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Letter to the Editor

Generalism and specialism within medicine: a viewpoint from internal medicine training and perspective on the challenges of enthusing undergraduate UK medical students

Bright and Silverton present an interesting take on the various aspects of the duality of being a generalist.[1] We feel that the debate assumes that all patients seen within general internal medicine (GIM) are solely medical patients with comorbidities requiring variable input from subspecialists *within* medicine alone.

As a bright-eyed internal medicine trainee (IMT), one certainly sees their supervising consultants as widely skilled, knowledgeable 'jack of all trades' who will also help them navigate the MRCP PACES.[2] However, other non-medical specialties seem to have become fixated on the 'master of none' part if we are to take account of the ground realities within the acute hospital. The widespread feeling across all levels and specialties is that general medical wards are a 'dumping ground',[2,3] to facilitate more specialist, more *exciting* work within the more *specialised* fields. Several illustrative examples include patients who are deemed to be best left '*under medicine*' being the path of least resistance,[2] for *monitoring and observation*. These involve patients with small bowel obstruction, traumatic brain haemorrhage or postoperative complications and infections such as collections of pus in the abdomen and spine, to obstructive uropathy and new intracranial space-occupying lesions. Many of these patients may not necessarily require imminent surgical intervention, but will subsequently need to be transferred across to the respective appropriate specialty ward. These patients would have been better placed being looked after by the right team on the right ward, provided their care was taken over at the outset from the time of presentation at the acute portals. These occurrences almost always tend to happen in conjunction with safari rounds for medical outliers in surgical wards.[3] We all experience this in routine daily clinical practice in GIM, and it has become the norm, more or less all year around for the general physician, in contrast to any other medical or surgical specialty in terms of the number of patients to be reviewed by an individual team across the hospital site. This specific situation, in our experience, then translates to an increased workload and the ensuing evaporation of learning opportunities and the more light-hearted parts of the job. The direct effect of this is to indirectly drive medical trainees towards even more specialised and more procedure-based fields, with members of the IMT cohort being drawn to cardiology, dermatology, gastroenterology, haematology, nephrology, neurology, oncology and rheumatology, where the intensity and rigours of the challenges of GIM have less of an impact in comparison.

There are a range of reasons why the generalist route has lost its appeal to some if not all,[4,5] including anecdotally from personal experience as well as discussions and deliberations at formal and informal training forums, the sustained increase in workload of non-medical conditions. IMT or, for that matter, higher specialist training in medical specialties does not prepare us for managing surgical patients. These conditions should be medically managed only by the respective surgical specialty, even if they are not deemed for an imminent operation, with medical expertise and input as and when required for the individual patient.

Indeed, this is precisely when the feeling of the 'dumping ground' effect[2,3] is sensed more conspicuously and the difficulty to enthuse budding physicians among UK medical students becomes even more of a challenge. They are exposed to witnessing the logistic dilemmas faced by the medical registrar and general physicians from a very early stage of their undergraduate training.[2] Surveys conducted in collaboration with the Royal College of Physicians (RCP) from foundation, core and medical registrar trainees have demonstrated the disillusionment with the intensity of an unmanageable workload, poor work–life balance and better job satisfaction-related aspects in the main specialty versus GIM.[4] The initial data on recruitment and retention, after application and interview into the standalone GIM training programme, are testament to the subsequent change of decision by candidates to have acquired some specialist skills at the end of training.[6] The trend in that pattern is perhaps not just for existential reasons, but also for maintaining interest and variety. It is indeed obvious that most generalists are specialists in their own specialty and all specialists have generic skills within their expertise.[2]

We fear that until the broader concept of generalism is defined, there is a risk of the disappearance of the generalist consultant irrespective of the debate about whether it is a viable option or not within the modern healthcare setting, as more IMT doctors veer towards organ-based silos.[7,8] However, despite all the negative rhetoric about being a generalist, we believe that it has a prudent role within the UK National Health Service (NHS), and could well become a respected choice among the different medical specialties on offer if there are managed entry and exit criteria for admission pathways from acute portals. This will then demonstrate the ability of the generalist to continue to manage complex medical patients with only occasional subspecialty input, rather than having an open-door policy to any patient type being admitted under GIM, which is the path of least resistance.[2]

Generalists represent the epitome of what most medical students and IMT trainees want to be, in that they embody knowledge and instil confidence, with most of them being analogous to a walking MRCP PACES textbook. For us to elevate GIM within the hospital environment, all clinicians and management teams must begin to recognise its value once again. The recently published programme evaluation of GIM training[6] demonstrates the need to attract not only predominantly international medical graduates (IMGs), but also UK undergraduates to consider

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pursuing a career that involves GIM in isolation or in combination with specialism. Their assessment highlights the significantly higher number of IMG doctors in both cohorts of the GIM pilot, through other non-IMT '*alternative certificate*' routes.

In this context, of significant relevance are the results of the RCP census survey that has also demonstrated the variation in consultants that undertake research according to specialty.[9] In particular, working in a specialty that participates in care of general medical inpatients was negatively associated with undertaking research. This could also have longer-term consequences and implications for consultant-led and -delivered future healthcare services in the NHS.

CRediT authorship contribution statement

James Riley: Writing – original draft. **George I Varughese:** Conceptualization, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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