Are you my generalist or the specialist of my care?

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ABSTRACT

There are ongoing debates in medical literature as to whether it is possible to measure the health outcomes of generalist or specialist care and which approach is more beneficial or cost-effective. A factor that complicates this debate is whether health care practitioners and policy-makers fully understand what the essential dimensions of generalism are. Indeed, other authors have found that the breadth and comprehensiveness of a generalist approach has made it *'notoriously difficult to define what it is'*.[1] These definitional issues are combined with the extent to which, if any, the dimensions of generalism might translate into measurable health outcomes or even contribute to cost-effectiveness of primary health care. In view of these definitional complexities, the question of what the essential dimensions of generalism are is the topic of a review of national and international literature currently underway by the authors.*

Keywords

Generalism, ethics, primary care.

Introduction

The debates between specialism and generalism can be traced back as far as differences between ancient Egyptian and ancient Greek medical practices. Issues such as workforce supply, getting the balance between generalist and specialist skill mix right, keeping costs down in response to ageing populations, and biological and technological changes have faced health care systems historically and presently. Wofford et al. noted this from the Greek historian Herodutus's perspective on the nature of medicine and the *'state of health care manpower [sic] in ancient Egypt'*.[2] Herodutus's perspective was that: *'[m]edicine is practised among them on a plan of separation, each physician treats a single disorder and no more: thus, the country swarms with medical practitioners, some undertaking to cure disease of the eye, others of the hand, others again of the teeth, others of the intestines, some those which are not local.'*[2]

The picture is one of single-focussed, disease-specific care. Not all that dissimilar to current approaches to health care in many Western countries as chronic disease rates rise, co-morbidity increases and multi-morbidities emerge. In this context, governments are trying to find ways to respond to burgeoning

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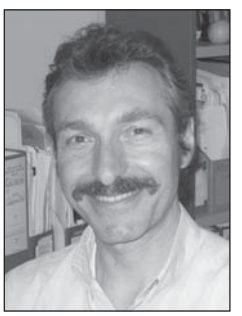

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* This review is funded by the Australian Primary Health Care Research Institute (APHCRI). Co-investigators include Dr Catherine Pope (University of South Hampton, UK), Professor Judith Lathlean (University of South Hampton, UK) and Dr Renata Kokanovic (The University of Melbourne, Australia). Details of the full report can be found at http://www.anu.edu.au/aphcri/index.php

diseases, but often strategies remain singular focussed, and rarely account for the life complexities that people present with.† Dowrick argues, for example, that there is a mismatch between policy and evidence in terms of realignment of fee-for-service systems designed for acute care toward managed care, financial support for high-quality electronic information systems and the need to generate funding models that enhance multidisciplinary care rather than encourage individualist approaches to health care delivery.[3]

In this paper we begin by returning to the Hippocratic conception of physician work from ancient Greece: *'[which was] reflected in the practice of generalist medicine. The patient, not the disease, was to be treated, and to treat the patient well, the physician was to examine him or her as a whole, not merely the organ or body part in which the disorder was located.'*[2]

Generalists as individual practitioners are thus seen to embody the above principles of the Hippocratic Oath to treat the whole person and not simply the disease. To achieve this, the Hippocratic formula was to enquire into the patient's background and gather their life story. Today, this is seen in such approaches as patient-centred care which emphasises that all care ought to be person-centred, holistic, compassionate and provided within a continuous framework that can result in optimal health outcomes.

Heath, Evans and van Weel note that general practitioners' (herein referred to as generalists) working diagnostic and therapeutic knowledge spans biomedical science whereby generalists must be able to forge effective and continuing relations with patients, family members, other carers, and other medical professionals involved in a person's care.[1] Generalists seek to understand equally the *'processes by which illness is socially constructed within the patient's life'* and they mediate between the subjective and scientific domains.[1] In these ways generalists appear as specialists of people's care, a process and practice that is undertaken within quite often complex health systems and under uncertain conditions.

Hippocrates's Oath and formula of care thus provide the underpinnings of generalism and a generalist approach to health care that can be called a philosophy of practice. It is clear that a disjuncture between generalism and specialism has existed for long periods in human history. It is a disjuncture that has largely rested on philosophical differences whereby the kind of person a generalist is, the values which shape their personal character and the principles which guide their practice have been largely overlooked. In addition to this, there has been a growing emphasis on tangible and measurable outcomes which has seen the tacit and less measurable values and principles of a generalist approach overlooked and undervalued.[4] Some have partially articulated the values and principles of generalism, but not as a coherent framework of practice, nor as an overarching definition.[5] Many are making calls for a re-valuation of these values because of the declining graduate numbers,[6] the ways that specialist-focussed systems have become more costly,[7] and the greater focus on patient-centred care.[4]

Debates concentrate on an argument that ignores how both generalists and specialists are important parts of the complex whole of any health care system

The generalist and specialist debates revisited

Arguments have been made that studies which compare the clinical outcomes for specialist and generalist care within a specialist's narrow domain (for example, cardiologists) have tended to favour specialty care.[8] Such studies have found that specialists are better at adhering to guidelines, that is: *'[s]pecialists [are] more concerned with specific disease-related measures and adherence to guidelines for these diseases and primary care physicians [are] more targeted to multiple aspects of health, that is, generic health.'*[9]

The overarching theme is that specialists are good at treating disease-specific conditions, while generalists provide broad health care. Donohoe, however, reported that the overuse of diagnostic and therapeutic modalities by certain specialists led to increased costs with either no benefit or added risks to patients.[9] For generalists: *'[t]he range of undifferentiated problems, or non-disease, that the generalist encounters inevitably creates an inherently uncertain environment, in which the generalist calls on an extended set of management skills, using time to reveal the natural course of a problem.'*[10]

Generalists coordinate and take responsibility for people's care, they ensure that multiple problems are attended to by a variety of strategies and referrals, and they deal with uncertainty and translate this to patients as required. Generalists see undifferentiated conditions and there is debate about whether the patients seen in primary care differ importantly from those in specialist care. Yet, the literature has not, it seems, explained generalism as a philosophy of practice. There is limited material available that explores, in detail, the humanistic values which underpin generalism and how this influences

† For example the National Chronic Disease Strategy in Australia aims to prevent and manage: asthma, diabetes, heart, stroke and vascular disease, osteoarthritis, rheumatoid arthritis and osteoporosis. The Strategy does not, however, account for the co-morbid conditions which accompany these diseases such as depression and other related disorders.

quality of patient care. Instead, debates concentrate on an argument that ignores how both generalists and specialists are important parts of the complex whole of any health care system.[11] What needs to be discussed further is how both practices will only be as strong as the funding, training and educational resources that are provided to them.

We know that specialists may follow guidelines because quite often they take responsibility for one problem or part of a condition that a person presents with so they only need to refer to one specific set of guidelines. In contrast, generalists usually take responsibility for multiple problems and conditions, and because a patient may have heart disease, asthma and any number of other related conditions for which there are accompanying guidelines, it is difficult to use all of these. It is hardly surprising that specialists might well have advanced knowledge in disease-specific treatment and, indeed, one would expect this to be so given the focus in specialist training and knowledge of one part of the body (for example, a hand surgeon) or specific conditions (for example, cardiologists). How a professional uses a guideline is only one indicator of the kind of care that a specialist or generalist provides. This seems to be particularly important to emphasise given the focus in the literature on the tacit and less tangible features of generalist care.[10]

The problem lies with the implication that specialists do better because they can diagnose certain aspects of disease and they have advanced knowledge for treatment pathways that result in better clinical outcomes and enhanced quality of care. However, specialist work is better remunerated than generalist work, and it occurs in a technical and hospital setting that might be influencing the debates further. The tension here is that these measures of outcome rest on a view of quality of care as being to the equivalent of absence of disease, the ability to apply certain knowledge sets, or follow guidelines. This sidelines the holistic, person-centred and longitudinal care offered by a generalist approach, which has been said to be in conflict with the push to evidence-based practice. It is not the case, however, that generalism lacks evidence, but rather that a range of evidences are used and some of these are not valued by the wider health care system within which generalists operate.[4] Generalists are still interested in disease, but this is combined with biographical (life-story) evidence as well.

There has not been an adequate mapping of generalism as a philosophy of practice

The problem seems to be that the care offered by generalists is not well documented and is poorly understood. In this respect there has not been an adequate mapping of generalism as a philosophy of practice, though Charles-Jones et al. have noted that people refer to the importance of the biographical aspect, the humanistic values and principles that are present in social medicine.[12] Care provided in the specialist domain may gain value in wider policy circles because of its more quantifiable, measurable outcomes. The deeper problem in the specialist and generalist debate is that there is limited research *'of detailed characteristics of practitioners, patients and outcomes as well as determining whether the power of [studies are] adequate to detect meaningful differences.'*[13] Others have bemoaned that the sad state of generalism itself is not really an issue so much as the: *'[o]ppressive lack of spirit, of soul, of nonnumeric adjectives. Nowhere in this vast collection of deadly serious writings [did Lee] find a description on the nature of generalism or of the personal requirements and characteristics of generalists as opposed to specialists... [Lee thought] specialism and generalism define states of mind first, and occupations second.'*[14]

Part of the issue seems to lie with a larger one that is concerned with what kind of care is valued by wider society

Lee's comment points to the importance of being able to see and appreciate generalism as a philosophy of practice. We believe that this philosophy provides the underpinnings for primary care teams and approaches to health care. Indeed, state of mind as Lee refers to it, is reflective of particular values and principles which characterise the kind of care provided by generalists. For example Coulter's study of the National Health Service (NHS) in the UK suggested that patients care more about the quality of their everyday interactions with health professionals than about how the service is organised.[15] They want people with good interpersonal and communication skills, people who are interested in their lives, people who give them attention and who provide fast, accessible, affordable, safe, quality, universally covered, responsive and flexible health care.[15] All of these features are those which authors refer to in relation to generalists.

Conclusion

'Generalists are specialists despite themselves.'[16]

Tensions lie in the different concepts of care and the sorts of values which underpin the two distinctive practices of generalism or specialism. It is difficult to have values valued in the current health policy climate. The push toward evidence-based medicine (EBM) tends to emphasise cost-efficient outcomes over qualitative dimensions of care. There is no reason that EBM could not value these qualitative aspects and include them in cost-effectiveness analyses and outcomes measures. Part of the issue seems to lie with a larger one that is concerned with what kind of care is valued by wider society. For

example, a neurosurgeon is often positioned as being of higher value than say the counselling service offered by a GP for smoking cessation. It is easy to understand why in terms of the skill, knowledge and importance of neurosurgery, the technical setting and professional standing presented. But the broader issue is which one ought society value, should generalism be considered equally with specialism and what are the consequences of this if it is not?

Importantly, what the debate over specialist and generalist outcomes misses is, first, that both generalists and specialists are required in any given whole health system and, second, generalist care is highly valued by patients and this is critical to the achievement of primary care goals. Those studies that have put the value of specialist treatment as higher than generalist treatment for disease-specific conditions based on the use of guidelines miss how guidelines are perhaps ill-conceived for the generalist setting and ignore the context of this. Indeed, a guideline is only one factor that contributes to the decision making for a particular problem.

The philosophy of generalism as a practice is highly valued by patients and it requires better understanding. This is in spite of some people's views that it is problematic how 'generalism is defined in terms of specialism' meaning that generalism is unappreciated in its own right if not understood as a specialist discipline.[17] It seems timely though to reflect on generalism given the calls by some that contemporary health care systems need to include the essence of generalism. Such a debate need not be centred on outcomes and diagnostic differences, but rather it should look to the ethical questions of how to best articulate generalism as a philosophy of practice, how best to provide care that contributes to better societies, improved well-being and community connectivity. By incorporating generalism as an 'essential specialty' it does not mean that generalism is being explained in specialist terms, rather it means the development of an appreciation of the importance of generalism within primary care. For these reasons we are undertaking the review of generalism and its place in the 2020 primary care team.‡

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Acknowledgement of grants

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.

Competing interests

None declared.

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‡ Details of the full report can be found at http://www.anu.edu.au/aphcri/index.php