Out of Hours

A revolution in the making:

a suggested model for training NHS doctors

A STRUGGLING SERVICE

I believe that the NHS is in need of a revolution. The service is struggling to provide the correct balance of specialists and generalists to meet the complex and multiple demands of today's patients. Suffice to say, a successful future NHS needs a flexible, adaptable workforce with the right skills and in the right numbers for the population's medical problems. Service provision must be patient centred and clinical career trajectories need to attract doctors into the community.

I envisage an NHS that provides efficient and holistic patient care at each point of contact. In addition, I want to work in an NHS that looks after me, as a doctor, considering my needs to train flexibly, to pursue my career interests, and to raise my family. I want to utilise my skills and my training; fulfilling my clinical and academic potential in a career flexible enough to allow the opportunities for this.

A PROPOSAL FOR CHANGE

Here, I present a proposal for change but, in the first instance, I would like to consider the concept of 'expert medical generalism' as per the Royal College of General Practitioners' projects of recent years. It is certainly correct that it takes great skill and training to undertake the role of the expert generalist well and that this role is central to joining up a patient's problems in a holistic fashion. However, the expert generalist cannot always provide the detailed specialist knowledge a patient often requires and, as such, there will always be a need for sub-specialist knowledge. Fundamental to my proposal is the idea that expert generalism and sub-specialising are not mutually exclusive. Indeed, many GPs have portfolio careers and develop skills in addition to their regular GP work.

Thus, first imagine that all care is community-based unless acute or in-patient care is needed. Newly-qualified junior doctors train for a year each in the community and in hospital. Following this, trainees enter either general practice (community generalism), hospital practice (acute and in-patient generalism), or stand-alone training (for example, anaesthetics). The number of training posts in each specialty is concordant with predicted patient need. The community and hospital generalists are trained and assessed by

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their respective educational bodies on expert generalism in the community or acute/in-patient fields, thus achieving generalist qualifications.

Community and hospital colleagues may continue to develop expert generalist careers or additionally train in a sub-specialty. Sub-specialising trainees would work in a team, towards a specific curriculum with sub-specialty qualifications

provided on completion of training. In some sub-specialties, training for hospital and community colleagues may involve different experiences; for example, training hospital doctors as interventional cardiologists and community doctors as heart failure consultants. Because they would also be qualified GPs or hospital generalists, they would also be equipped to provide or facilitate a holistic approach in service provision. Sub-

Figure 1. A suggested model for a new NHS workforce.

Figure 2. Comparing doctor training models: current versus proposed.

specialty training programmes could include non-clinical subjects such as management or healthcare planning (Figure 1).

CAREER FLEXIBILITY AND PATIENT BENEFITS

The model gives junior doctors experience in both community and hospital fields at a foundation level, so that a more informed choice on their futures may be made. It allows career flexibility for the clinician, who may become an expert generalist and a sub-specialist in the community or hospital. Medical generalism in the community

(a.k.a. 'general practice') would be a more popular choice as the avenues of possibility within the community setting increase.

Equipping community GPs with sub-specialist skills supports the movement of services into the community. Training all doctors as expert generalists first would create sub-specialists who are in tune with the holistic needs of their patients. Training hospital and community doctors together in sub-specialties would create teams who jointly design the relevant services. These teams would break down the artificial primary-secondary care boundary and

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reduce the incidence of patients bouncing from community to hospital to community where problems are solved in a piecemeal fashion with several layers of bureaucracy in between (Figure 2).

The ideas presented here are a potential blueprint for an improved and sustainable NHS. If they could be debated/adapted/improved on, I believe that they have the potential to create a brilliant new NHS and a lasting legacy for the future health care of the nation.

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