

Report of the Generalism and Generalist Task Force
Education Strategy, Innovations, and Development Unit
Royal College of Physicians and Surgeons of Canada
July 2013

Background

Foreword

The production of this report represents a synthesis of intellectual contributions of a dedicated group of individuals who participated at the formal consensus conference on Generalism in Medicine. This event was held on February 21, 2012 at the headquarters of the Royal College of Physicians and Surgeons of Canada in Ottawa, Ontario. The Task Force wishes to thank all of those who lent their perspective on the meaning of generalism in medicine. This report is based on the outcomes of that conference and is informed by the experts who contributed to the overall process to develop consensus.

The Task Force is grateful to the Canadian Institute for Health Research (CIHR) for their financial support of this project.¹

Introduction: Defining the Problem

It is a closely-held, but unverified belief, of the Canadian healthcare system that generalism, and increasing the number of generalist physicians, will ensure coordination of care; a function that is increasingly absent in the Canadian healthcare system whereby multiple independent specialists look after apparently independent episodes of care. The interrelation between generalism in medicine has, for decades, been a focus of discussions among specialty and Family Medicine, federal/provincial/territorial governments, medical regulatory authorities, academia, and research institutions. Discussions have primarily centered upon the number and mix of physicians from generalists² to subspecialists, as well as the implications for workforce planning, medical education, and access to care.

However, it is clear within the literature as well as discussions with key stakeholders in this dialogue, that there is a lack of a common definition of the term generalism as it relates to medicine, and specifically, medical education; this gap has hampered the ability for various healthcare stakeholders to advance the agenda, using a common language, regarding timely access to the right care by the most appropriate providers, across the continuum.

In consideration of this existing gap, the Royal College of Physicians and Surgeons held a Canadian Consensus Conference on the Future of Generalism in Medicine (CCC), funded by the Canadian Institutes of Health Research (CIHR). The CCC focused on resolving five key implications:

- Generalism is a strongly held value in medical culture, yet common agreement on a definition of generalism in medicine is lacking.

¹ The Development of a National Consensus on the Definition of Generalism in Medicine; Meetings, Planning and Dissemination Grant - Canadian Institutes of Health Research (#236835)

² In this document, generalists include medical practitioners providing primary or specialty care, engaged in a broad based practice.

- Without a common definition, medical education institutions and clinical teachers are left to their own devices to interpret and teach the skills, attitudes and values of generalism.
- Planning for the appropriate mix and number of generalists, specialists and subspecialists to meet societal health needs is further complicated by the multiple interpretations of the definition, which translates into further debate regarding which medical disciplines are thought to embody the principles of generalism (i.e. generalist disciplines).
- Lack of consensus regarding which providers are generalists also confounds the dialogue regarding timely access to the right care by the most appropriate providers, across the continuum.
- Improper understanding of the impact of generalism on both health human resources and the health care system can negatively affect the creation of targeted policies and strategies, which could result in harmful unintended consequences.

Objectives of the Conference

The key objectives of the CCC were to:

1. Reach a consensus on the definition of generalism in medicine;
2. Reignite a national level debate on the future of generalism in medicine including its relationship to: a) medical education, and b) health human resources (HHR) and the health care system; and,
3. Discuss strategies to support the development of generalism in medicine in Canada.

Outcomes: Proposed Definitions

The first objective of the conference was to come to a consensus on a definition of generalism in medicine as a first step towards future discussions and decisions regarding health human resources, medical education, training, and the health care system, among other issues. Participants emphasized the need for a positive and inclusive definition that equally validated the importance of both the specialist and the generalist in medical practice, placing patient welfare and the needs of the community at its core.

Participants felt that using one all-encompassing term, “generalism,” did not differentiate between the philosophy of generalism within medicine and the specific generalist role within the health care system. To delineate between these two concepts, participants proposed two interrelated terms: generalism and generalist.

Participants proposed that the term ‘generalism’ be used to refer to a philosophy within medicine that can be considered a core value and a fundamental principle that all physicians should understand and incorporate to varying degrees into their practice:

Generalism is a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs.

Participants proposed that the term 'generalist' could be used to refer to a sub-set of physicians who possess a unique group of competencies. Implicitly, this term captures the concept that dependant upon the nature of one's practice, one can be both a specialist³, while still considered a generalist:

Generalists are a specific set of physicians and surgeons with core abilities characterized by a broad-based practice. Generalists diagnose and manage clinical problems that are diverse, undifferentiated, and often complex. Generalists also have an essential role in coordinating patient care and advocating for patients.

There is a different emphasis placed on generalism ... depending on where you are in that spectrum.
– Dr. Jeffrey Turnbull

Generalism: An Approach to Care

As described above, the concept of generalism in medicine is one that should be embraced and practiced by all physicians. As a subset of patient-centeredness, with physicians able to provide a comprehensive range of services within their discipline, generalism is considered the antonym of fragmentation.

Endorsing the concept of a spectrum ranging from generalists to sub-specialtists, conference participants saw this continuum as a primary factor when considering the function of generalism in practice. Where one lies on the spectrum influences the application, incorporation and utilization of the philosophy of generalism in one's practice. The professional's responsibility and role within their community also dictates the application of generalism.

To outline an example of a generalist approach, a Cardiologist seeing a diabetic patient in hospital for congestive heart failure should be able to adjust the patient's medication for diabetes without referring them to an Endocrinologist, unless in atypical cases or where otherwise required for the best care of the patient. Conversely, an Orthopedic Surgeon who *does not* apply the concept of generalism into their practice will provide a narrower range of services to patients. For example, in a smaller community, an Orthopedic Surgeon with a focus in shoulder and elbow surgery on call sees a patient requiring repair of a non severe ankle fracture. Instead of addressing the patient's needs, the Orthopedic Surgeon instead refers the patient to a "foot and ankle" Orthopedic Surgeon in another town. The result of this type of practice increasingly leads to fragmentation of care.

³ Although the term 'specialist' has many different definitions, the use of 'specialist' in this paper is congruent with how 'specialist' is traditionally defined: a physician who is considered an expert in a particular discipline.

problems. Participants highlighted three key elements of the role and responsibilities of a generalist:

a) Generalists as managers of “the whole patient”

Participants noted that one of the fundamental strengths of the generalist physician is their involvement in and knowledge of all aspects of the patient’s life and their management of undifferentiated problems and multiple conditions. As one participant, Ivy Oandasan, noted, “Someone has to know the whole...and who is that person if we define each of ourselves as specialists?”

It is much more important to know what sort of a patient has the disease than what sort of disease the patient has.
– Sir William Osler

Generalists are able to provide broad-based medical care, cutting across disease pathologies or systems within the body. Using this understanding, they excel at differential diagnosis, particularly for complex or undifferentiated patients. The generalist, aware of a patient’s social circumstances, is able to understand the patient in the context of their world and can therefore effectively intervene to prioritize care.

Example in practice:

A General Internist sees a patient with multiple pre-existing conditions, including cardiac disease and diabetes, who has now contracted an infectious disease. The General Internist is able to not only diagnose and manage the new (acute) illness, but also continues to monitor the pre-existing conditions within the new context, relaying this information back to the referring physician, to ensure the overall health of the patient.

b) The Generalist’s role in coordinating care

There was strong consensus regarding the importance of the generalist’s role in the coordination of care within clinical practice. Participants considered this role as a key aspect of the generalists’ responsibility. Dr. Bill Fitzgerald validated this assertion through his comment: “The generalist undertakes that a patient’s needs will be met.”

Accountability to coordinate...I think that is the critical element for a generalist.
– Dr. Ian Bowmer

Participants recognized coordination of care as a way of addressing the challenges inherent in navigating the health care system. Participants highlighted the problems experienced by their patients in accessing and moving between various components and outlets of the system that function as separate silos. This navigation was found to be especially challenging for those who had multiple chronic conditions.

While generalist physicians are not necessarily able to provide all care necessitated by a patient’s condition, they do have a role in facilitating the patient’s navigation through the system, ensuring they obtain the care they need through appropriate

care and referrals and also maintaining responsibility for the overarching care of the patient as the patient is moved through the system. However, participants agreed that this role in coordinating care does not imply generalists are exclusively primary care; rather, all physicians should facilitate navigation and help to ensure comprehensive care for treatment that is consistent across all encounters with the medical profession.

Example in practice:

A Family Physician sees a patient who has chronic, but well-controlled schizophrenia. Upon each regular visit, the Family Physician monitors the patient for any marked changes that are beyond their scope of practice, alerting the patient to a possible need for referral to a Psychiatrist. The Family Physician ensures that any records from the patient's visits to the Psychiatrist are included in the patient's chart, monitors for metabolic side effects of antipsychotic medications, and also ensures that when she is treating the patient's other acute or emergent conditions, she is mindful of prescribing drugs or therapies that will not have impact on or interfere with the patient's mental health.

c) Generalists as advocates for patients

Although all physicians are responsible for being a health advocate on behalf of their patients, participants emphasized that generalists have a unique role in patient advocacy. As generalists have collective responsibility for the person, including orienting care for the patient as a whole, they should advocate both at the individual and community level for access to the best care possible. Ideally, generalist physicians would be familiar with the socioeconomic and political context of health, and would be able to adopt a caregiving perspective strongly rooted in an awareness of the determinants of health. As a result, generalists are able to advocate for patients widely across the health care system, for a broad range of issues across many audience levels.

Somebody has to accept the responsibility for the overarching wellbeing of that patient and advocating for that patient when [they are] falling through the cracks.

– Dr. Jeffrey Turnbull

Participants at the conference highlighted the distinct and heightened importance of this role for vulnerable individuals and communities. These communities may include: children; the elderly, populations marginalized on the basis of their socioeconomic conditions, and those requiring mental health services, among others. Generalists are able to navigate within these communities and direct patients to appropriate resources to ensure the overall wellbeing of their patients. Generalist physicians are particularly needed in rural and regional communities because of the time and distance separation from highly specialized physicians and medical services.

Example in practice:

A Family Physician sees a patient who has just given birth to her first child. The patient is young, has newly immigrated to Canada and is not familiar with the resources available to her and her new baby. The Family Physician provides the patient with information on local programs to meet her needs, which may extend

beyond immediate health needs to include nutrition, etc.

Implications

The second objective of the Canadian Consensus Conference on Generalism in Medicine was to articulate implications for medical education, health human resources, and the health system.

Comments were raised regarding generalism, generalists, and specialists in the Canadian medical system. Participants were clear about the following: both generalists and specialists fulfill crucial roles in the health care system. Discussions underscored the necessity of both types of practitioners; the system's stability ultimately depends on achieving balance.

Through commentary and discussions at the conference, participants delineated main implications for medical education and health human resources. The following section highlights the participants' identified implications.

I think I'm privileged because I'm training with someone who values the team and the link with community physicians.
– Dr. Nathalie Saad

Implications for Medical Education

a) Teaching the Values of Generalism

Recognizing that the philosophy of generalism applies to all physicians and surgeons regardless of their scope of practice, participants recommended integrating the values of generalism into medical education for every physician. Participants highlighted opportunities to promote this foundational approach throughout the education institution to enshrine these core values.

In particular, participants reiterated the importance of role models as a strong and important influence on the next generation of physicians and surgeons. To ensure uptake of the philosophy of generalism as a commitment to breadth of practice within one's discipline and responsiveness to patient needs, it was agreed that trainees should be exposed to mentors whose practice incorporates these important values.

Participants also commended training initiatives in community-based centres, in addition to tertiary care centres, to impart the role and importance of generalism to future generations. Participants felt that greater opportunities to train in underserved areas might improve retention in these geographic areas across Canada. In addition, participants felt that training in these locales may facilitate learning in integral areas such as collaborative care and, finally, would also ensure residents are exposed to different models of care delivery.

The competencies that we are talking about are the competencies which have undergirded the profession from time immemorial and that is the most difficult thing to teach.
– Dr. Bill Fitzgerald

b) Ensuring the Right Mix of Generalists and Specialists

There was clear consensus on the need for both generalists and specialists in the medical system. However, if the goal is to develop more generalist physicians, it is important to ensure learners are exposed to role models who are generalists.

Participants noted that both undergraduate medical education (UGME) and the rotations of postgraduate medical education (PGME) are systems-based: trainees are taught various physical components of the body and organ systems in relative isolation. Participants saw a key challenge in overcoming this approach to allow more focus on generalist, integrative approaches.

Participants also spoke of various incentives that drive trainees to choose between careers as generalist versus specialist physicians and surgeons. As one trainee, Dr. Nathalie Saad, noted: "As much as I believe in generalism...I am forced, in order to get a job, to sub-specialize...in order to work later on, it's part of the deal." There is a prevailing perception that super-specialization represents strengthened job security and additional ease in securing positions. The converse however is the case in many regional centres, where more often there is a shortage of generalist specialists, as narrowly focused specialists and sub-specialists are not able to provide the broad based care required especially for on call and urgent services.

Participants identified that training opportunities in an environment conducive to generalism would improve retention in communities or disciplines experiencing more difficulty attracting physicians. The group highlighted examples of this approach:

- More family medicine and general specialty residents (and medical students) are spending longer periods of their training in rural communities and regional centres where generalist practice is the norm rather than the exception
- Quebec's third-year residents are streamed into the community in which they will be practicing to gain experience in their community prior to practice and to get more exposure to the types of cases that will be prevalent in their practice population.

c) Curriculum and Structure

Participants noted a concern regarding the rigidity, specificity, and generalizability of current training models with regards to settings. By design, there is remarkable homogeneity in training programs. Our medical education system trains everyone in the same way, regardless of their final practice destination; whether in a metropolitan centre or a remote community. For example, physicians training for rural and remote practice need to develop the generalist knowledge, skills and behavioural competencies to meet community needs with limited local specialist availability. Moving forward, questions may be raised regarding the ongoing appropriateness of a training model that is used for all professionals, regardless of their final destination in practice. In this vein, discussions highlighted the potential of shortening training through the development of individualized approaches and training plans that are clear and specific about training objectives.

Implications for the Health System and Health Human Resources

Discussions about generalism have primarily centered upon the appropriate number and mix of physicians, from generalists to subspecialists, that are needed in Canada given implications for workforce planning, medical education, and access to care. Although this dialogue typically focuses on fostering the development of generalists as a result of trends toward subspecialization within Canada, it is important to note that decision-makers must not only aim to find a balance between generalists and specialists, but they must also strive

to conceptualize a system that allows generalists and specialists to best work together in different models of care delivery and different settings across the country.

Indeed, it must also be noted that specialists can also contribute to the generalism philosophy as the generalism philosophy and specialist practice are not dichotomous. Thus, considerations regarding implications for workforce planning, medical education, and access to care must take into account the roles of both generalists and specialists by acknowledging how specialists can contribute to broader care by embracing the generalism philosophy.

Example in practice:

An Orthopedic Surgeon with a practice focused on spinal care is providing care to a young girl with scoliosis who has travelled from her small community a few hours away to receive specialist care. When examining her, he notices signs of physical abuse, which is confirmed when he asks the young patient about the origin of her injuries. He ensures that the appropriate authorities are alerted, refers his young patient to a Psychiatrist in her community and notifies her local Family Physician for follow up.

The Impact of Incentives

Participants spoke about the challenge of maintaining the value of generalism and the importance of a broad focus on generalism through the postgraduate years, when career-based incentives such as remuneration and status are typically seen to favour specialization and subspecialization in terms of career choice.

Participants acknowledged that maintaining the breadth of practice was difficult for practicing physicians, identifying two primary, external forces that drive the constriction of one's practice:

- Response to community need – Participants saw this as the socially responsible evolution that a physician's practice may undergo in response to a large need within the community in which they practice.
- Remuneration – Participants felt that the current structure of remuneration in the health care system acted as a disincentive to practicing general medicine, as current fee structures provide better financial compensation for more subspecialized services. As a result, physicians could begin to narrow their scope to benefit from such structure, or begin dedicating more of their practice to a narrowed range of procedures or conditions due to such incentives. Participants spoke about situations where physicians had restricted their practice to the point that they either refused or did not feel comfortable performing procedures or treating conditions that are widely accepted as being within their breadth of practice. The group felt this narrowing of practice may have an impact on access to care including the provision of needed on-call and urgent services.

The Importance of Data Collection for Effective Planning

Participants felt that a better understanding of the current mix and distribution of physicians would improve health human resource forecasting, particularly because better data would help determine which geographic areas require more generalists and in what capacity they are needed. Specifically, participants felt that federal and provincial/territorial governments should have a larger role in this area to better synchronize interprovincial planning and coordination. Participants also believed that provincial governments should have a larger role in collaboration with regulatory bodies and universities in order to facilitate sound

planning and training of future physicians. Participants did acknowledge, however, that accurate health human resource planning and modeling is extremely challenging.

A Health Care System in Evolution

Participants emphasized the impact of cost drivers on generalism in medicine: the increasing utilization of health care (i.e. in terms of prescription drug use and diagnostics) and the pressures exerted by an aging population. If sustainability is a focus of health care policy-making, there may be significant opportunities to engage aspects of generalism and team-based care in order to leverage the provision of better, more sustainable, and more integrated care.

The care model is going to have to move outside of the hospital environment, and it's going to be coordinated by people like generalists. – Dr. Jeff Turnbull

Future Research Agenda

In recognition of the need for ongoing deliberations on this multi-faceted topic, participants highlighted several areas for future research. These are as follows:

Explore alternative models for care delivery

Participants noted that there is a need to explore and evaluate models of care organization and delivery, such as interprofessional team-based care, and models that best accompany generalist principles, and designing a system of care delivery.

Additionally, many participants spoke about the concept and models of the patient's medical home and the role this has in generalism. However, there was a limited understanding of this term and its potential application in the Canadian context. In particular, participants raised questions regarding the ideal configuration of this concept so that it is integrated and seamless with the current structure and configuration of recognized disciplines in Canada. This model was considered by participants as a model that may reinforce generalism as it could provide effective and efficient navigation of patient care between various other providers of care; however, it was later noted by the Task Force that this should not be the sole model considered when exploring systems of care delivery.

Furthermore, participants noted that there is value in exploring whether or not generalism and generalists contribute to good quality care at effective cost. A strong evidence base in favour of the fiscal sustainability of a model of care based upon generalism would bolster deliberations and considerations of its role in the health care system.

The ultimate aim is to determine evidence-based answers to the following questions:

- *What is a care delivery system that would best support the generalism philosophy?*
- *What is the ideal model for team-based care? Which of the models best supports generalist principles?*
- *What types of competencies should be included on a team?*
- *How will the structure, role, and members of the care delivery team vary by community or individual needs?*
- *How does the model of the patient's medical home work in the Canadian context? Are there other models that should be considered?*
- *What are the implications for models that shift focus to generalists? Will it lead to improvements or more duplication? What is the fiscal impact?*

Gain a better understanding of current practice undertaken

Deliberations of the Canadian Consensus Conference highlighted a need to gain a better understanding of the types of practices that individuals have to determine whether those who are trained as a generalist go on to maintain a broad-based practice. Participants noted that there may be tremendous value in tracking the actual work patterns of recent graduates over time to understand how practices evolve while also capturing the amount of generalist trainees who go on to maintain broad-based practice and understanding how practice is influenced by job security in specialties (i.e. tension between scholarship and need to serve patients; need to subspecialize to obtain a job). In particular, participants thought it may be valuable to modify accreditation standards, requiring more tracking and data collection from programs; for example, regarding the practice patterns of graduates from the program in clinical practice in order to ensure a consistent and reliable source of data and encourage accountability of residency programs to meet the HHR needs of the country.

Next Steps

In addition to the research agenda, participants of the Canadian Consensus Conference on Generalism in Medicine would like to articulate the following concrete next steps:

1. Engage Royal College Specialty Committees

Given their ability to engage professionals across the country, participants noted a role for the Royal College specialties committees in future discussions surrounding generalism in medicine. Participants felt these committees could work in tandem with their committees and practicing physicians in their discipline to develop strategies to foster generalism within each discipline, such as incorporating the philosophy of generalism, and how it will be taught and practiced within each discipline. Specifically, participants noted that each committee could contribute by developing a statement on key generalist competencies and the three key elements of the generalist role (managing the whole patient, coordinating care and advocacy) that should be maintained by professionals practicing within the individual specialty.

Specialties Committees should also engage the Accreditation, Assessment and Credentials Committees to enhance flexibility and effectiveness of their recommendations in the preparation of generalists.

2. Increased collaboration between key stakeholder bodies

Participants noted a need for collaboration between the three colleges: the College of Family Physicians of Canada (CFPC), the Collège des médecins du Québec (CMQ), and the Royal College of Physicians and Surgeons, as well as other stakeholder groups, with the express purpose to develop new educational models that foster the value of generalism in medicine both within and across disciplines. It was recommended by the Task Force that a subcommittee comprised of the three colleges, Deans, AFMC-PG Deans, ACAHO, ACHDHR (Committee on Health Workforce), Canadian Medical Forum, Canadian Medical Association and government health deputy ministers to help uptake of the proposed definitions and action future research.

3. Dissemination, implementation and future research

To increase uptake of the definitions on generalism and generalist, the final report post-consultations with the Generalist and Generalism Task Force, Royal College Specialty Committees and key stakeholders will be published on the Royal College and other stakeholders' websites. The implementation of recommendations or future research will be led by the Task Force.

Appendix A: Task Force Members

Co-Chairs

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Appendix B: Participants at the Canadian Consensus Conference on Generalism in Medicine

February 21, 2012, Ottawa, ON

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