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THE PRACTICE OF MEDICINE TEN OR TWENTY YEARS FROM NOW*

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This is an attempt, perhaps a rather rash attempt, to predict what the practice of medicine - and in particular the working life of a consultant physician in the National Health Service (NHS) - will be like in 10 to 20 years' time. I have little claim to originality, still less to powers of prophesy. Others with more direct experience of the changes that have taken place in NHS hospitals in the last six years may well be in a better position than me to predict what a consultant's role is likely to be in the first two decades of the next century. But even if what I suggest seems banal or highly unlikely it may still serve a useful purpose if it stimulates discussion and provokes others into making their own forecasts.

Predictable developments

The main social, political and financial influences that will provide the backdrop to the practice of medicine in the medium term future are, I believe, fairly easy to predict.

As the number of effective but highly expensive drugs and other therapies available to us continues to rise, the gap between what is technically possible and what the country can afford will continue to widen, and as a result the demand for maximal cost effectiveness will become steadily more insistent. The demand for 'evidence based medicine' is therefore here to stay, even if the phrase itself is replaced by some other slogan. This probably means that clinical audit, clinical guidelines and outcome measures are also here to stay. There will be more large clinical trials as well, and more of them will involve comparisons of cost effectiveness as well as of efficacy.

The rationing of health care will also become more overt, though the emotive word rationing will probably be avoided in favour of some euphemism or other - health care priorities, perhaps. It is difficult to predict which mix of techniques will be used, but governments will almost certainly try hard to avoid making the difficult decisions themselves, or at least to be seen to be doing so. Their stance will continue to be that they are providing billions of pounds of tax payers' money, more than ever before, and it's up to others closer to the patient - health authorities, fundholding GPs or even hospital consultants - to decide how best to spend these huge sums.

As a consequence of this, single disease pressure groups like the Multiple Sclerosis Society and the Cystic Fibrosis Trust will probably become more numerous and more sophisticated, and more interested in obtaining a larger slice of the cake for 'their' disease. Indeed, we can see this happening already for breast cancer and haemophilia.

Partly because the public will continue to want more and better healthcare than as voters and taxpayers they are prepared to pay for, healthcare will remain high on the political agenda. Public expenditure on healthcare will always be threatening to

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get out of hand, and economists and politicians will advance novel suggestions for better ways of controlling that expenditure. The main political parties are therefore likely to continue to disagree, and each incoming administration to want to change at least some aspects of the structure and organisation of the NHS. The stable consensus that existed between Conservative and Labour governments from 1948 to 1988 does not, I fear, seem likely to return.

The public will become ever more knowledgeable about healthcare and ever more demanding. Fifty years ago doctors were members of a small, educated élite and their views, particularly the views of hospital consultants, were treated with deference. In many communities the doctor, the schoolmaster and the minister were the only people with a university education. Those days have gone. The educated middle class has expanded hugely and will expand further over the next 20 years. Deference also is out of fashion. If the heir to the throne, the Archbishop of Canterbury and the Prime Minister can no longer expect to be treated with deference despite the offices they occupy there is obviously little hope for physicians. In the last few years many doctors have angrily criticised the Government for encouraging patients to be more demanding and to complain if they are dissatisfied. It is true that the Government has stoked the fires of consumerism, but it did not light them. They were there already. Whatever governments do in the next 20 years, patients will continue to become more assertive, more demanding and better informed. They will insist on high standards both of courtesy and of care, they will want to influence what topics are chosen for clinical audits, they will ask questions about their illnesses and the treatment options open to them, and they will increasingly want to make their own decisions about the treatment they receive. And if they are dissatisfied they will complain, and sometimes they will go further and sue. Formal complaints and litigation are almost certain to be commoner in 20 years' time than they are now; the only open issue is how much commoner and how much more expensive.

The balance of power between hospital consultants and general practitioners (GPs) will also change. The introduction of fundholding GPs has already changed that balance, rather brutally in some cases, but whether or not fundholding survives, and it may not for very long, GPs are bound to have an increasing influence on what services hospitals do and do not provide. As governments throughout the world try to strengthen primary care, and restrict the expansion of secondary and tertiary care, they are bound to pay more attention to the needs and opinions of GPs - and the GP's role will become steadily more complex and more important. A relatively high proportion of the most able medical graduates presently choose to go into general practice. In 10 years' time, for the reasons I have referred to, GPs will have nearly as long a formal training as many hospital doctors - 5 years rather than 3 - and the salary differential between general and hospital practice may have narrowed considerably.

Finally, we can be fairly confident that by the 2nd decade of the 21st century the long predicted revolution in information technology really will have taken place. Although computer enthusiasts have been predicting the demise of written case notes ever since I was an SHO, and it still hasn't happened in most NHS hospitals, it soon will. General practice has already been transformed and hospital medicine is bound to follow before long. At least one private hospital in Scotland - Health Care International - already has no handwritten case notes or prescriptions, and, before long, basic computing skills will be as essential for all healthcare workers, including consultant physicians, as the ability to read words with more than 2 syllables. At the

same time considerable information, both about individual patients and about the best ways of treating them, will be available on the printers and computer screens of every ward and clinic and will transform clinical decision making. It will not, however, provide cook book answers, except perhaps for new breeds of non-medical clinical assistants.

Unpredictable developments

Other changes are going to take place over the next 10 to 20 years which are much harder to predict, and the most obvious of these are scientific and technological innovations in medicine itself. As we are all painfully aware, the volume of potentially relevant information - the number of papers published in our journals - has been doubling every 15 years or so since the end of the 18th century and the pace of change in medical practice is getting faster and faster. That is why everyone, and the Royal Colleges in particular, is so conscious of the need for what were once fully trained doctors to keep themselves up-to-date, of the need for continuous medical education. We can confidently predict that over the next 20 years the pharmaceutical industry will provide us, at a price, with a wide range of powerful new drugs, some of which will provide at least partly effective remedies for illnesses which are at present essentially untreatable - acute brain injury from trauma or strokes, carcinomatosis, multiple sclerosis, motor neurone disease and, of course, Alzheimer's disease are all likely candidates. We can also confidently predict the advent of xenotransplantation, probably starting with pigs' hearts, of artificial blood, of robot-assisted surgery, and of widespread DNA profiling enabling both doctors and their patients to know long in advance what diseases the latter are likely to develop and die of. We can also be sure that there will be other innovations which most of us have entirely failed to foresee, and some of these may have a profound effect not just on the prognosis of individual diseases but on the way healthcare is delivered. Which of us predicted the revolution in the management of peptic ulcers, or the advent of AIDS, or the explosive development of minimal access surgery? There may also be unexpected changes in the range of diseases physicians are called upon to treat. Cardiovascular and cerebrovascular disease will almost certainly decline in importance, except in old age, as the prevalence of smoking falls and eating habits slowly change. Tobacco related cancers, emphysema and chronic bronchitis will also become less common. But other problems will almost certainly rise in their place. New forms of drug misuse will provide a rich crop of new complications and toxic states and Hepatitis C, not to mention Hepatitis G, H, I, J and K, will transform hepatology into a booming speciality. Antibiotic resistant staphylococci will become an increasing problem and we may well find ourselves confronted with several other infections, bacterial and viral, for which there is no longer any effective treatment. Malaria and tuberculosis are already heading rapidly in that direction. Indeed, 20 years from now we may be looking back rather wistfully on the 2nd half of the 20th century as that brief period in the history of medicine in which there were effective antibiotic treatments for most infectious diseases. That is part of the reason why major pharmaceutical companies like Glaxo Wellcome are taking a renewed interest in vaccine development. It is quite likely, too, that some time in the next decade or two one or two quite new infectious diseases will start to afflict human populations as a result of mutation or passage from an animal host. AIDS is unlikely to be the last novel human illness to emerge from some unsuspected animal reservoir.

Partly for reasons such as this, it is very difficult - and if you are a hospital planner,

hazardous - to predict how many hospital beds are going to be needed in 20 years' time, or what the optimum size and configuration of a general hospital is likely to be. The downward trends and the extrapolations of the last 20 years cannot continue for ever, or even for very much longer.

It is also difficult to predict how large a part private practice will play in the working lives of most NHS consultants in 20 years' time, partly because much will depend on the political complexion of future governments. One could argue that in the recent past the main stimulus to private practice has been the inordinately long NHS waiting lists for most forms of cold surgery, and that, as waiting lists are reduced, as they already have been, the demand for private treatment will fall. I doubt, though, whether this will happen. There are always going to be sizeable gaps somewhere between what the NHS can afford to provide and the healthcare demands of the wealthiest 10-20 per cent of the population and private medicine will inevitably fill them. It will also be in the Government's interest to continue to allow consultants to engage in private practice, if only to take the edge off their demands for higher salaries.

Implications for physicians

I am keenly aware that if even half the things I have predicted turn out to be true, the working lives of physicians will be even more stressful in 20 years' time than they are already, particularly as the number of training grade staff will fall further as the length of their training is reduced. Being a consultant physician in 2015 is not going to be as attractive a prospect as it was in 1955 or 1985. But before cursing governments, or even me, it is important to reflect on two things. We need to admit that the hospital consultants of the 1950s and 60s were a singularly fortunate generation. They had inherited the mantle of the voluntary hospital consultants of the 1930s and 40s - a small, privileged élite who were literally 'consulted' by other lesser doctors and who condescended to treat the poor without charge - and they had modelled themselves on that earlier generation for whom they had worked as housemen and registrars. They were handsomely paid - their mouths stuffed with Aneurin Bevan's gold - most of them had a private retinue of deferential nurses and junior doctors, and no-one dared to challenge their clinical judgement, their timekeeping or their manners. Most of them were admirable men, skilled, conscientious and hardworking, but a conspicuous few were arrogant or idle, or even incompetent, and quite a number of them were condescending to their patients. It could not last. Changes in society as a whole would have seen to that, regardless of what health ministers or the new breed of hospital managers did or did not do.

It is also important to realise that the profound and uncomfortable changes which have taken place in our NHS in the last 7 years are not all attributable to Kenneth Clark, or to a misguided, doctrine-driven Tory Government. Very similar changes have been taking place throughout the Western industrial world as governments everywhere have struggled to contain the escalating costs of healthcare, and sometimes panicked at their failure to do so. Indeed, more brutal things have been done to the medical profession by managers or governments in several other countries in the last few years - in the USA, in Canada, in France and in New Zealand, for example.

Being a hospital consultant in the early years of the next century may not be as attractive a prospect as it was from the 1950s to the 1980s, but it is still going to be a much more attractive prospect than most of the alternatives. It would be nice to be

chief executive of a newly privatised monopoly industry, of course, but there aren't many such jobs on offer, and I suspect that in 5 years' time it will be less attractive than it has been recently to be chief executive of a water authority or a gas company. And how many physicians would really rather be accountants, or stockbrokers, or corporate lawyers, or Trust chief executives, or export managers, even if they did earn rather more? Being a really good doctor is always going to be one of the most satisfying and most highly respected of all rôles. And the practice of medicine will remain in the future what it has been in the past - a vocation.

No previous generation of doctors has had the power which physicians now possess to relieve suffering, to bring desperately sick people back from the jaws of death, and to cure once incurable diseases. And 20 years from now they will have even greater and more remarkable powers. It is a curious paradox that we all have to accept that, as the therapeutic powers of medicine have increased beyond our predecessors' wildest dreams, the public has become increasingly more willing to criticise us, to complain about us and to question our judgement. That paradox is likely to persist. But the British public rarely criticises its doctors for incompetence, for ignorance or for lack of technical skills. On the whole they have learnt to take a high level of technical competence for granted and it is a considerable tribute to our medical schools and our Royal Colleges that this is so. They criticise us instead for other failings - for being off-hand or patronising, for not explaining things to them, for not appreciating how worried or distressed they are, for appearing unsympathetic, and for treating them as if they were simply 'another case'.

Twenty years from now I suspect that the standing of our profession in the eyes of the public, and the extent to which physicians themselves find their jobs satisfying and rewarding, will depend more than ever before on whether or not they can really appreciate their patients' feelings, whether or not they can communicate with them, and above all whether or not they really care about them. Fairly or unfairly, diagnostic and therapeutic skills will be largely taken for granted, partly because electronic data bases and a vast array of investigative procedures and up-to-date clinical guidelines will make these skills easier to master and maintain than they were in the past. In the future as in the past, medicine's standing in the eyes of the public will be determined by the corporate behaviour of British doctors towards their individual patients, who will make their own, fairly accurate, judgements about how competent, caring and compassionate they really are. In an era of dazzling technology doctor/patient relationships are going to be more important than ever before and old fashioned bedside skills will again be at a premium. Patients will not be subservient, or easily blinded by science, still less by Latin, but they will still respect competence and be deeply grateful for understanding and compassion. And doctors who possess these qualities will still enjoy being physicians.

Let me end by reminding you of one of Auden's poems. He was describing the kind of doctor he wanted for himself and that is, I think, the kind of physician patients will still want, and value, and be grateful to in the future, despite the awesome powers and gadgetry that the next century will bring.

Give me a doctor partridge plump
Short in leg and broad in rump
An endomorph with gentle hands
Who'll never make absurd demands
That I abandon all my vices
Nor pull a long face in a crisis
But with a twinkle in his eye
Will tell me that I have to die