



*To note*

### **What do patients expect from their doctors and what this means for training?**

#### **Issue**

1. We have gathered information and evidence about patients' needs and expectations as part of this review. This paper looks at some of the trends and issues about patients that may impact on how we train doctors in the future.

#### **Discussion point**

2. To note trends and issues related to patient expectations and needs identified in the evidence collected for this review and how it may impact on postgraduate medical education and training (paragraphs 5 to 17).

#### **Further Information**

Paula Robblee	020 7189 5207	<a href="mailto:probblee@gmc-uk.org">probblee@gmc-uk.org</a>
Richard Marchant	020 7189 5024	<a href="mailto:rmarchant@gmc-uk.org">rmarchant@gmc-uk.org</a>
Vicky Osgood	020 7189 5319	<a href="mailto:vosgood@gmc-uk.org">vosgood@gmc-uk.org</a>
Stuart Carney	079 6719 4247	<a href="mailto:Stuart.Carney@foundationprogramme.nhs.uk">Stuart.Carney@foundationprogramme.nhs.uk</a>
Jessie Moye	020 7189 5330	<a href="mailto:jmoye@gmc-uk.org">jmoye@gmc-uk.org</a>

## Background

3. In October 2012, we looked at the impact of changes to doctors' training on patients. Members of the group recommended a review of the literature about patients' expectations and needs. It, along with our conversations with patients and patient groups, has helped us understand better the patient perspective on training.

4. This paper sets out some of the evidence gathered in this review about what patients expect from their doctors and what this means for training. You can read the literature review on patient expectations and needs in Annex A.

## Discussion

5. The purpose of this review is to consider what changes are needed to postgraduate medical training to make sure it continues to meet the needs of patients and health services in the future. That means at its core, this review is looking at how people will be cared for and want to be cared for in the future. And how the medical training should be designed to meet those needs. As a patient said to us: *'My hope is that any doctors who treat me do so with competence and kindness and always professionally. I want to be treated as a thinking person and not to be talked down to or over. I would like to be treated holistically and humanely and not just as a representative of a particular complaint'*.

6. Based on demographic forecasting, we think the UK population will become increasing elderly and frail as well as continue to be affected by lifestyle diseases. More people will need to manage one or more health conditions, requiring more complex treatment and care. For example:

a. According to the King's Fund, the combination of increasing life expectancy and the ageing baby boomers means the population aged over 65 is growing at a much faster rate than those under 65. By 2030, the population aged 65-84 will rise by 39%, those over 85 by 106% and number of older people with care needs is expected to rise by more than 60%.<sup>1</sup>

b. The Department of Health (England) suggests the number of people with three or more long-term conditions is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018.<sup>2</sup> Research indicates the number of conditions can be a greater determinant of a patient's use of health service resources than the specific diseases.<sup>3</sup>

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<sup>1</sup> The King's Fund analysis of Office for National Statistics 2010-based National Population Projections

<sup>2</sup> Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition

<sup>3</sup> Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). Research paper.

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study The Lancet online

7. These trends suggest we will need different kinds of doctors working in different ways in the future.

*How will patients use healthcare in the future?*

8. Through the literature review, written and oral evidence, it is apparent that people want a healthcare system that mirrors their understanding and experiences of their conditions. Barriers between primary and secondary care results too often in people being bumped around the system rather than being treated. Patients and carers need a more integrated, holistic and multi disciplinary approach with communication, caring and professionalism at its heart. The Patient Liaison Group for the Royal College of Surgeons confirmed this in their written response: *'Patients are not interested in the lines of demarcation between professionals, such as the boundaries between primary and secondary care, health and social care. What they want are integrated healthcare teams that can meet all their health and social care needs effectively without letting something slip through the cracks.'*

9. This evidence suggests we will need to train doctors who can work in different settings within the community and in hospitals.

10. Our literature review found that *'patient centred, patient involved and patient engaged practices are on a continuum and that increased patient involvement, engagement and patient centred-ness are to be strived for in all healthcare settings'*.<sup>4</sup> Indeed work by the Health Foundation suggests patients must be involved in quality, safety and care evaluation, clinical decision making and service development and through being enabled to increase their health literacy and self care.<sup>5</sup> This is important for a number of reasons including growing evidence that subjective experience can impact on outcomes and the expectation that patients take responsibility for their own health.

*What kind of doctors can deliver this?*

11. With more focus on patients identifying their own care needs and expecting to be included in care decisions, doctors will have to work differently. They will have to work more and more within multi professional teams and within increasingly complex organisations and systems. National Voice in their oral evidence describe it as *'a different picture is one where that doctor is working with and trusting other people in a multi disciplinary team and trusting or trying to develop if possible the role of the patient in their care and being willing to be part of that process of multi care planning and acknowledging their own role is only part of that, so that the expertise that others might bring to that picture is valued, sought and respected.'* This was reiterated and supported by the National Dignity Council in their written response: *'Doctors will have to work in teams and be prepared to listen. Doctors will have to communicate well*

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<sup>4</sup> Oates, J. Shape of Training literature review, Paper 4: Patient expectations. May 2013. See Annex A

<sup>5</sup> Christmas and Milward, New medical professionalism: A scoping study for the Health Foundation. October 2011.

*with one another, other members of the team and with patients and be prepared to treat all members of the team with respect and dignity.'*

12. Evidence is also pointing towards the need for a kind of doctor that can take a more holistic and broader role in caring for patients. Barnett et al. sums it up nicely by a call for medical education and practice to produce '*generalist clinicians to provide personalised, comprehensive continuity of care, especially in socioeconomically deprived areas.*'<sup>6</sup>. The Patient Liaison Group of the Royal College of Surgeons in their written response to us also highlighted that '*As patients our interest lies in seeing healthcare practitioners who understand that we are a whole person not a collection of parts to be looked at in turn by different professionals. This means that while healthcare practitioners might specialise in one area they retain / develop the ability to see that area within the whole and take responsibility for coordinating their actions with those of others in the healthcare team*'.

13. But MenCap warned that a move towards training doctors more generally would also require more emphasis on the wider team to make sure patients receive specialist care when necessary: '*steps [should be] taken to ensure that a move towards a more general approach to training does not result in trainees being unaware of the specialist care needs of people with a learning disability and other vulnerable groups and therefore less equipped to meet their needs ...As part of this, doctors should establish a stronger working relationship with colleagues in social care to ensure that nobody slips through the gaps*'. Rather the National Association of Patient Participation in their written response thought doctors and in particular GPs '*need to be signposting patients for the appropriate treatment which may not necessarily be medical.*'

*What does this mean for postgraduate medical education and training?*

14. According to our literature review, there is no research looking specifically at whether current postgraduate medical education prepares doctors for working with patients and the public in the way that will increasingly be expected. But work by the Health Foundation and others shows that patient involvement is crucial to improving health outcomes and to help patients take care of themselves.

15. Some studies show that doctors struggle to implement the patient centred learning from medical school into their clinical practice. A lack of support and learning opportunities with supervisors, coupled with more administrative work are blamed for doctors in training failing to involve patients in their own care. This trend suggests that if we want doctors to work in partnership with patients, we need to strengthen how they are supervised and supported in training. This is discussed more in Item 3. The Patient Liaison Group for the Royal College of Surgeons made this point in their written evidence: '*We recognise as patients that providing a service*

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<sup>6</sup> Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). Research paper. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study The Lancet online

*can itself be a learning opportunity but this only happens when individuals are given the time and support to learn from what they are doing and provided with feedback on their activities as well as being allowed to focus on those areas of care for which they are being specifically trained.'*

16. A number of respondents emphasised the need to use patients in educating and training doctors, with patients taking on increasingly more proactive roles including teaching and giving feedback. For example, Mencap suggests '*training of doctors would benefit from being delivered by patients*' while the National Dignity Council recommend '*Patients ought not only help students take histories and observe physical signs but also inform medical students and doctors in training how it is and was for them as a patient.*'

17. But our literature review shows there is little understanding of doctors' career pathways by patients and members of the public. Patients are often not aware of the expertise and seniority of who is treating them. But respondents to the review have made it clear patients should, and want to, know who is taking care of them. In both their written and oral evidence, the National Association of Patient Participation emphasise that patients must be told in advance that they may be treated by doctors in training and that they have an option to ask for a different doctor. But they suggested patients would support doctors' training, provided they are informed about the level of supervision: '*many patients are unaware of the roles of doctors at various points in their career. It is important that clinical staff introduce themselves at all times to patients and inform them of their designation. it is important to have sufficient supervision and support/mentoring and trainees should not be left unsupervised*'. By clarifying the level of competence for doctors at different points in their career, we may be able to reassure patients that they are being treated by the right doctor for their needs. This is picked up more in Item 3.

**Discussion point:** To note trends and issues related to patient expectations and needs identified in the evidence collected for this review and how it may impact on postgraduate medical education and training

### **Resource Implication**

18. There are no resource implications for this paper. We will be evaluating the feasibility and value for money of the recommendations.

### **Equality**

19. As we evaluate the evidence collected in this review, we will consider how the recommendations may impact on the different protected groups.

### **Communication**

20. This paper will go on the website.