19 December 2012

Expert Advisory Group

SHAPE OF TRAINING

3

To consider

A definition of generalism

Issue

1. This paper looks at how generalism could be defined in this review.

Discussion point

2. To discuss whether we should define generalism as the broad based competencies and skills that allow doctors to care for and manage patients who have undifferentiated or multi system conditions across and between different care contexts (paragraphs 8-15).

Further information

3.	Paula Robblee	020 7189 5207	probblee@gmc-uk.org
	Richard Marchant	020 7189 5024	rmarchant@gmc-uk.org
	Vicky Osgood	020 7189 5319	vosgood@gmc-uk.org
	Stuart Carney	079 6719 4247	Stuart.Carney@foundationprogramme.nhs.uk
	Richard Green	0207 972 5053	Richard.Green@dh.gsi.gov.uk

Background

4. In 2007, the independent inquiry into Modernising Medical Careers, led by Sir John Tooke made a number of recommendations about the shape and structure of postgraduate medical education and training in the UK.[1] It called for a more flexible and broad based approach to training, integrating both training and service objectives into workforce planning. The inquiry also raised profound issues about the role of trainees, SAS doctors and consultants within the service and the implications of the Certificate of Completion of Training (CCT) on training and practice. It recommended more clarity and a shared understanding of the role of all doctors within the multi-professional team, including the contribution to service delivery by trainees.

5. Following on from Tooke, other inquiries also highlighted the need to develop the current structure of postgraduate medical training so it continues to provide consistent, high quality and fit for purpose training for doctors throughout the UK.[2] They too have pointed to the need for more flexibility in order to equip doctors to respond better to the changing needs of patients and the service.

6. On 24 October 2012, the Expert Advisory Group discussed what employers, doctors in training and patients might want from changes to postgraduate training. Much of the discussion centred on the case for and against what is referred to as 'generalism'. Given the different views on this term, the group suggested further work should scope out what exactly we mean by generalism.

7. This paper looks at some of the prevailing definitions of generalism and how they might relate to this review. It is not meant to suggest the review has settled on any specific approach or model. Rather, we want to flush out how we understand the concept of generalism, particularly given one of the key themes of this review is to look at the balance of the medical workforce between generalists and specialists.

---

[1] *Aspiring To Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers*, led by Sir John Tooke, January 2008, http://www.mmcinquiry.org.uk/Final_8_Jan_08_MMC_all.pdf

[2] *High quality care for all: NHS next stage review final report*, Professor Lord Darzi, June 2008; *Foundation for Excellence: An evaluation of the Foundation Programme,* Professor Jon Collins, October 2010; *Scottish Foundation Programme Review Report*, Dr Alistair Cook, November 2010; *Time for Change: A review of the impact of the European Working Time Directive on the quality of training*, Professor Sir John Temple, May 2010.

Discussion

Push towards speciality focused postgraduate training

8. The UK has more specialties and subspecialties than many other countries with only the USA having a higher degree of specialisation and subspecialisation.[3] With 65 specialties and 35 subspecialties in the UK, we should consider whether a structure organised into discreet specialities and subspecialties will remain effective for medical training and practice over the next 30 years.

9. In practical terms, this level of specialisation and subspecialisation means many doctors in training, once they have completed the two year Foundation Programme, spend as little as one year acquiring general knowledge and skills in their specialties. They move quickly into more specialised areas of practice, often at the expense of gaining experience in acute, community based or other care areas. For some specialties, this approach may be entirely appropriate. But for others, a different way of training, focusing on a broader level of knowledge and skills within that specialty or range of specialties, may be more effective for both patients and the service.

10. People will need to be cared for in very different ways in the future as the population ages and lives longer with more co-morbidities and increasingly complex conditions. Leading organisations suggest we will need far more general practitioners and other doctors who can provide community based care with a much smaller number of specialists, concentrated in specialty units.[4] In the future, the majority of doctors may be expected to deliver care in contexts where general capabilities will be needed as patients need more integrated and coordinated care across acute, community based and social care settings.

Our definition of generalism

11. There is no clear cut definition of generalism in medicine. But the way generalism is used in medical practice depends on how it is formalised within different jurisdictions, settings and specialties. In countries where the medical profession is highly specialised like in the USA, generalism refers to doctors working in primary care or general specialties such as general internal medicine. These doctors see patients in the community and often coordinate hospital interventions.

---

[3] *Specialties, sub-specialties and progression through training the international perspective*, April 2011, published by the General Medical Council. http://www.gmc-uk.org/Specialties_subspecialties_and_progression_through_training___the_international_perspective.pdf_45500662.pdf

[4] Royal College of Physicians, *Hospitals on edge: Time for actio*n, 2012; N Timmins, *Tomorrow's Specialist: The future of obstetrics, gynaecology and women's health care,* Royal College of Obstetrics and Gynaecology, 2012. *Fit for the Future? Dr Foster's hospital guide 2012*, Dr Foster Intelligence.

However, medical students in the USA are discounting a career as generalists because these disciplines are perceived as less prestigious and have the potential to be reimbursed at lower levels than specialists. This is particularly notable in the USA where the imbalance between generalists (28%) and specialists (72%) has resulted in concerns about the quality and cost of care. Organisations like the American Medical Association are committed to encouraging medical students towards a career in general areas of medicine.[5]

12. This skew is one of the reasons why a new specialty of hospital medicine was created in the 1990's in the USA. [6] Hospitalists provide general medical care for hospitalised patients. Unlike most hospital based specialists, their practice areas are organised around places of care rather than fields of medicine. Of particular interest to our review, hospitalists make sure patients are seen by the right specialists and other healthcare professionals and coordinate the range of care that is provided within a hospital. But this specialty focuses only on the care of the patient in hospital rather than linking back to primary and social care, particularly when patients leave hospital. As a consequence, this approach has further distanced the relationship between primary care physicians and hospital care.[7]

13. By contrast, generalism is increasingly being defined as an approach that provides a broad based comprehensive level of care to patients, bridging the gaps between different health and social care settings.[8] By shifting the discussion away from specific disciplines and specialties, it begins to identify the competencies and skills doctors need to manage patients who have undifferentiated or multi system conditions. Specialists, then, are doctors who restrict or narrow their practice within their discipline and are only accessed when referred to by a generalist or other specialist. Within the UK, the shift towards this generalist approach to care has been endorsed by, among others, the Royal College of General Practitioners and the Health Foundation.[9]

14. It is this more holistic definition of generalism that should underpin the Shape of Training review. Patients want their care to be seamless and integrated across

---

[5] Prislin, Michael D et al. The Generalist Disciplines in American Medicine One Hundred Years Following the Flexner Report D Academic Medicine: February 2010 - Volume 85 - Issue 2

[6] Faculty of Hospital Medicine http://www.hospitalmedicine.org/AM/Template.cfm?Section=Hospitalist_Definition&Template=/CM/HTMLDisplay.cfm&ContentID=24835

[7] Meltzer, David O et al.U.S. Trends in Hospitalization and Generalist Physician Workforce and the Emergence of Hospitalists. *J Gen Intern Med*. 2010 May; 25(5): 453–459.

[8] Taber, S. Towards a definition of generalism in medicine: preliminary results of a systematic review. Royal College of Physicians and surgeons of Canada, September 2011. Gunn, J et al. *What is the place of generalism in the 2020 primary care team?* Australian Preliminary Health Care Research Institute, 2011.

[9] Royal College of General Practitioners and the Health Foundation. G*uiding patients through complexity: modern medical generalism*, October 2011.

different care contexts.[10] Healthcare will become more personalised and treatments will be developed to address particular individual factors, such as drugs based on genetic profiles. Given these drivers, we will need doctors who are able to identify what kind of care a patient may need and the context or setting in which it should be provided rather than the current configuration where the site determines how patient care is accessed and organised.

15. This approach would be relevant not only to General Practitioners (GPs) but to most other specialities, particularly where they provide front line treatment in the community or in hospitals. Generalists, regardless of the context, would determine when more specialised care is needed, would manage that transition and work with specialists to provide the right care in the best possible way. This role would also help alert specialists to any other factors or issues that may impact on care or outcomes and would also link to other health and social care professionals, especially for care outside a hospital setting.

> **Discussion point**: To discuss whether we should define generalism as the broad based competencies and skills that allow doctors to care for and manage patients who have undifferentiated or multi system conditions across and between different care contexts.

Resource implications

16. As we begin to explore and develop potential reforms for the future shape of postgraduate training we will identify the resource implications of the different options.

Equality

17. The review will consider the impact of its recommendations on patients, doctors, trainees and medical students. We will include specific questions and opportunities to feedback about equality issues through our formal evidence gathering activities.

Communications

18. Information about the review will be available on the Shape of training website. The discussion points in this paper do not necessarily reflect the direction of travel of the review or endorsement of any specific approach or outcome for the review. The paper is meant to provoke discussion and debate about some of the emerging issues in this review, which will be revisited and refined through the written responses to the Call for ideas and evidence and the oral evidence sessions.

---

[10] National Voices, Integrated care: what do patients, service uses and carers want? 2012. http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/what_patients_want_from_integration_national_voices_paper.pdf