‘Black sheep in the herd’? The role, status and identity of generalist doctors in secondary care

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Abstract

Changing patient demographics raise important challenges for healthcare providers around the world. Medical generalists can help to bridge gaps in existing healthcare provision. Various approaches to medical generalism can be identified, for example hospitalists in the US and the restructuring of care away from medical disciplines in the Netherlands, which have different implications for training and service provision. Drawing on international debates around the definition and role of generalism, this paper explores one manifestation of generalism in the UK in order to understand how abstract ideas work in practice and some of the benefits and challenges.

Broad-based training (BBT) is a two-year postgraduate training programme for doctors recently piloted in England. The programme provided 6-month placements in four specialties (General Practice, Core Medicine, Psychiatry and Paediatrics) and aimed to develop broad-based practitioners adept at managing complex and specialty integration. Our longitudinal, mixed-methods evaluation of the programme demonstrates that although trainees value becoming more holistic in their medical practice, they also raise concerns about being perceived differently by co-workers, and report feeling isolated.

Using identity theory to explore the interplay between generalism and existing boundaries of professionalism in healthcare provision, we argue that professional identity, based on disciplinary structure and maintained by boundary work, troubles identity formation for generalist trainees who transcend normative disciplinary boundaries. We conclude that it is important to address these challenges if generalism in secondary care settings is to realise its potential contribution to meeting increasing health service demands.

Introduction

The challenges inherent in changing patient demographics

Across the globe, countries face competing demands to balance monetary and fiscal policy and sustain healthcare priorities in a context of ageing populations and increasing prevalence of multi-system diseases and lifestyle-related illnesses. These shifting demographics have widespread implications for health and social care. As life expectancy has increased, so has the average number of years spent in ill-health, as many previously life-threatening conditions now manifest themselves as long-term conditions.[1,2] In Britain, those with long-term conditions and multi-morbidities account for 64 percent of outpatient appointments and 70 percent of hospital bed days, leading Ham *et al.* to describe this group as 'the most intensive users of health and social care services'.[3] This has important ramifications for the delivery of care, as more patients require continued support and management rather than episodic interventions .[4] This overall rise in the number of individuals with complex, long term conditions and multi-morbidities presents significant challenges for healthcare providers in both primary and secondary care .[5] A growing demand for primary care (community-based) services has been linked to longer waiting lists and increased pressure in secondary care (hospital-based).[6] In England in 2012-13, 26.5 percent of unplanned accident and emergency attendances were preceded by unsuccessful attempts to secure a convenient appointment to see a general practitioner (GP).[7] In the secondary care setting concerns have been raised by physicians about a lack of continuity and overall responsibility for the care of this type of

patient.[8] Specifically, problems include delayed admissions, 'safari' ward rounds (in which a specialist supervises patients distributed across many wards) and a lack of access to specialist consultation.[9-11]

Generalism as a possible way forward

Current modes of organisation in healthcare provision based on discipline-based specialisation[12] are not ideally calibrated to caring for patients with complex needs.[13] This has led healthcare providers in the US and Europe to consider alternative arrangements.[14,15] There are calls for a shift away from single-disease frameworks to enhance efficiency, safety and effective health coverage. [16,17] Multiple treatment strategies for multimorbid patients involving contact with a multiplying number of different professionals, increase the risk of conflicting medical advice and polypharmacy (patients taking four or more different types of medication).[18] Many healthcare providers now seek to offer integrated and multidisciplinary approaches to care.[19] For example, at the Erasmus Medical Centre in Rotterdam, care provision has been restructured away from medical disciplines to a model based on patients with multiple conditions.[17] The building international interest in medical generalism, as an important part of the integrated care agenda, is rooted in the belief that doctors who combine primary care with specialisation, or those in secondary care who acquire inter-specialty expertise, can help address these challenges by bridging gaps in existing provision.[20-22]

There are a number of different interpretations of the generalist role[21] and various models have been developed in different national contexts. For example, in the US the role of the

'hospitalist' has become increasingly important: the hospitalist is a generalist physician responsible for patients throughout their hospital stay – in medicine, intensive care, 'step down' (high dependency), paediatric and surgical units.[23-25] Contrary to traditional conceptualisations of generalism that are limited to the primary or community setting,[26-28] the term hospitalist draws attention to the role of medical generalists in secondary care.

Debates on medical generalism in Australia have largely been focussed on meeting the needs of remote populations, but the Cairns Consensus Statement on Rural Generalist Medicine also recognises the importance of medical generalism in addressing the challenges posed by ageing populations.[22] In this model generalist doctors develop the skills of a family physician in addition to skills in specialist areas (such as emergency medicine, palliative care, obstetrics, anaesthetics, surgery, paediatrics or elderly care).[21,29] Increasing numbers of Rural Generalist Medicine trainees in Australia are being trained to adapt their skills to the needs of the population they serve and to work in collaboration with both 'local' and 'distant' others.[21,22] In the UK an increasing number of acute physicians, (a variant of the hospitalist role with some important distinctions[23]), now work in Acute Medical Units (AMUs) to provide rapid multidisciplinary medical assessment. AMUs have been associated with significant decreases in length of stay and cost without diminishing the quality of care or patient satisfaction.[30,31] There are calls in the UK for greater integration between general practitioners working in the community and hospital-based specialists.[3,20] A number of Royal Colleges argue that interdisciplinary teams of specialists, nurses and other clinicians will need to work together.[32]

Whilst it is widely argued that more generalism is needed amongst medical practitioners to deliver healthcare services that meet the demands of multi-morbidity and complex care needs, there is little consensus on what constitutes generalism and a range of different definitions exist.[21] This paper contributes to these debates by examining a specific mobilisation of generalism: the Broad Based Training (BBT) programme in England. It complements the established body of work exploring inter-disciplinary boundaries between doctors and other members of the multidisciplinary team,[33-36] by focussing on disciplinary boundaries *within* the medical profession, and how these boundaries might hinder the *intra*-professional integration of care.[19]

BBT as a particular mobilisation of generalism

In England, a new postgraduate training programme aimed at fostering generalism ran between 2013 and 2017. We have chosen this Broad Based Training (BBT) programme as a means of exploring ideas about generalism, since it was specifically designed to address the generalist agenda. Three key aims of the programme were to (1) promote specialty integration, (2) develop practitioners with a broader perspective and (3) develop practitioners who are able to manage complex cases. The programme, introduced by Health Education England and The Academy of Medical Royal Colleges, means that postgraduate medical trainees experience 6-month training placements in four specialties (GP, Core Medicine, Psychiatry and Paediatrics). The effect of this is to broaden their experience and extend their overall training period by one year. Trainees began the BBT programme after completing two

years of postgraduate Foundation training, at a time-point when they would traditionally be starting specialty training in just one medical discipline. After BBT, trainees go on to further training within one of the four participating specialties, joining those in the second year of the traditional training route.

Our mixed-methods longitudinal evaluation suggested that the BBT programme met its aims and that trainees developed more holistic generalist skills, demonstrating competency in managing complex cases and applying an integrated understanding of specialty areas to their practice.[37] This fits with existing research exploring the potential for a more generalist approach to improve patient experiences and outcomes.[23-25] We note that the relationship between generalism and the quality of patient care is a somewhat contested and context-dependent issue,[16] and requires further study. However, in this paper we turn to the experiences of medical trainees to focus on another, often overlooked element of the debate: the challenges that generalism poses to existing models of professional identity. Such understanding is needed in order to be able to address the challenges posed by remodelling healthcare systems.

We briefly outline some of the concerns expressed by trainees from the first and second cohorts of the BBT programme during focus group discussions. Cohort 1 (BBT2013) began the programme in August 2013 (n=42 at outset), cohort 2 (BBT2014) enrolled in August 2014 (n=30 at outset); eight trainees left the programme for a variety of personal reasons. We held nine focus groups with 61 participants in total, 49 unique individuals and 14 trainees participating in

more than one group (see Table 1). Focus groups were conducted bi-annually at national BBT meetings in London between 2014 and 2015. The voices of trainees not attending any of the meetings were unheard (n=15). Unfortunately, due to the wide geographical spread of these particular trainees and their timetabled commitments it was not possible to arrange additional focus groups with them. Trainees were initially invited by letter to take part in the evaluation prior to their first national meeting. Research team members introduced themselves to new trainees in person at the national meetings. Participation was voluntary, participants provided written consent and are anonymised. Research ethical approval for our study of the BBT programme was obtained from [removed for blind review] University (02/10/13).

Table 1: Focus Groups – data collection points

	May 2014	**November 2014**	**May 2015**	**Total participation**
BBT Cohort 1 (2013) n=42 at outset	3 groups (n=28)	2 groups (n=11)		**39 participants** *33 unique individuals*
BBT Cohort 2 (2014) n=30 at outset		2 groups (n=11)	2 groups (n=11)	**22 participants** *16 unique individuals*
Total trainees n=72 at outset.8 trainees left programme (n=64)				**61 participants** *49 unique individuals*

A topical steering approach was taken to moderating focus groups.[38] To counter the deductive tendency of focus groups[39], question guides included general open questions designed to capture a range of views. Our objectives were to explore trainees' experiences of the BBT programme and how they felt BBT was performing in relation to its stated objectives, and gather their views on the shape of future medical provision. A directed approach to content analysis was employed to systematically categorise collected data.[40] A coding frame was developed iteratively and subjected to ongoing concordance testing by three members of the research team, with the whole team meeting to discuss coding at points during analysis. Data coding was managed using NVivo 10.

Within this paper, we use these data to explore the interplay between generalism and existing boundaries of professionalism in healthcare provision. We note that this paper draws on just one aspect of our ongoing mixed-methods evaluation of the BBT programme and should not be read as a comprehensive report of findings. A more detailed description of our complete study and methods employed are provided elsewhere.[37]

Challenges of generalist training

Isolation and uncertainty about professional identity

Lack of knowledge about the BBT programme amongst colleagues was regarded as a key problem, with trainees having to 'trail-blaze' and explain the programme to others. Colleagues struggled to understand 'what kind of level' BBT trainees were at in terms of their skills, expertise and training grade, and trainees often reported being incorrectly labelled as 'just a GP trainee'. This is unsurprising considering that the programme was initially implemented as a pilot with small numbers of trainees in each region (n=42 in cohort 1 and n=30 in cohort 2 spread across 7 and 6 English regions respectively).

Interestingly, whilst lack of knowledge seemed to be less of a problem amongst cohort two as more found that those around them had some familiarity with the programme, trainees continued to describe issues related to their identity and how they fitted in with others in the workplace and the more troubling issue of isolation emerged (see Box A). As there were so few in the cohort, they felt isolated from other trainees on the BBT programme. Not having regular

meetings with other broad-based trainees, and spending most of their time with those on traditional GP/core medical/paediatrics/psychiatry programmes led to feelings of uncertainty about identity.

BOX A: isolation and uncertainty about identity

Two of us are in [City A] and two of us are in [City B], so we never meet…we won't see each other. We don't follow each other around…its very isolating (Cohort1 May 2014)

I don't feel like I'm BBT. I mean I do in that I tell everyone that I'm a BBT but also a CT1 [year one core trainee], but I feel like I'm more of a CMT [core medical trainee] at the moment rather than broad based trainee, because I'm going to so much teaching in CMT (Cohort2 November 2014)

You just feel like you're completely just a black sheep in the herd (Cohort1 November 2014)

Training, availability, and experiencing resentment from others

Trainees also experienced resentment from others, due to the 'special treatment' they were given. The additional training opportunities (notably the requirement that they spend time in different specialty areas) that are not a feature of traditional programmes caused friction between trainees and colleagues (see Box B). Both senior and junior staff questioned the legitimacy of trainee absence from the ward due to training commitments. This 'lack of understanding' caused some trainees to feel 'guilty' about their additional training opportunities, seeing it as a 'privilege' not afforded to regular trainees. This led to some feelings of anxiety amongst trainees. One trainee called for 'a wider understanding of what BBT actually is' in order to 'champion a better understanding' of the importance of their inter-

specialty training rather than 'trying to, kind of, excuse it'. However, that these concerns were particularly prevalent amongst the second cohort suggests that it was not merely a problem of lack of knowledge of BBT, but indicative of a negative attitude towards BBT from some quarters. Some trainees suggested that these issues were related to systems rather than to individuals (see Box B).

BOX B: experiencing resentment from others

I get a lot of resentment for taking the [time in other specialties]...[it] has been educationally great, but they basically were blaming me for not being on the ward, and juniors were being resentful towards me (Cohort2 May 2015)

They're very helpful as actual people…but the practicalities, it's very difficult to take the time. So when you take the time off they're annoyed that you're not there (Cohort2 May 2015)

Barriers to skill development and recognition

The problem of being seen differently was also linked to skill development, with trainees on the BBT programme reporting that those on traditional training pathways were sometimes given priority over BBT trainees when it came to practising procedures. Trainees also expressed concern that those around them did not recognise their competence (see Box C).

BOX C: barriers to skill development and recognition

You get overlooked for procedures...if you're the paediatric trainee then you're the first name that comes up if there's a lumbar puncture that needs doing. They'll come and ask you if you want to have a go. I didn't get any of that. (Cohort1 Nov 2014)

In certain specialties the people around you are still a limiting factor, because although you might feel that…you could manage this, actually the people around you…don't feel like you could (Cohort1 Nov 2014)

There's no point in having all this knowledge if really what you are made to do is hand to someone else when you could do it yourself. (Cohort1 Nov 2014)

Trainee perspectives on generalism and current organisational structures

Trainees reflected on existing structures of organisation and expressed frustration that the current healthcare system may not be ideally calibrated for medical generalists. Although they were confident that the generalist skills they were developing would make them 'better doctors', it was unclear to trainees how these skills would be utilised, whether they would be able to keep abreast of new developments across a wide area, and how generalism would look in their future careers (see Box D) .

BOX D: Generalism and current organisational structures

We talk about generalism and patient centred care…[but] you have people who work in specialties with no understanding how anyone else works, so you get…people saying, 'well they don't want…anything to do with that, refer it to that person'. That patient then becomes…disadvantaged as a result. (Cohort1 Nov 2014)

You can see it, but whether you can do something about it is a different matter…We see people who will come in…and [experienced doctors] say, 'oh they probably need to see someone about X, send them back to their GP and they can refer them' and you think, I can send that referral now… [but] it's just not the way the system works. It's not the way it's funded…there's a lot more restrictions that you hadn't realised. (Cohort1 Nov 2014)

I think the whole concept has got to change to adapt…it doesn't seem to me like it can really carry on…in its current form (Cohort1 Nov 2014)

Discussion

Our evaluation of the BBT programme[37] indicates that it is successfully achieving its aims, and that trainees are confident about their ability to integrate care and deal with complex cases. However, whilst equipping doctors with generalist skills seems to be good for patients with complex care needs, it may be troubling for trainees themselves. In this discussion we draw on sociological theories to understand and interpret the challenges faced by generalist trainees. First we consider the issue of trainee experiences of isolation on this programme (Box A) through the lens of Lave and Wenger's communities of practice[41] linking this to conceptions of role modelling and 'legitimate peripheral participation' [41](Box C). We then use identity theory, and in particular, ideas about professional identity and boundary work within the medical profession to offer potential explanations for our findings. We suggest that medical

generalists, in transcending the disciplinary boundaries that have been central to the development of doctors' professional identities as specialists, disrupt normative structures of meaning making and professional identity formation (Boxes B and D)

Isolation and lack of role modelling: implications for professional identity development

The identity issues experienced by these trainees are not solely linked to lack of knowledge about BBT as a nascent programme. Indeed, issues related to isolation and identity were more prominent in the focus groups with trainees in the second cohort than in the first, despite enhanced awareness of the programme in the second year. To make sense of this, Lave and Wenger's concept of 'legitimate peripheral participation' is instructive. It concerns 'the process by which newcomers become part of a community of practice'.[36] Lave and Wenger argue that learning is a socially embedded process that entails involvement in a group and 'opportunities for participation' (p.101):[41]

> *To become a full member of a community of practice requires access to a wide range of ongoing activity, old-timers, and other members of the community; and to information, resources, and opportunities for participation*

BBT trainees, as learners, are 'engaged in the process of becoming a full participant in a sociocultural practice', in this case, a doctor in a specific specialty (p.27).[41] However, they experience some difficulties in relation to their professional identity and opportunities to more fully participate (Boxes A and C). Lave and Wenger suggest that 'hegemony over resources for learning and alienation from full participation' can 'truncate possibilities for identities of

mastery' (p.42)[41]. In other words, if trainees are denied legitimate access to learning experiences and membership to a community of practice (for example, the community of Paediatric trainees in a particular unit), then their opportunities to become part of that group and to master that identity are curtailed. Our analysis suggests that in some instances BBT trainees might be denied the status of full participation during their specialty rotations, for instance through not being invited to undertake certain procedures or take responsibility for referral decisions (Box C). This has the effect of leaving them at the periphery of the group. The consequences of this seem to be exacerbated by limited opportunities to develop their own identity as BBT trainees, and their own sense of a community of practice as they are dispersed across different regions, teams and specialties (Box A). Whilst the experiences of isolation felt by trainees may be a characteristic of this particular programme, there are important implications for other generalist programmes in which trainees are expected to work across wide geographical areas (e.g. rural generalists in Australia) and who may find it difficult to participate in communities of practice.

Trainee isolation and perceived lack of role models may well act as barriers to identity formation and recognition. One concern is that these doctors are being trained for roles that do not yet exist in the UK context, where healthcare organisation in hospitals is still largely based on discipline-based specialisation. In the UK, hospital-based doctors predominantly work in specialised departments and individual clinicians either 'own' patients, or refer them on to another department (p.220).[15] This might mean that the only generalist role models that these

trainees are able to identify are in the primary or community-based setting. However, our research suggests that a degree of generalism already exists in secondary care and needs to be better recognised.[42]

Intra-professional boundaries: implications for professional identity development

Ideas about professional boundaries and boundary work are also instructive and assist our understanding of the challenging experiences demonstrated in our data. Professional boundaries, defined as 'socially constructed demarcations that establish what is, and what is not, a profession's sphere of competence and legitimate domain of activity' are constructed, negotiated and maintained by social actors, including doctors themselves (p.32).[19] Given the longstanding functional organisation of secondary care services in the UK, as with elsewhere in the developed world, Liberati et al. argue that 'medical disciplines have become deeply internalised organisers of meanings, identities and social norms' (p.35).[19] Their view fits with our understanding of identity as dynamic, multifaceted and constructed through individual, interactional, institutional, and national orders.[43]

Thus, medical disciplines or specialties do not just organise the medical division of labour but also play a key role in shaping professional identities, loaded with moral and normative connotations, and providing the means for collective identity-making.[19,43] Medical specialists in different disciplines each constitute their own jurisdictions through processes of

differentiation from other professional groups, and this 'labour of division' allows for the formation of distinctive professional identities[44]. Specialist medical training is a key site of professional socialisation, and those training in different disciplines will develop different professional identities (Boxes B and D).[45]

Current trends towards interdisciplinary working and fostering generalism may therefore challenge and disrupt existing means of professional identity formation amongst specialist doctors. Indeed, if specialist doctors' sense of 'authority' and 'exclusivity', are forged on the basis of their 'independent and self-contained field of knowledge' (p.69),[44] it follows that any attempt to reorganise the professional boundaries of specialist care may threaten or undermine specialist doctors' sense of status and identity. Some of the trainee excerpts in this paper may therefore be read as responses to the 'boundary work'[44] of their medically specialised colleagues. In Box D, for example, we hear how organisational structures mean that doctors work in *exclusive* specialties and develop *independent knowledge* with "no understanding how anyone else works". In Box C, we see that BBT trainees feel that they are denied access to certain speciality *exclusive* procedures and the *authority* to practise according to their skills. If disciplinary boundaries are deeply rooted in processes of professional socialisation[19] and reflected in restricted organisational structures that enable individuals to forge their own professional identity, then changes to disciplinary boundaries, such as the introduction of a generalist training programme, may disrupt this organisation.

Conclusions

The ability of healthcare providers to address complex population care needs whilst providing sustainable healthcare coverage is critically important. The well-documented calls for a shift away from single-disease frameworks in healthcare systems are premised on the idea that more holistic approaches to patient care will enhance the efficiency, safety and effectiveness of healthcare provision. However, without appreciating the experiences and understandings of those working in healthcare environments, we will not be able to understand and address the challenges posed by remodelling healthcare systems. Whilst medical generalism, as a key arm of the integrated healthcare agenda, is gaining international attention, our study suggests that challenges faced by the trainees on the BBT programme have broader implications for the training of medical generalists. Trainee experiences of isolation raise important questions about how medical generalists can forge a sense of professional identity when separated from peers during their training. If the generalist agenda is to progress, then it is paramount to find ways to establish communities of practice for generalist trainees and to provide sufficient role models. These should be important considerations for those wishing to design and implement generalist training programmes. The work of the Association of Elderly Medicine Education (AEME) to raise the profile of geriatric medicine amongst trainees, and the recent success of their 'Juniors4Geriatrics' movement in the UK might be regarded as a step towards a reappraisal of the generalist role.[46]

We also suggest that the introduction of a generalist training pathway affects workplace relations between different groups of doctors. Using identity theory to explore the interplay between generalism and existing boundaries of professionalism in healthcare provision, we argue that professional identity, based on disciplinary structure and maintained by boundary work and labour of division, troubles identity formation for generalist trainees who transcend normative disciplinary boundaries. This has wider implications for the generalist agenda as intra-professional boundaries and silos within the medical profession may challenge holistic approaches to patient care. Our work echoes existing research finding that the effective integration of care may be inhibited by attempts to maintain existing boundaries, knowledge and practices.[19] Of course, it is important to recognise that factors outside of education and training will also shape professional identity.[47]

This paper lends some insight into the way that boundaries among discipline-based groups are constructed, and into the 'struggles and adjustments of health professionals confronted with macro-level policy changes' (p.32).[19] By providing an account of how one mobilisation of the generalist agenda troubles existing categories of professional identity, this paper makes a nuanced contribution to knowledge on the likely implications for implementation of such new systems. This knowledge may then be used to offset or manage some of the issues raised, thereby enhancing the likely success and sustainability of these new models. If generalism in secondary care settings is to realise its potential contribution to meeting increasing health service demands, then how medical generalists are supported and trained needs attention.

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