Medical Schools Council

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ROYAL COLLEGE OF GENERAL PRACTITIONERS
COMMISSION ON GENERALISM

Response from Medical Schools Council

1. What do you understand by the term medical generalism?

Medical generalists are doctors who are prepared to deal with any problem presented to them, unrestricted by particular body systems, and including problems with psychological and social causes as well as physical causes. They take a holistic approach, mindful of the context of the local community.

Medical generalism is therefore distinct from specialist care restricted to a particular body system or subset of medical practice, or restricted by virtue of having access to, or involvement in, providing particular types of interventions in particular settings, usually hospitals.

Where you can, please give examples of where you see it:
(a) In general practice

General medical practitioners provide first contact and ongoing, continuous integrated care for a comprehensive range of problems to all members of the population for whom they are responsible. In well developed primary care systems they undertake long term responsibility for a defined, registered list of patients, restricted only by geographical area, addressing both acute and chronic conditions and increasingly co-morbidity.

Research has shown that medical generalists working in a well developed primary care system improve the quality and efficiency of overall health care by acting as gatekeepers, referring only those patients likely to need specialist help into the secondary care system, optimising the use of resources [1].

General practitioners need to be prepared to make at least an initial response to all people seeking help for what they perceive to be a medical problem and to arrange appropriate follow up.

Generalist responses will include:

- advising on the self-management of minor self-limiting illness and giving advice and support on help seeking for such problems in the future
- deciding that the problem is not a medical problem, and giving advice on help-seeking and sources of non-medical help and support
- managing those medical problems which it is possible to manage given the range of interventions and ongoing support available in a community based medical centre (including psychosocial aspects as well as physical aspects)
- recognising problems which require referral for outpatient or inpatient medical care by practitioners specialising in particular body systems or particular interventions
- managing the medical aspects of co-morbidity or multi-morbidity, including a range of disorders across different body systems. This includes the drug treatment of co-morbid disorders, and the interactions between those treatments, which is increasingly a problem with the ageing of the population

(b) In other settings
In community and hospital settings doctors may provide a generalist approach to particular sections of the population defined by age, such as the elderly (geriatricians), or children (paediatricians), being willing to accept, at least initially, any undifferentiated problem presented to them by people in the defined age group, or by their carers. Doctors working in Accident & Emergency, acute physicians and psychiatrists are also required to provide a generalist approach to patient care.

2. What are the core values of medical generalism?

- A willingness to accept the initial presentation of patients' problems which may not be caused by diagnosable medical disorders
- A willingness to assess and accept uncertainty and risk, and avoid investigating or intervening in problems unlikely to need medical intervention
- A willingness to undertake the responsibility to recognise possible serious illness when presented with an undifferentiated range of patient experiences, which have not already been assessed, classified, and/ or modified through previous contact of the patient with a referring doctor
- A willingness to accept the management of a range of disorders across body systems, including psychosocial as well as physical disorders, and the interaction between disorders and their treatments
- A willingness to maintain the required competence to undertake the generalist role through continuing professional development designed for that role, conserving a breadth of knowledge across a comprehensive range of medicine, sufficient to recognise and refer severe illness even if uncommon
- As a consequence, a willingness to eschew opportunities to develop the deepest knowledge of particular problems required to be a specialist practitioner, and to avoid sub-specialisation, except as a minority aspect taking up just a fraction of the whole of the practitioner's practice
- Patient centeredness and a willingness to place the patient agenda at the centre of management , respect shared decisions, and tailor guidance to the person's social circumstances
- A desire to conduct or participate in research into the practice of generalism and its outcomes

3. How do the values you describe fit with what you recognise as generalism in practice (as you outlined in your response to question one)?

They need to be identified explicitly and learnt during the undergraduate training of all doctors, since all medical graduates have to possess the potential to be generalists through further postgraduate study for the 'specialism' of general practice, and for other specialties including psychiatry and emergency medicine. They obviously need to be further developed during the postgraduate training of those graduates opting for the role of a general medical practitioner. Doctors in training need to recognise whether they have the skills to deal with undifferentiated presentations including the ability to deal with uncertainty and risk and handle a breadth of knowledge within a bio-social setting.

Primary care academics are needed, trained in the appropriate research methods for the sector, and all general practitioners need to be involved in research into the clinical and health service implications of generalist practice.

4. Where do the boundaries of medical generalism lie? What are the challenges at the interface of medical generalism with other areas of practice?

A particular challenge is the continuing and progressive sub-specialisation of secondary care medical and surgical practice. Historically it was possible to refer a patient for a 'general surgical' or 'general medical' opinion, but with sub-specialisation this is no longer possible except for the elderly or children.

Also, as intermediate care services are developed across the primary/ secondary care interface, it will need to be made clear where generalist responsibility for patients lies.

5. **Are there elements considered to be part of medical generalism that ought to be modified or abandoned? Does medical generalism need to adapt, and if so, how?**

Some elements of generalist function in primary care can largely be met by nurses or physician assistants and need not necessarily be provided by medically trained staff. Preventive care, the triage and treatment of minor self-limiting illness, and regular routine care for chronic conditions such as diabetes, asthma, COPD and hypertension, can all be provided safely by non-medical staff [2]. As such substitution takes place, medical generalists need to adapt to be able to take an overview of generalist care within primary care, and provide a second opinion when non-medical practitioners need help. Generalist medical practitioners will need the skills necessary to handle the increasing complexities of co-morbidity, complex pharmacology, and psychosocial issues in the community.

6. **What threats and challenges do you think medical generalism faces today? What threats and challenges do you foresee in the next 10 to 15 years?**

Nurses and physician assistants might progressively replace general medical practitioners in providing general assessment, monitoring and treatment. The former are less expensive to train and, once they gain confidence in assessing patients at risk, could be less expensive in practice. However, trials have shown that, initially at least, such role substitution is more expensive as these professionals take more time to assess patients and they order more tests than medical generalists. However, such generalist non-medical practitioners will still need to have access to more highly trained medical generalists in primary care to act as second opinions where necessary, for both acute problems and in particular for the more complex problems presented by patients with multi-morbidity [3].

There is a great threat currently of increasing fragmentation of care as services move into the community, especially if the service is opened up to a multitude of providers and competition rather than collaboration is promoted. It will be more difficult to ensure continuity of care if geographical boundaries are more fluid due to increasing patient choice, and a range of service providers develops.

Under NHS reforms, medical generalists are being expected to take a greater responsibility for managing an NHS budget that will be diminishing in real terms year on year. There is a need to recognise the skills, values, knowledge and understanding required of a medical generalist to effectively plan, prioritise and commission secondary care. The skills and values associated with managing individual patient's needs are different from those that are needed for the effective commissioning of services for a population. This will also have implications for teaching and learning within an undergraduate curriculum to prepare for the leadership and management skills required by medical generalists of the future.

7. **What can be done to strengthen medical generalism – particularly those aspects that you care about? How would you propose to go about doing this?**

General practitioners in primary care need to be better trained to undertake the functions previously offered by general surgeons and physicians in secondary care, by extending the length of their training. This means that more undergraduate training should take place in primary care, not limited to training needed for general practice, but involving teaching general medicine in primary care settings. Along with the fact that patients spend less and less time in hospitals these days, this implies a progressive movement of undergraduate education and training into primary care settings.

Ample opportunities need to be provided during undergraduate medical training and education for students to experience:

- the undifferentiated presentation of a range of problems outside the specialist environment
- the challenge of identifying serious illness when presented with a range of problems and complaints unclassified by particular body system or system of care
- the acceptance of risk in not immediately investigating or intervening in problems where serious illness is unlikely
- the challenges of managing co-morbidity and multi-morbidity, including the interaction of disorders and their treatments

- the challenges presented by decisions about when and where to refer patients whose problems are not self-limiting or manageable in community based medical centres
- disease progression following short hospital stays, and ongoing continuity of care
- the patients journey across the increasingly fragmented NHS, between primary, secondary and tertiary care

Students need to be educated to see the need for generalism, in terms of optimising the use of resources. They also need to understand the values needed to practise as a generalist. This implies a need to adequately fund medical education and training in primary care.

The need to broaden and deepen the curriculum for training in the specialism of general practice also implies a need for a longer postgraduate training than the three years currently required. GPs in training need to spend far longer than they currently do learning about the less common and more challenging aspects of care for chronic conditions, and be better prepared to deal with co-morbidity and multi-morbidity, including aspects of interaction between illnesses and between interventions (such as polypharmacy).

Primary care research needs to be strengthened. Academic GPs make up only 1% of all GPs, compared to 6% of all consultants. Sources of funding for research into the generalist role need to be increased. The NIHR should look at developing more programmes of research into primary care, across more universities, building on the School for Primary Care Research which is currently limited to only eight medical schools. Other primary care practitioners need to get involved in research besides the GPs, through nursing and allied health programmes focused on primary care.

8. What recommendations would you make about the future development of medical generalism; are there particular aspects of this that relate solely to general practice?

Medical students need to learn general medicine in general practice settings where they can meet patients with undifferentiated presentations, a broad range of medical disorders, and chronic conditions usually managed outside hospitals. This is essential if they are to understand modern health care and develop the necessary holistic approach to care.

NHS payments for clinical placements in primary care for medical students should be set at a level adequate to allow an increase in such placements over time as undergraduate curricula move out of more traditional secondary care settings. In practice this means the primary care placement tariff needs to be equal to the secondary care tariff, so there is no perverse incentive for medical schools to move more of their placements into unrepresentative secondary care settings.

GPs in training need to be prepared for the role of community-based medical consultants specialising in the management of patients with complex co-morbidities. Training should be extended from three to five years to accommodate this.

To allow a continuum of experience and development across undergraduate and postgraduate training, the current separation of postgraduate from undergraduate education and training should be reduced by aligning postgraduate deaneries with undergraduate medical schools within universities.

References

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