Report of the meeting of the WFME Task Force

The Global Role of the Doctor in Health Care

Schæffergården, Copenhagen, Denmark 19-20 March 2010

Contents

1. Summary

This is a report of a meeting on the future role of the doctor in healthcare, and the start of the development of an agenda for further work.

The background to this project includes stimuli that are political, social, demographic and international. Work preliminary to the meeting identified several themes for discussion and development. The objectives of the meeting were to develop, discuss and agree these stimuli and themes; the objectives of the project included the development, in due course, of an agreed statement on the future role of the doctor; as a paper suitable for publication.

The meeting developed the themes, and identified questions for further work. These were further elaborated in electronic discussion after the meeting. The future course of the project was planned.

2. Background to the meeting

Identification of the need for the project: the stimuli for the project are multiple:

- Political pressures and the changes in medicine
- Changes in the social and economic role – and social accountability – of doctors
- The need for medical education to know what it should do
- Changes in the demography of populations and of doctors
- The internationalisation of medicine, and of medical schools

These are summarised and discussed in the World Medical & Health Policy paper[1]

Preliminary discussion at the WFME Executive Committee and with WFME collaborating organisations indicated support for the project being led by WFME.

Members of the Task Force (TF) are listed in Appendix 1.

Note: in this report, responses and comments are intentionally unattributed to individual TF members.

3. Themes identified before the meeting

All TF members were asked to identify themes for discussion at the meeting. The subjects identified are listed in Appendix 2.

Following internal discussion within the WFME team, the following were tentatively identified as themes for small-group discussion amongst TF members:

- Personal and professional development
- Education, research and communication
- Demographic changes in populations and in doctors
- Management of changes in healthcare
- Social role of doctors, social accountability
- Membership and leadership of the health-care team: inter-professionalism

WHO Geneva provided a list of topics in a different style:

- Past and present role
- Changing context and its effect on the role
- Career development and lifelong learning
- Roles beyond the clinical
- What is needed for the profession to embrace new roles and assess traditional/ conventional roles

4. Introduction and summary of the meeting

The introduction concentrated on three issues:

- The aims and objectives of the project as a whole, and of this Task Force meeting
- The educational context
- The demographic context

[1] Gordon, David and Lindgren, Stefan. (2010) "The Global Role of the Doctor in Health Care," World Medical & Health Policy: Vol. 2: Iss. 1, Article 3.
DOI: 10.2202/1948-4682.1043

Aims and objectives of the project and the meeting

The main aim of this meeting was to debate and discuss themes relevant to the role of the doctor in a global context, including the implications for medical education. One objective was to develop (if it proved possible) a statement of global utility on the role and values of the doctor. Other objectives were to inform thinking about, and development of, policy on medical education, and policy more widely.

The meeting aimed to look at world-wide themes but also to highlight specific regional issues relating to these themes. Key drivers for defining the role of the doctor in a global context were identified as:

- To support the search for what can be defined as a good doctor, promoting the qualities and values that we want from our doctors and to promote the attractiveness of the profession, across the world
- To consider the factors effecting doctors' decisions to leave the profession and how these might be addressed. These factors might be unattractiveness of work as a doctor, or positive features of life and work outside medicine
- To protect the profession from politically driven changes that are not in the best interest of patients and of health care
- To guide medical education and the development of curricula

The educational context

A perceived gap has developed between what medical schools produce, and what healthcare systems believe they need. This has led to education becoming more outcome-based, with outcomes at the heart of the design and delivery of education, in contrast to traditional medical education, which is more orientated to inputs and to the educational process: different in nature, and different in practice.

Medical schools must be cautious about adopting outcomes based education but, because of its appeal to regulators and healthcare organizations, it has gained acceptance. Desired educational outcomes vary globally, because of obvious differences in healthcare needs. Outcomes-based medical education is more value-based than medical education based on traditional curricula, and may also make education a means to an end rather than an activity of value in its own right. Also it can be perceived inappropriately to reduce the emphasis on individual scientific and clinical subject areas. This may be partly overcome by appropriate focus on expected competencies as outcomes

Process and outcomes in education are interdependent and there is little evidence to support the need to emphasise one over the other in medical education. However there is sense in focusing on outcomes and competencies, because we are concentrating on what we want at the end of the process – the "good doctor", however defined. The development of outcome-based education depends crucially on the definition of the role of the doctor, and understanding of that role also is essential for development of assessment measures for the identified outcomes.

Graduates need to be fit for practice within a given healthcare system and healthcare systems need to meet the needs of the communities they serve; thus, educational outcomes must also be informed by population health needs as well as healthcare system needs.

Question for further work:

- *How do we balance the need to produce graduates who can function as life-long members of the medical profession, but who must also starting by working as junior members of the local healthcare system?*

The demographic context

Migration of health professionals is desirable and necessary in professional development, and for the advance of medicine. It is of value to the patients we serve. However, strong east to west migration, and from Africa north to the USA and Western Europe, has led to a global health workforce crisis. New Zealand, the UK and the US rely on overseas physicians for over 25% of their workforce and even more in some specialties. On the donor side, almost 40% of South African trained physicians go on to practice overseas. The impact is greatest on those countries facing the highest levels of the global disease burden, and which are left chronically under-resourced.

Incentives to migration. The attractions of the destination or recipient countries may be:

- better life
- better remuneration
- better working conditions
- more time for your patients
- more treatment options
- safer workplaces
- better facilities
- better managed health infrastructure.

The primary driving factors for migration may be, not necessarily in this order:

- insufficient payment
- poor working conditions
- poor living conditions
- lack of possibilities for personal professional development.

As well as donor and recipient countries there are transit countries which supply as well as receive doctors; however the biggest problem is still for the donor countries which tend to have small health workforces from the outset, only to lose valuable practitioners to transit and recipient countries. There is a need to balance the incentives to experience other healthcare systems with incentives to return to the practitioner's place of education.

Social migration. There is also the problem of movement of the medical workforce away from the profession. Flow between professions is a growing phenomenon. Of students entering medicine in Germany in 1997, 41% failed to enter the profession – half the loss was during the course, the other half completed the course but failed to register. These graduates were lost to other occupations, motivated by social factors.

Simply educating more physicians will not solve the problem. An effective approach to making careers in healthcare across the world more attractive is required. There is a need to continue to support health professionals in their professional development beyond qualification, as many feel neglected post qualification.

Solutions. Any solution must consider the needs (and wants) of the population, society and of the individual doctor as a professional,, as well as what is practical within the economic and social circumstances of the country or region. This is not just about the provision and distribution of doctors, but the provision and distribution of other members of the health care team.

Some "solutions" are wrong or do not work

- Short-term visas etc., designed to "force" doctors to go home
- Forced or "Bonded" labour, short term or long term
- Taking away the freedom of the student or the doctor

All these are short-term, isolated measures that do not take a systematic approach. Furthermore it should be noted that creating a workforce that is unemployable in other countries, by training health

professionals to a standard that is not accepted by other countries, is not a solution and is irresponsible at best.

It must be acknowledged that there must be solutions other than just producing more graduates. It is generally agreed that closing the borders is not the solution. For example, a WHO report on primary care (2008) describes a framework that puts an emphasis on the development of whole healthcare systems. As well as developing the right conditions and incentives for people to practise where they were educated if that is where they are most needed, we need to instil the values of social responsibility in our young doctors, and develop an understanding of the consequences of migration. Doctors need to feel engaged with the community through the creation of a culture based on 'mutual value'. Doctors also need continued educational, professional and personal support so as not to feel isolated or disillusioned.

Questions for further work:

- *What are the limits of the social responsibility of receiving nations?*
- *How could richer countries contribute to counteract the global imbalance of health care team resources?*
- *What will be the effect of the recent (2010) WHO declaration on migration?*

5. Subjects developed in discussion

5a Professionalism: its meaning and significance today, and its relevance for personal development

Personal development and professional development are phrases that are often used but rarely defined. It is therefore essential to define them, and each element within, and to indentify the qualities that should be associated with each element. These qualities should be considered in context, recognising that we are graduating and regulating doctors in a constantly developing healthcare system.

First, there is a need to understand or define what is meant by 'profession', 'professional' and 'professionalism'.

One pre-existing definition of a profession defines:

- a calling with an extensive and specialised body of knowledge and practice, requiring long study
- that body of knowledge and practice being sufficiently complicated and arcane that it cannot fully be explained to and understood by the public, to whom the professional offers his or her services
- because of this impossibility of complete and open communication with the public - who are vulnerable to any inadequacy on the part of the professional - a person who is a member of a profession has obligations to be competent and to remain competent; and because the body of knowledge and practice is specialised and cannot fully be understood outside the profession, then a profession must be self-regulating.

Question for further work:

- *Do we accept this definition, or do we wish to develop it further, or adopt a different definition?*

Changing context. It is increasingly common for students to become disillusioned with medicine: they do not retain the sense of delight in being a physician. It is generally agreed that the enjoyment of medical practice is lost under the pressures of regulation, market forces and student debt. Understanding professional and personal development might enable us to avoid this outcome.

The most important context for personal and professional development is the health care system and its ever changing features, often motivated by political intervention. An enduring theme in medicine is that of change. Knowledge changes and develops, as do professional practice and social values. Political interventions mean that the health care system continually changes. Given that development is more than just learning or being taught, creating the best environment to engender the professional and personal development of doctors is crucial. The medical student, specialist trainee and independent practitioner all learn, to a greater or lesser extent, in the context of the health care system. That system provides the context for practice and learning and for development, therefore:

> 'Personal and professional development of the doctor is in symbiotic relationship with the development of the health care system.'

Professional development. What are the characteristics of a profession that must be developed in students and trainees, and then that should continue to develop throughout the years of independent practice? We agreed:

- Having a recognised role in society
- Contributing to the working of society
- Collaborative working with all members of the healthcare team including the patient
- Having education as a central activity - a life-long learner
- Being rewarding in terms of satisfaction and compensation
- Having rights to education and reward
- The duty to be involved in self-regulation
- Being accountable and open about self-regulation mechanisms
- Having skill, knowledge and service to others as the foundation of professional practice
- Exercising informed judgment based on knowledge and experience
- Having an interest and role in development of the health care system
- Having an interest and role in research and development in medicine

These features should develop during basic medical education and postgraduate training and continue thereafter. But development occurs best in the context of practice which implies that the health system must offer the conditions for continuing professional development. Increasing numbers of women in the medical workforce highlights the need to consider issues of how best to support professional re-integration and further professional development after re-entry into the workforce after a career break.

Professional development must fit to the personal career stage of each individual. For example, students are unlikely to be able to think seriously about the health system and their role in it, until they become personally involved in the delivery of health care and, later, when they might try to change or develop the health system for better care of patients and colleagues.

Professional development must take account of the increasing complexity of specialties. This raises the issue of whether we should produce physicians who specialise early or before qualification (as in some former Soviet countries, and in Colombia). We felt that this does not necessarily produce a professional who may call himself or herself a doctor, a designation which implies broad and deep knowledge and skill and the ability to deal with the unexpected. Atomised curricula do not describe the complex practice of the profession.

Personal development. There has been a generational shift in career aspirations: a new generation is coming into medicine, far more vocal about its personal priorities and desire for an acceptable work-life balance. The achievement of a good work-life balance has, now, an irresistible momentum. Personal development is impacted on by the pressing issues of money, family, quality of life, lifestyle and values. It is possible to have accountability and professional regulation and a personal sense of enjoyment in ones work. Pride and enjoyment in one's work is a quality that we should want to preserve, not just in medicine, but also in other professions and indeed trades. This becomes particularly significant when looking at mentoring and training.

There is the need to balance the personal with the professional and *vice versa*; the profession must have the flexibility to deal with interruptions and pauses in a doctor's professional development. An individual's personal development must not put the professionalism, and the trust between doctor and patient, that are essential in his or her behaviour at risk.

Few individual doctors actually have a global role, but the personal and professional qualities that are the true values in a doctor should be the same in any part of the world. As always: think globally, act locally.

5b The doctor as communicator, educator and researcher

It is significant that 'doctor' means 'teach' in Greek. However, there is a mismatch between the honourable connotations of "teacher", and the mis-use and uncritical application of evidence-free educational theory.

We consider:

- The function of teaching in creating the doctor for his future role
- The role of the doctor as a teacher
- The doctor as a researcher and as a user of research
- Communication: as part of education, as the dissemination of research, and (particularly) as the role of the doctor as communicator to his patients, to other doctors and other health care professionals, and to society at large.

<u>The role of education in developing the role of the doctor</u>. Medical education and medical schools must, in what they do, be preparing doctors for their future role. Part of that role is for the doctor himself or herself to become an educator – a teacher.

Medical education and medical schools have a responsibility to explain why they use the teaching methods that they do: this would foster development of educational skills and the understanding of educational methodology in students. Students must understand how people learn, as much as it is possible to do so, thus (crucially) to maximise their own learning. Therefore exposure to a broad range of teaching methods is important. Students need to be informed of the importance of their ability to educate and transfer their knowledge to colleagues and patients. There is a need to emphasise and value the role of trainees as teachers and mentors of their immediate juniors. It is recognised that in a clinical context individuals learn best from those who have recently been through the training-process themselves.

In addition there should be opportunities in the undergraduate and postgraduate curricula for students and trainees to gain exposure to clinical academia, and to engage in teaching and research.

All medical education curricula should:

- Define the characteristics – specified by the role and values - of the doctor who will be produced at the end of each stage
- Include both the necessary global characteristics and any local variations of that doctor.

- and all education should be:

- Aimed at a particular defined outcome and competence preparing the graduate for the next stage
- Structured
- Have clinical context if not clinical work
- Have a balance of flexibility and quality assurance
- Be meaningful for the health of the population to be served by the doctors being educated
- Pay due regard to assessment
- Take into account all the successive stages of medical education

Particular current problems in medical education, relevant to the role of the doctor. There are a number of relevant current problems.

- Pressures against clinical education. In the US, there was a model whereby people could access free care, given that the care is provided by a supervised trainee. This is, effectively, also the current UK model, which would be threatened if the NHS were further privatised. Recent pressures have made it necessary to micro-manage the junior doctors, with seniors almost always in attendance, which infantilises and limits the development of the junior doctor.
- Pressures on postgraduate education. There is dominant bureaucratic approach to managing postgraduate training. A review of the relationship between the stages of medical education is required, especially how the transition is handled: student to doctor; trainee to independent practitioner taking up CPD; and how each stage prepares for the subsequent one.
- Lack of flexibility and autonomy. Clinical education should foster the developing autonomy of physicians with a realistic understanding of risk to the patient [and physician] and minimisation of that risk. We are missing opportunities for extended medical education, for flexibility in career paths and for re-entry education.
- Inappropriate pressure from quality assurance agencies. Every education system should use appropriate quality assurance tools, but a balance is required between freedom to learn and to develop a career alongside quality assurance and support. The voice of medicine, rather than politics, has to be heard in quality assurance frameworks.
- Mindless regulation. In regulation of medical education, a dominant check-list approach is emerging with lack of alignment between different agencies and no clear derivation of criteria, despite the existence of the WFME global standards.

WFME is explicitly an education-oriented organisation: what might it do, in medical education, as the outcome of this project?

What WFME does now:

- Establish standards
- Exercise authority in utilising the standards.
- Working with accrediting bodies to apply the standards

Actions following this project might include:

- Define what we want to achieve as the product of a medical school
- Decide how education can deliver this
- Review the current stages of medical education
- Consider the function and effect of each stage
- Set out the challenges and dangers that education faces
- Look for metrics that might enable us to judge the effect

To what extent are the “global minimum essential requirements” (GMER) for medical education relevant in developing the doctor for his or her future role?

Question for further work:

- *We devoted a lot of time to the role of medical education in defining the role of the doctor. Do we need to do more to define the role of the doctor (of all doctors) as a teacher?*

Research. A profession necessarily has an academic basis, and professionals such as doctors should have the research skills to reflect on, review and investigate their own practice. Improvement in practice involves skilful application of research and critical appraisal of research reports. At its highest level this is the role of the clinician scientist, which must be valued.

However, all should have an understanding of evidence in medicine but few will have a career in research. The emphasis will often be on research that is relevant to the communities in which the doctor serves. Uncertainty about the quality of some published work means that doctors themselves need the skills to analyse research reports. The process starts at undergraduate level, so that every post graduate doctor has the core competencies relating to research – critical appraisal of evidence, with also some understanding of research governance and ethics in research. The focus should be on the research problems and process, and students should be involved in formulating research questions and developing research project. Teaching about research should be explicit rather than implicit, and there should be global standards for what is required of curricula. The same should be the case with education skills, and this should be promoted through group working and mentoring.

The same standards of critical appraisal of clinical research should be applied to educational research and theory.

Question for further work:

- *We need to be more clear about what distinguishes doctors with a direct role in doing research, and all doctors who must be able to understand and apply research.*

<u>The doctor as communicator</u>.

Question for further work:

- *We spoke about the doctor as communicator, and communication relates to teaching. However, we said little about communication itself. How should we develop our thinking about the doctor as communicator?*

5c Demographic changes, migration, and the future of medicine

Freedom to move is for many doctors a real and indisputable fact. Doctors are leaving their countries and sometimes the profession as a consequence of economic and social pressures. There is a need to address the unbalanced distribution of resources, and we need to change the arrows of migration. There is also a need to identify and address the causes of social migration.

Furthermore the profession also needs to understand and prepare for the impact of the gender shift within the profession. The impact will vary according to the cultural tenets of the country concerned. As doctors and medical educators we have a role to monitor and identify trends in migration and to assist in developing solutions to the problems that cause doctors to leave the profession and to leave those countries where doctors are most needed.

Politically driven changes to the medical profession are a powerful stimulus for doctors to leave the profession. Therefore there is a need for doctors to influence politicians and political decisions affecting both geographical and social migration.

At local and regional levels there is a need to develop and enhance the roles of the doctor to make the profession more attractive. Countries could also consider the concept of “contracts to return”.

Medical schools are well positioned to listen to the new generation of doctors and support them in being heard. There is a need to ensure exposure of undergraduate students to the reality of postgraduate practice. There is also a need to develop students’ understanding of clinical management, medical education and research, and public and population health, in order to promote these areas as careers and to promote the values that these areas carry.

Narrow specialties and a lack of flexibility leads to gaps in healthcare provision: to address this it is felt that medical education should move towards training doctors more widely and away from narrow specialisation.

Questions for further work:

- *How will demographic changes, in populations, impact on the future role of the doctor?*
- *How will the number and spread of doctors in the future, effect the role of the doctor?*
- *Is there a role for the medical profession in dealing with the global crisis in healthcare workforce provision?*
- *Can medical schools do anything to help deal with the global crisis in workforce provision?*
- *Should can medical schools increase the exposure of students to teachers with generalist and public health competencies, rather than primarily to teachers with a highly specialised perspective?*

5d The doctor as a manager of health care within society, and as a community health leader

Whilst the one to one doctor: patient relationship is of central importance to the practice of medicine, doctors are not accountable solely for the care of their individual patients. Individual decisions on care of individual patients can have large effects on the healthcare system when these individual decisions are cumulated, for example, expensive anti-cancer treatment and provision of prolonged life support for brain dead patients. Doctors in all healthcare contexts have some responsibility for the management of resources, but also as advocates of population health needs.

Good healthcare management. Good healthcare management has as its focus the patient, and not the often divergent agenda of the different professions. Management of healthcare requires skills and understanding of a range of health and societal issues and therefore managers need to be educated and trained in these areas. Health care systems need to be constructed and managed in a way that is appropriate for the health context and the care health needs of the population. Management of health care is a partnership; involving various sectors, professions and constituencies.

There are major regional differences between countries in the proportion of health and healthcare managers who are medically trained, for example in Jordan all management position filled by doctors. However, as previously stated healthcare managers require education and training in public health, health systems management and societal issues. Whilst Ministers of Health usually are physicians, a recent study showed very few had formal public health training and that Ministers in post would appreciate mechanisms for coaching on-the-job. Furthermore, in the World Health Assembly where the majority of the 193 Ministers are doctors, a recent study showed that only very few (15-20) had any formal training in public health or management of healthcare systems.

More research needed on the effectiveness of doctors in roles with responsibilities in the management of healthcare. By taking on management roles, doctors are better placed to be advocates of population needs-based healthcare systems.

Identifying good management. Methods for identifying well managed healthcare institutions and systems are needed. The parameters for measurement of performance of healthcare systems are:

- Effectiveness in achievement of health outcomes
- Efficiency
- Equity
- Evidence of emphasis on prevention
- Patient and public satisfaction.

Question for further work:

- *Who should be the judge of acceptable performance of a health care system - doctors themselves, patients, governments or politicians?*

Doctor as a community health leader. Politicians and special interest groups are often the loudest voices, but doctors are responsible for the communities which they serve and ultimately the good of

society as a whole. Responsibility for a community is most easily understood in smaller scale communities; public health, occupational health, social accountability, and health and safety concerns all come under this general responsibility. A strong element of social accountability is setting priorities, taking each decision in the wider context of the given community.

Consideration for how to deal with those people who do not present is also required. There is a need to respect people's autonomy to choose not to seek medical care, or to refuse treatment. However there the doctor has the role to educate, empower and reach out to those that need treatment both for their benefit and for the benefit of the community.

The Doctor has an obligation to apply their knowledge in a way that is of most benefit to the patient. Doctors must be able to translate their knowledge into language that patients can understand. There is a need to communicate the evidence base for treatment options to patients to help them to make decisions about their own care. This is a role that seeks to empower the patient, one which respects the patients' autonomy. This is related to the concept of social competence; the ability of doctors to deal with patients and their families as people.

Is the community in this context the global community? It is difficult to describe the doctor's global role in management of health care.

Questions for further work:

- *To whom are doctors responsible?*
- *Does the doctor decide what is appropriate for society or does society decide what is appropriate?*
- *What about situations where a doctor's responsibility for a patient conflict with the rights of others in society, for example the patient's parent?*
- *How do we demonstrate a patient's comprehension of the information they are given by the doctor?*
- *Is there a global role of the doctor in the management of healthcare?*

5e The Social Accountability of medicine and the doctor

The role of the doctor in society (within and beyond medicine) is multi-faceted, and the concepts of social responsibility or social accountability are acknowledged. The concept of reciprocity is also important; the doctor has to show social responsibility but in return requires autonomy from society in medical matters in order to deliver the care that is the duty of the profession.

Much of this interaction with society is manifest as the role of the doctor as a community health leader, and manager of health care within society (section 4d, above).

The doctor as manager of health resources, and as an agent for change. The rational use of resources balances the needs of the individual patient with the wider health needs of the community. A doctor has a responsibility to make decisions on the management of the available health resources on the basis of the evidence. However, scarcity of resources means that doctors need to make difficult decisions on the basis of this evidence, through the prioritisation of care. We are faced with situations where we are unable to recommend the treatment supported by the best evidence, due to lack of cost-effectiveness, or (more particularly) lack of cost-effectiveness in the context of the economy of a particular society. Part of this role is also a willingness to be part of a developmental process of building and promulgating evidence.

Doctors have a role duty to speak out on medical related matters of particular social importance when medical practice is regulated in a way that is not in the best interest of patients, or society, or both.

What is the role of medical schools in promoting the social accountability of medicine? Medical schools need to anticipate the needs of society for the next ten, twenty, or more years, to produce competent professionals who have the ability to be agents for change. Medical schools can bring about an awareness of these issues and an international perspective, however, there is a need to

respect the limitations of medical schools and undergraduate medical education. The meaningfulness of these complex issues can only be understood in the context of practice within a healthcare system. This understanding of the social and economic role therefore comes through postgraduate education and training. Unfortunately this is the time when outside pressures might lead it to be lost.

There is a lack of a systematic approach to this issue. The ideal would be that social accountability be taught in an integrated way as part of all education and training, along with other issues relating to medical ethics, the economic impact of decisions, and communication with society as well as with individual patients.

Questions for further work:

- *Are we preparing doctors properly for the social responsibility associated with being a doctor?*
- *What is the role for medical schools within this?*

5f Leadership and membership within the health care team

Team Work implies:

- Recognition of group process and of the individuals within the group
- Practice of team working skills
- Value given to team work

For effective team work it is necessary to make clear and to agree on:

- Aims and objectives of the team
- The role of each element and its responsibility within the team
- The management of the team

Essential features of team working:

- Mutual respect
- Clear roles
- Mutual recognition
- Agreed responsibility
- Constructive feedback
- Ability to lead, to follow, to share and to improve and develop together
- An ethical approach within the team, of support for the team, and of team loyalty
- Facilitation of the development of other team members, the transfer of knowledge and skills
- Constructive criticism
- A duty to express opinion and to interrogate and evaluate the team or the system
- A move from a passive to an active attitude
- Management skills particularly in terms of allocating resources and roles

Should opportunities for students to develop the all the above skills be created in undergraduate curricula?

<u>The culture of team working</u>. Developing the right culture to support effective team working is a difficult task. The doctor's role is not to do everything; we have to accept that others are better at doing some things. At the same time the culture of team working is not only related to "task-shifting", but much more on working together, with a collaborative and flexible approach to tasks being done by the most appropriate member of the team. How can the doctor to patient relationship be preserved in the context of the healthcare team?

There are factors which pose risks to effective team working:

- Organisational structures that lead to working in silos.

- Whistle blowing.
- Political drivers which have led professions to have incompatible expectations of their respective roles, outside of the context of the group.

Inter-professional education and practice. The inter-professional approach to education, where members of different health care professions are taught together is often spoken of, hardly seen and the effect rarely researched. There are however a number of political and financial drivers towards inter-professional education.

There is the belief that inter-professional education and training can break down the barriers between the professions and to develop a culture of mutual respect and understanding. Whilst inter-professionalism can also refer to the promotion of the team approach to work, shared leadership and cultural acceptance of the different professions, 'those that work together should learn together' is an oversimplification, and there is a need to understand roles first. Learning together is different to working together and early inter-professional education, where different professions are taught together, could be counter-productive, as it may impede on the healthcare professional's ability to understand their role and 'individuate'. There is also no evidence that inter-professional training works when applied at an early stage in education and training.

Clarifying roles and purpose. The first step is to clarify the role of each relevant profession. Once these roles have clarity it is possible to define the competencies required in each. Clinical and non-clinical managers are also part of the healthcare team, and so also need to have their role clearly defined in the context of this team. In the context of a clinical team there is then the need to look at the purpose of the team as a whole and then apportion the work to the individual team members. Doctors should also be able to take a step back from certain roles, activities and responsibilities that other professions might do better. A clearer understanding of roles from the outset would facilitate this process. There are however serious dangers in role substitution, particularly when driven by cost saving political drivers rather than what is best for the patient.

Gaining better clarity of the roles will also help to develop team-working and good leadership in situations where there is no continuity of team members. This lack of continuity has been a consequence of shift working in Europe. In this context the ability to communicate to groups as well as individual team members also becomes even more important. The tasks and roles for the group need to be articulated, and all team members need to understand what is required of them.

Leadership. Leadership in healthcare has changed in response to an increased emphasis on the doctor: patient relationship. This has led to shared leadership, where who takes on the role of leader role is changeable within a given health care team including the patient. All members of the team should be aware of, and accept, their own personal responsibility for the team's performance and ready to lead, intervene and constructively criticise.

Whilst the doctor no longer automatically assumes the role of leader, doctors do have the wide educational competencies to be leaders. The development of the leadership role should be encouraged throughout their education and training. There is a need for education on leadership both undergraduate and postgraduate, and there is a need to separate leadership from management.

Leadership should be understood in a variety of contexts not just in the context of the clinical healthcare team. Doctors and other healthcare professionals need to be able to take on leadership roles in healthcare systems, and challenge leadership when decisions have negative consequences for patient care. There has been a collective failure of leadership of the profession that has led to the implementation of health systems and initiatives that go against patient care and quality. It could be argued that these changes have contributed to the increase in attrition rates from the medical profession, world-wide

In the global context of leadership in medicine, there is a lack of women who can be identified as leaders of the profession.

In a global perspective, these questions on leadership and membership within the health care team together with aspects of the role and values of the doctor are particularly important. They offer ways

to develop the health care systems in different parts of the world in a flexible way, based on available resources and competencies, without producing a doctor with local, special or restricted characteristics.

6. Retrospect: electronic dialogue following the meeting.

TF members were invited to offer their personal summary of the five main points coming out of the discussion.

Responses:

Doctor A

- Doctors should have the same professional characteristics, regardless of where on the globe they work.
- Doctors should think globally but act locally. In other words, that by improving the health care of their own populations, they will contribute to the knowledge and betterment of medical care everywhere.
- There should be an equal and mutually beneficial exchange of knowledge, skill, practice and experience between doctors across all borders
- There is a necessary symbiosis and synergy between the education and training of doctors and the development of the health care service since medical education takes place within the context of the health care system.
- There is considerable political interference in medical education, and a necessary political direction of the health care system. The former should be monitored and resisted if it is not in the interests of high quality training. The latter should be monitored for its effects on training and on the health care and health of the population and politicians made aware of the effects of changes they make.

Doctor B

- The unique attribute of a doctor is the ability to work off protocol in situations of complexity and uncertainty and to apply scientific knowledge for the benefit of patients. This fundamental truth is applicable globally.
- The educational requirements to support the above take time to acquire and thus are expensive for Society to provide. The trust patients put in a doctor's judgement should not be put at risk by seeking to diminish the requirements of education and training for reasons of finance or political expediency. Equally doctors must justify the trust put in them and ensure that they remain competent.
- Team working is at the heart of patient care and so each member of the healthcare team requires a clearly defined role.
- The role of the nurse should be defined as a matter of urgency.
- Doctors need to take the lead in envisioning the system required for optimal healthcare delivery to their population, given local financial constraints - and then articulate it.

Doctor C

- Doctors are member of the team. The leadership of the team is a partnership, so Doctors should be armoured with leadership skills to play the leadership role for the team when it is necessary.
- There should be social responsibility for the receiving countries towards the donor countries in the issue of Doctors immigration.
- Doctors should learn the skills to communicate to groups not only to patients.
- Doctors should have the skills to be good Educators.

- Doctors should have good management skills to participate in management of health care and participate in the decision making, writing the policies and implementation of all steps in the management which affect the health professionals.

Doctor D

- A provider of highest possible level of care to best meet health needs of patients as well as the general population.
- A health leader in the community by being well aware of health determinants and able and motivated to mobilize resources for acting on them.
- A communicator to enable individuals and groups to prevent risks and promote healthy lifestyles.
- A good user of health resources, be it skills of other health professionnals or medical procedures, to meet social justice and cost-effective requirements.
- A team worker, able to delegate and coordinate activities in the health and social sector, for providing comprehensive and longitudinal care to patients and their families.

Doctor E

- Caring - Medical Doctors should give excellent care to their patients without discrimination except for medical reasons. This is and will be their first obligation. Medical Education should prepare them for that task, with all aspects of the complexity of that work like working in teams and mastering the necessary technology.
- Ethics – Doctors have ethical duties to their patients and society. They live in societies and they have social obligations and responsibilities to their communities, populations and nations. They have to respect the common good and to be – to a certain extend – accountable to the community. This has to be balanced by professional autonomy and clinical independence. The ongoing commoditisation of health care is contrary to this principle.
- Science - The renewal of medical knowledge gets faster and the value of classical specialisation gets less important. Mobility within the profession and between professions will increase. To be competent, able and willing to apply the relevant knowledge and skills will be more important then ever and the education focus has to change to life-long learning. Performance will not be measured on the basis of rigid criteria or on the ability to please somebody, but on the outcome for patients and the community.

Doctor F

- All doctors must behave and perform in a professional manner. (We now have enough papers / research to be able to define what we mean by professionalism, respect, morals, ethics, altruism and caring) Professionalism remains throughout the doctors lives
- All doctors must understand and synthesise into their daily practice the concept of teamwork. I feel that teamwork and leadership are inextricably aligned; you work in a team but often have to show leadership qualities when required
- All doctors should be aware of the local and national organisation that they are working in, its structure, management and purpose. They will be expected to work with these structures for the good of their patients, either on an individual basis or with patient / illness orientated groups
- All doctors should understand their social responsibilities and their social accountability. I think this is different to point 3 above. It’s to do with contributing to society, putting something back rather than taking, and often putting society's needs before their own. Responsibility is about understanding and being involved, accountability more to do with being at the front line, making things happen and taking either the glory or the blame for your actions. This social side to the doctor would cover local, national or international domains

- All doctors should be life-long learners, to know how to teach, learn and assess themselves and their peers, to maintain their clinical and non-clinical standards to their own personal fulfilment, their peers and those of their patients

Doctor G

- It is said that “amateurs” invest time and efforts in conforming strategies, as opposed by the “professionals “ who rather concentrate efforts in the “logistics” to make things to happen. The role of a Doctor as a manager-leader is to be seriously supported. It is key to plan and measure the desired outcomes. In fact and as we discussed should be linked in the education for life processes. So Managerial Sciences, leadership oriented to outcomes and professionalism to perform as the best are key issues.
- Knowledge as the basis for change, and most specially understanding of the “Global Burden of Disease” not only at his or her community level and local surroundings but also at a National, regional and continental levels is to be stressed.
- As said, and hereby stressed, the knowledge of the Health Care System or its absence in the place where he or she works is mandatory, if we want to build up contributions which ultimate should produce changes needed to better serve the population and patients, ultimate goal of our profession. This is a sensitive issue in the primary health care settings and of utmost importance for physicians working in primary care services.

Doctor H

A doctor is a healer, wise in the art and science of fighting disease and caring for persons in their social environments.

- "Wise" to mean sagacious, ethical, expert, empathetic, experienced, smart
- "Fighting disease" means prevention, cure, rehabilitation;
- "Art and science" refers to medicine and public health; it extends to the fields of education, research, management and administration in medicine and public health;
- "Caring for persons" means working to bring back wholeness in all its different senses;
- "Persons" refers to individuals, groups, large populations;
- "Social environment" refers to geographic areas, families, communities, populations, societies, cultures

Doctor I

- Educator. Not only responsible for educating patients and communities on health issues, but also for educating the next generation of doctors. If we are to fill the human resource gap, each health professional must play a role and feel a responsibility in education, and they must receive some formal training in order to educate others effectively.
- Life-long learner. The exponential growth of information, knowledge and technology leaves doctors with no other choice than to continue learning and developing throughout their professional lives.
- Team member. At different levels and contexts - that is, as part of a care delivery team, a facility management team, a community health team, or a district/national health team.
- Knowledge Translator. Translating scientific information and knowledge into language that the average person can understand and benefit from and, thus, ensuring that research is relevant to needs and that the findings of research are captured by potential beneficiaries.
- Facilitator. Conscious of the need to ensure a continuum of care within health services and over the life course, and to empower populations and patients to take responsibility for their own health.

7. Next steps

It was agreed, at the meeting and in later email discussion

- To prepare and distribute this report, for comments from TF members
- To prepare a revised version in the light of comments received
- For the report then to be taken to regional associations for medical education for local discussion and development
- To set up five subgroups of the TF to take forward five main themes
- On the "Social Accountability" theme, to work using the outcome of the Global Consensus on Social Accountability of Medical Schools (GCSA)
- For the TF to be reconvened for a second "Schæffergården" meeting to prepare the report for the proposed World Congress
- Seminars, regional meetings to take forward the themes from the report in groups such as FAIMER, AMEE etc
- To start discussions in online fora?
- Material emerging from this meeting and subsequent discussions to be considered for separate publication
- To engage with other viewpoints, particularly medical students but also patients and other healthcare professionals
- (Note 2015 deadline for UN Millennium Development goals)
- To lobby governments and identify the political and other relevant levers for change
- Develop strategies together for implementing any recommendations we might suggest, this might be done through reconvening this meeting prior to any World Congress in 2012

8. Longer term aims and actions

The possibility of a World Congress on the global role of the doctor in 2012 should be considered: if so the purpose would need to be pre-defined, maybe with a consensus statement on the role of the doctor, or an agreed framework for medical education, or both.

9. Bibliography

Note: this bibliography is a guide to further reading, rather than references supporting specific items in the report.

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Appendix 1 - Members of the Task Force

(Listed in their discussion groups)

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Invited, unable to attend, but participating in electronic discussion etc.

Elizabeth Armstrong
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Appendix 2 – topics identified by TF members