“Generalism”
A Hospital-Based Specialist (Personal) Perspective

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Once upon a time...

Sir William Osler 1849-1919

“There are, in truth, no specialties in medicine, since to know fully many of the most important diseases a man must be familiar with their manifestations in many organs.”
Osler... more on Generalism vs Specialism

By all means, if possible, let him be a pluralist, and...let him not get early entangled in the meshes of specialism.

No more dangerous members of our profession exist than those born into it, so to speak, as specialists...

The extraordinary development of modern science may be her undoing. Specialism, now a necessity, has fragmented the specialties themselves in a way that makes the outlook hazardous. The workers lose all sense of proportion in a maze of minutiae.
The Modern Era:
Multiple Specialties & Sub-Specialties...

Figure 1: Historical recognition of medical specialties and subspecialties in Canada, 1919-2009

Core competency project, RCPSC 2009
The Modern Era: Multimorbidity is the most common long term condition!
We need minimally disruptive medicine

The burden of treatment for many people with complex, chronic, comorbidities reduces their capacity to collaborate in their care. Carl May, Victor Montori, and Frances Mair argue that to be effective, care must be less disruptive.
Designing Health Care for the Most Common Chronic Condition—Multimorbidity

Mary E. Tinetti, MD
Terri R. Fried, MD
Cynthia M. Boyd, MD, MPH

Changes Needed in Quality Measurement, Health Care Delivery, and Payment

JAMA, June 20, 2012—Vol 307, No. 23
Corrected on June 19, 2012

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

Beyond diagnosis: rising to the multimorbidity challenge

EDITORIAL BMJ 2012;344:e3526 doi: 10.1136/bmj.e3526 (Published 13 June 2012)

Urgently needs radical shifts in research, evidence based guidance, and healthcare

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A “Specialist” Perspective:
Australasian Colleges of Surgeons (RACS) & Physicians (RACP) and Canadian College (RCPSC)

CONJOINT MEDICAL EDUCATION SEMINAR 2013
Friday 8 March 2013 Sofitel Sydney Wentworth, Australia

“Serving the Community:
Training Generalists and Extending Specialists”
Specialist Generalists...

Are a specific set of physicians and surgeons with core abilities characterized by a broad-based practice.

Expertise in diagnosis and management of clinical problems that are diverse, undifferentiated and often complex.

Have an essential role in coordinating patient care and advocating for patients.

Generalism...

Is a philosophy of care...

Distinguished by a commitment to the breadth of practice within one’s discipline and collaboration with the larger health care team.

That values responsiveness to patient and community needs.
“Breadth” = ability to diagnose & manage problems that are diverse, undifferentiated and often complex.

- “...Each doctor he saw expressed how his condition was ‘not their area’, yet their GP wanted help with his case...”

- Fragmentation

- End of Professionalism
But - how much “Breadth of Practice” is appropriate?

“What my voters need is a surgeon who is comfortable fixing a hip, and an appendix, and a thyroid...Why can’t you produce someone like that?”

Access to “uber-doctors”
“In providing the best health care for our patients and community, we must stop thinking of generalism and specialization as two opposing dichotomies, but consider them in a spectrum, with each uniquely contributing to the integrated delivery of health care ...

For optimal health care to be provided, a critical balance between generalism and specialization is needed. Neither can exist in isolation.”

Dr Jeffrey Turnbull RCPSC 1996
Generalists: an endangered species
Andrew Connolly RACS, General Surgeon, Middlemore
at Tri-College meeting, Sydney, March 2013 (modified by JG)

• A Generalist is a clinician competent across the broad scope of their vocational specialty

• A Generalist may practice on the border of other vocational specialties (sub-specialties)
  – Essential for most hospitals if the hospital is to provide excellence in acute care
    • Excellence includes timeliness
  – Under considerable threat from the explosion in the ranks of sub-specialists
    • May only be useful within a limited scope of practice
    • Practice mainly electively
Generalists are discouraged: The demands for “expertise” are many

• Subspecialty groups have created sense of clinical superiority
  – In surgery: breast, endocrine, colorectal/lower GI, upper GI, (& middle GI?), bariatric, vascular...
  – Who judges (retrospectively) incidents & events?

• More complex cases need subspecialists
  – Play the cancer card?
  – Employers / funders see cost savings
A world without the generalists!

• **Elective surgery:** everyone outside main centres would need to travel for almost everything
  – Sub-specialists need high case volumes
    • Otherwise they have nothing to do
• **Acute systems:** Very difficult to provide a sustainable acute system *even within main centre*
  – Who triages the case to the right sub-specialist?
  – Who manages multi-morbidity?
• **Total sub-specialization is necessary only in relatively few clinical circumstances**
We need specialist units

• We need (sub) specialists for:
  – Less common & high complexity elective cases
    • Good data on importance of unit volume
  – Training in “how do it right”
  – Research, innovation, guidelines, leadership etc…

• Obviously do need “expert” services
  – Transplantation, Burns, Spinal Injuries
  – Elective procedures “on the border of the scope”

• But is the above actually true for most conditions – getting the balance right?
  – e.g. interventional cardiology (Nelson)
The Data

• Much published
  – Unit or clinician volume was *generally important*
  – Low volume units/clinicians now doing very well
    • Policies and practices that build on quality
    • Standardized reporting of outcomes

• Recent years has seen the topic revisited:
  – If the ethos of the hospital & clinician is right, case volume becomes far less important
To Encourage Generalists to stay General

• Establish and maintain clinical networks
  – Allows the smaller units to provide best practice
    • Case by case **not** diagnosis by diagnosis
    • MDMs very important
  – Tertiary units must not be clinical black holes

• **Promote generalists**
  – Within specialty training
  – Within the profession
  – With the public
  – With the regulators, planners, and funders
    • *By showing it is safe*
Society needs to ensuring “Rewarding” Generalist Careers (including General Practice!)

• “General” is a Specialty!
  – Medicine, Paediatrics, Surgery, Orthopaedics, Psychiatry...

• Ensuring appropriate...
  – Training
  – Recognition
  – Respect
  – Remuneration
  – & Resourcing of Generalism and Generalists
Training Generalists

• The training environment is crucial
  – Specialty training is usually in tertiary centres
  – General training in main centres is often secondary to specialty interests/needs
  – General training is truly general in provinces

• Generalist access to “other” specialty training
  – Ensuring General Trainees get access to (and can rotate through) other key specialty & sub-specialty training posts
An option: “Dual” training

• “Dual” training in general & another specialty
  – Trainee driven option - diversity of work, popularity & usefulness of dual training
  – Ensuring competence and credibility in managing both;
    • Acute undifferentiated on call duties
    • Another (often elective) specialty scope
  – Dual training now chosen by > 70% General Medicine trainees in NZ & Australia
Summary: GPs need Hospital Specialist “Generalists” for...

• **Acute services** for their acutely unwell complex or undifferentiated (often older) patients
  – essential in provinces and necessary in major centres

• **Long-term conditions** advice/management for their patients with complexity & multimorbidity
  – including polypharmacy advice re “too many pills” and competing evidence-based (but single disease) therapies

• **Local delivery** of some/selected elective specialty services in provinces

• **“Secondary care” partners & advocates for patient-centred care** (rather than disease-centred care)
• We must transform our health care “system” from one in which a multitude of participants, working in silos, focus primarily on managing illness, to one in which they work collaboratively to deliver a seamless, integrated array of services to New Zealanders from prevention and promotion to primary care, to hospital, community, mental health, home and end-of-life care.

Building on Values: The Future of Health Care in Canada, 2002

http://publications.gc.ca/site/eng/237274/publication.html