Title: Generalism and the Medical Licensing Assessment: The Devil's in the Detail.

The General Medical Council (GMC) introduced the Medical Licensing Assessment (MLA) to ensure that all doctors seeking registration to practise in the UK meet a common threshold for safe practice. [Ref] The MLA comprises an Applied Knowledge Test (AKT) and a Clinical and Professional Skills Assessment (CPSA), underpinned by a *content map* structured into six domains [Ref]. For instance, Domain 4 is an extended list of presentations the Foundation Doctor might be likely to encounter.

The content map (MLA-CM) is hugely influential in determining the nature of exit assessments in UK medical education. As such it embodies the values of modern medicine in the UK. Rightly, the GMC is keen to ensure that the MLA-CM is fit for purpose and reflects society's expectations of newly qualified doctors. To achieve this, the GMC launched a review process for the MLA-CM in 2024.

As GP educators in the *Society for Academic Primary Care* (SAPC) Heads of Teaching group, we coordinated a response to this call. We suggested presentations and conditions missing from the first iteration – for example Domestic Violence and Abuse. We also emphasised the importance of understanding the context in which disease states arise – with reference to things like childhood trauma, migration status, poverty, insecure housing, discrimination and other social determinants.

The GMC has recently published the results of its 2024 MLA-CM review and is asking for further feedback. In this editorial, we reflect on the latest iteration on the MLA-CM, and explain the vital contribution of medical generalism to the framework.

Progress Made

The GMC's recent revision of the MLA-CM deserves recognition [Ref]. Their "you said, we did" summary document, now in the public domain shows responsiveness to a wide range of stakeholder feedback. For instance, 126 new conditions have been added to the master list. These includes additional conditions proposed by the SAPC: gender dysphoria, pre-diabetes, health anxiety and metabolic syndrome. There is clearer signposting to the social determinants of health and EDI principles within Domains 2 and 3, and more nuanced language around managing uncertainty, complexity, and polypharmacy.

Domain 3 of the MLA-CM covers the "Clinical and Professional Competencies" and this section now contains more reference to the importance of acknowledging social determinants including lifestyle factors, housing, digital literacy, and protected characteristics. Additionally, bias awareness and deprescribing are included, and "avoiding over-investigation" is newly emphasised. We can't claim credit for these additions, but they feature prominently in our feedback to the GMC in 2024.

The Devil in the Detail

While the MLA-CM has a more generalist feel, the document still feels heavily swayed towards a medicalised perspective. You might get the impression that if only doctors knew how best to manage the long list of presentations and conditions, all would be well. As all doctors know, reality is more complex. For a start most people develop multiple conditions with advancing age. [Ref] We know that doctors tend toward over-investigation and over-treatment especially when many specialties are involved. And often the diagnosis is far for clear, and presentations are underpinned by social problems. We feel these generalist perspectives need to be more clearly articulated for the MLA-CM to meet its potential in serving patients in the modern NHS.

Generalist Perspectives in Need of Emphasis

Though Domain 5 (presentations) of the MLA-CM now includes different types of abuse, other presentations of social complexity are conspicuously absent. For instance, there is no mention of the need for F1s to understand how best to use interpreter services. Similarly, migration-related issues, and insecure housing don't get a specific mention in this domain. These are not peripheral concerns. They are central to equitable and effective care in modern Britain.[Ref]

While Domain 3 now mentions social determinants, it stops short of requiring action—such as signposting for housing support or safeguarding referrals. Understanding these issues without tools to respond is inadequate. For instance, where an F1 perceives discrimination, they need the skills to take action in support of the individual. We know that between 43–61% of UK working-age adults having low health literacy [Ref], and we need to specifically emphasise communication skills for this (large) group.

The GMC's summary notes the importance of addressing "diet, nutrition, exercise, alcohol consumption, and fitness to work" [2], but this list is absent from the actual MLA-CM. We advocated that the phrase "health promotion" be unpacked into specific, assessable lifestyle conversations that foster agency and shared decision-making. Medical students have already shown efficacy as health coaches. [Ref]

As said, the revised map remains silent on the complex interplay between migration status and health. This is a glaring omission. Many Foundation doctors will encounter patients facing trauma, housing precarity, and fear linked to asylum status. These social presentations demand understanding and confidence in signposting.

Patients (including doctors!) frequently use CAM therapies—sometimes in ways that interfere with or delay effective treatment. Doctors must be able to elicit, interpret, and respond to this information respectfully and safely.

What's at Stake?

If the MLA omits these dimensions, we risk licensing doctors whose practice is blind to the social complexity of patient lives. We create clinicians who can diagnose Addison's disease but miss the signs of domestic violence. Who can prescribe insulin but fail to check if a patient has refrigeration or stable housing. Who can explain treatment risks but lack the skills to communicate in plain language or with an interpreter. The MLA rightly avoids trying to assess everything. But what it chooses to include—and exclude—sends a powerful signal about what matters.

Generalism as a Foundation, Not a Specialty

Generalism is not synonymous with general practice. It is a core professional orientation: a willingness to work across boundaries, balance competing needs, and see people in context. It is the ability to navigate uncertainty, co-create plans with patients, and adapt to limited time and information.

This approach is needed in A&E, psychiatry, care of older adults, and beyond. It should be central to how we train and assess new doctors. The GMC's themes of uncertainty and person-centred care open the door to this. But without a deeper integration of generalist skills and values into the MLA, that door risks closing again.

Recommendations

To make the MLA better reflect generalism and real-world readiness, several integrated changes are needed. First, the list of presentations in Domain 5 should be expanded to include poor health

literacy, language barriers, the use of complementary and alternative medicine (CAM), insecure housing, and migration-related health issues. These are all common and significant factors that shape patient care in real-world settings.

Second, Domain 3 capabilities should be enhanced to reflect the practical skills required of new doctors. This includes the ability to work effectively with interpreter services and to communicate using accessible techniques such as 'teach-back'. Candidates should also be able to initiate meaningful lifestyle conversations around nutrition, sleep, physical activity and alcohol use, and demonstrate competence in signposting patients to appropriate support for challenges such as unsafe housing, safeguarding concerns, or trauma.

Finally, both health literacy and cultural competence should be treated as explicit and assessable elements within the CPSA. These are not theoretical additions. Many are already embedded in undergraduate curricula and routinely assessed at the local level. The GMC now has an opportunity to normalise and elevate their importance across national medical licensing.

Conclusion

The GMC's latest revisions to the MLA content map are encouraging. They show a willingness to listen and evolve. But we must go further. If the MLA is to fulfil its promise of preparing doctors for safe and effective UK practice, it must more fully embrace the realities of generalist care.

That means confronting the social, cultural and linguistic complexity of the patients our graduates will meet. It means supporting doctors not only to identify problems but to act on them. And it means equipping them to see people—not just pathologies—in every consultation.