., “Substitution of Doctors by Nurses in Primary Care,” *Cochrane Database of Systematic Reviews* (2004).
The Need for Medical Education to Know What it Should Do

A particular need for redefinition of the role of the doctor comes from education. Only when we have defined what the role of the doctor should be can we define the content and processes of medical education necessary to produce a person equipped to fulfill that role, and with the ability to use continuing education and professional development to meet that role as it evolves in the future. Medical education has a regrettable history of producing doctors fit for the past—and perhaps for the present—but not for the future.

The definition of the role of the doctor is a necessary step in order to build the most effective education, from undergraduate to postgraduate. Standards for evaluation of quality and accreditation, such as the World Federation for Medical Education (WFME) standards, and comprehensive and accessible information about standards in medical schools (as will be found in the Avicenna directories), are ways that go toward ascertaining that education worldwide is of an acceptable standard and also recognized. (WFME is the global organization concerned with the education and training of medical doctors, with a stated mission "to strive for better health care for all mankind through the highest scientific and ethical standards in medical education." WFME manages the Avicenna directories.) "Standards" in this context include standards not only for practice but also for ethical, professional and standards of responsibility to society. Within Europe, the Tuning project has developed proposals for learning outcomes and competences for primary medical degrees.

This also relates to the demography of doctors (discussed below), so that doctors from poorer countries educated in the richer ones do not meet unnecessary obstacles if and when they choose to return to serve their home countries. The definition of role, and clear standards, may be an effective way to help increase the number of physicians active in poorer countries and may even turn the direction of net flow.

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7 Avicenna Directories: Global Directories of Education Institutions for Health Professions. Available at: http://avicenna.ku.dk/.
The Demography of Populations and of Doctors

The present net flow of doctors and other healthcare professionals from poorer to richer parts of the world puts even stronger emphasis on the need to define the tasks that can only be performed by doctors, and to define those that can be performed by other members of the healthcare team, albeit often supervised by doctors. This allows flexibility concerning how care is delivered, but still maintains the definition of specific tasks that can only be carried out by an educated medical doctor.

In richer countries, rising healthcare costs make it necessary to analyze critically the number of doctors needed (and the costs of providing education and employment for those doctors) and other healthcare costs such as for diagnostic and therapeutic equipment, drugs, and so on. The ever-increasing number of doctors employed in richer countries continues to swell the brain drain from poorer countries. This means that, with the generally agreed principle of free migration of individuals in the world, the most effective way to contribute to reduced net flow of doctors from poorer countries might be to limit the number of posts for doctors in the richer countries to what is strictly necessary, by a careful definition of the roles that doctors, and only doctors, can fulfil in the healthcare systems of these richer societies.

The Internationalization of Medicine and of Medical Schools

These demographic changes mean that we must use the opportunity given by redefining the role of the doctor better to understand what we intend by “internationalization” in medical education. Internationalization of medical education must surely imply a social contract between richer and poorer countries, a bilateral long-term agreement between the parties involved that will benefit all and assist the development of society and healthcare systems in the poorer partners to the agreement.

It might mean that richer countries should educate more doctors than are required for their own needs, to help supply doctors for service in poorer countries, as well as measures being taken to strengthen the healthcare and educational systems of poorer countries, to allow them to educate and retain adequate numbers of health professionals.

In summary, the background to this question has political, medical, social, economic, educational, demographic, and moral aspects and

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imperatives. Within this complex background, we believe that one important specific task of physicians, which cannot easily be done by others, is to identify all the needs for change and to have the attitude and tools that allow the start of reform and improvement.

What Other Relevant Work has Been Done?

The approach to this question should build on a number of other studies, but needs to take note of all the relevant elements in the background (above) and to have the objective of synthesizing worldwide themes into a redefinition that will be useful globally, both now and in the medium term. The statement produced should also have the potential to be adapted to future, as yet unknown, changes in medicine and in society.

Some very brief definitions are intended primarily for statistical and workforce planning purposes. There are a number of variously formulated papers setting out competences required of the doctor, including documents that explicitly link competences required at qualification into statements of the role of the newly qualified doctor. A consensus statement on the role of the doctor that was recently developed in the United Kingdom was stimulated, in part, by political, social, and professional uncertainty of how the role was seen and was developing.

An interesting approach is the 2009 position paper and recommendations of the Catalan Fundación Educación Médica, *El metge del futur* (The Physician of the Future). This paper critically examines various scenarios in which physicians work (such as the physio-pathological paradigm, evidence-based medicine, technology-based medicine, and so on), goes on to propose a profile of the professional physician of the future, and examines the gap between this future and the present, and puts forward ways in which the gap might be bridged, with specific recommendations. Although this report has a relatively short-term forward view, and is more

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13 Available at: http://www.chms.ac.uk/documents/FinalconsensusstatementontheRoleoftheDoctor.doc.
applicable to the richer world than the poorer world, its approach is to be commended.

There has also been relevant discussion in the debate about the future of academic medicine; again the necessity of a global perspective becomes evident.\textsuperscript{15}

\textbf{Particular Areas of Enquiry}

\textbf{Political, Financial, and Structural Changes}

We set out, above, some elements of the complex background to this discussion. These need to be further considered and analyzed. Furthermore, medicine is being turned (by political and other pressures) into a commodity, and this undermines the professional relationship between doctor and patient, and between doctor and society. Thus, there is the risk of money becoming the primary driver in the healthcare system, and thus altering the role of the doctor.

Issues of social accountability in medicine have never been more important, and the many elements discussed must be synthesized to propose a policy and philosophy for the future role of the doctor.

\textbf{Potential Lead Roles for the Medical Doctor}

The doctor is advisor, care giver, and healer to the individual patient. We have argued that doctors may not need, in the future, to undertake all the roles that have in the past. However, many functions still remain inextricably linked to the doctor, but this must not be accepted unthinkingly, for example.

\textbf{The doctor in primary care}
In many (probably most) societies, the patient expects his or her first contact when ill to be with a doctor. Is the doctor best at this role, and if so, why? At present, there is an increasing emphasis, worldwide, on primary care as the setting in which much more work can be done, both therapeutic and preventative. Again, does the doctor have the major role in this “new” primary care? Will patients be able to accept that the primary contact may often be with a health professional who is not a doctor?

The doctor as a technical expert
In many highly technical areas of medical care – cardiac surgery, interventional radiology, intensive care, and so on – the doctor has been seen as the person with particular technical skill in mastery and delivery of complex interventions and methods of care. Is this always truly part of the doctor’s role? For example, in many cardiology services, cardiac surgeons take no part in preoperative and postoperative management. Why does the surgery itself require someone who is a doctor? Could it possibly be done as well or better by a person specifically trained for the complicated but limited tasks of cardiac surgery?

In contrast to this example, the technological setting of intensive care might be argued to require not only technological mastery but also a complex and changing synthesis of information from many sources. This is a complicated but not limited task.

The doctor as a leader of the healthcare team
Doctors and other health professionals – nurses, pharmacists, midwives, and so on – work together in the delivery of health care. Traditionally, in most cultures, the leadership of this team has been with the doctor. We need to understand the historical and sociological reasons for this. Do medical skills necessarily relate to leadership skills?

In examining this question, it will be important to use expertise that can answer the question of what the other relevant professions believe about the leadership function of doctors in the healthcare team, and what is the leadership and management function of these other professionals.

Which of these “potential lead roles” should remain within the remit and role of the doctor? To what extent can and should they be found in all doctors? What other “lead roles” might be defined? Is it practicable for them all to exist in a single kind of medical doctor?

Research and Education
It is intrinsic to the role of the doctor that he or she passes on skill and knowledge to others. Therefore, education probably is within the core role for all doctors. On the other hand, should all doctors do research? The answer is clearly no, it would be impossible, but is it the role of the doctor to be research-aware and to be able to evaluate the relevance of research
findings to practice? Also, is it part of the role for doctors to be able to recognize problems and unsolved questions that need research?

Finally, the Doctor as a Leader in Health Policy and Practice

We have argued above that questions of social accountability in medicine are of pressing importance. The extent to which doctors are involved in the development and implementation of local, national, or international healthcare policy varies. The extent to which it is desirable and necessary is not agreed, but health policy will undoubtedly suffer if it does not have the right medical input.

Medical schools have a public duty, as part of their accountability to society, to educate future doctors to meet the needs of healthcare in the society in which they work. Also, medical schools share the general responsibility of universities\(^\text{16}\) to foster members of society who will contribute to overall global, social, democratic, and economic development. This includes promotion of an international outlook, and the development of international exchange programs that meet the needs of all parties involved. This internationalism should be focused on understanding the needs of healthcare in different societies and identifying mechanisms for growth, development, and improvement of regional healthcare systems.

The Process to Develop a New Statement on the Role of the Doctor

Clearly, the development of an agreed position on the role of the doctor requires wide input—from the users of health care, from political and social standpoints, and from the medical profession itself and other related professions. Medical education and the medical school stand at the point of interaction of all these inputs. Therefore WFME has initiated a project, led from a medical education standpoint, to bring these wide contributions together. Society creates medical schools because it wants trained doctors; politicians arrange for the funding of medical education to meet this need of society; the healthcare system and medical schools are mutually dependent.

Also, medical education is central to the need for, and application of, any agreed stance on the role of the doctor: as stated above “Only when we

have defined what the role of the doctor should be can we define the content and processes of medical education."

The Task Force for the Project

A task force of about 25 members is being called together. Members of the task force include representatives of regional organizations for medical education, of official international agencies in health and education, and individuals with expertise in relevant areas, such as social accountability, and internationalization of medicine and of medical education. The task force will need to approach the question dispassionately, and to be open in its workings, particularly with other relevant professions. The conclusions from this work will then be distributed widely, particularly to the six regional associations for medical education, which are coterminous with the six WHO regions. The proposals emerging will be considered and developed locally in each region: this is particularly important to ensure that input and understanding from the various regions of the world are appropriately balanced. The planned outcome is a set of draft proposals on the Global Role of the Doctor, from which worldwide themes can be identified, as well as specifically regional elements.

The final stage will be an international conference, probably in 2012, at which a final statement will be discussed, agreed, and disseminated.

What are the Potential Difficulties?

This is a piece of work with many potential difficulties. Three obvious ones are the following:

1. The essential need to avoid a definition that is bound to one culture or that is only region-specific. As noted earlier, many recent publications in this area fall into this category, with a particular risk of developed-world hegemony. The working process will need separate developments at each regional level.

2. A definition based solely on cognitive and technical outcome competences will risk being inflexible, and prone to political control. Thus, the definition of the competence of the doctor must include elements of his or her attitudes and personal development, together with statements about the ability of the doctor to accept and use continuous professional and educational development to meet

http://www.psocoommons.org/wmhp/vol2/iss1/art3
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the role as it evolves over future decades: the competency to change, improve, and develop.

3. A definition of the role of the doctor cannot be done in isolation from other professions. What is the role of the nurse, the public health specialist, the pharmacist, the physician-assistant, and so on? Interestingly, much of the literature on professional roles in health care is about these other professions, usually with little or no reference to the role of the doctor.\textsuperscript{17}

Conclusion

These potential challenges epitomize the need for a discussion and redefinition of the global role of the doctor. The role of the doctor has been taken as a known fact, a piece of implicit knowledge, in the midst of explicit statements about other professions and changing patterns of illness. As we develop health care and medicine in a rapidly changing environment, an implicit understanding of what doctors do, without a proper analysis of their function, is no longer acceptable. A definition is needed.