A historical perspective of the barriers to generalism

Kheng-Hock Lee

This article is part of a series on generalism that reviews some of the challenges facing general practice in Australia and worldwide, and considers possible solutions.

Background

As early as the late 19th century, there were calls to give greater emphasis to general practice. The momentum picked up after the Second World War. The voices calling for more generalism reached a crescendo in the late 1960s. Optimism was very high in the following two decades. Today, there is a pervasive sense of lost opportunity as generalism continues to languish behind the increasing momentum of specialisation of medicine.

Objective

This article is a view of generalism through the lens of history. It seeks to understand and draw lessons from the slow progress of generalism in the light of the forces that have shaped its development through the years.

Discussion

The tensions between sectors that promote generalism continue to this day. The ongoing antagonism between the plough, the town and the gown remains a dominant factor that shapes the path to generalism. Political activism seems to be an effective tool in promoting greater generalism.

Keywords

general practice; health policy; history of medicine; primary care; rural health services

Milestones in the history of generalism

The earliest call to give recognition to generalism could be traced as far back as 1845 when a proposal to form a college of general practitioners (GPs) in the United Kingdom was defeated by strong opposition from the Royal College of Physicians and the Royal College of Surgeons.[1] In the United States, the first awakening to the need for generalism occurred in the 1920s with the beginning of urbanisation and the migration of doctors from rural areas to the towns and hospitals that supported specialised practice.[2] The pace of specialisation in medicine accelerated rapidly after the Second World War. In part this was due to the rapid advances in medicine and consequent growth in the knowledge base, as well as the increasing availability of new technology in healthcare. Social policies such as the GI Bill of Rights in the United States, introduced after the war, elevated the status of specialists and promoted the rapid expansion of specialised medicine. The Bill provided subsidies for graduate medical education in specialist fields for thousands of veterans returning to civilian life.[3] In the United Kingdom, the introduction of the National Health Service in 1948 heightened the awareness of the neglect of general practice in medical training. As a result of this, vocational training for GPs was introduced.[4] The idea spread and this marked the beginning of structured and intentional training of doctors to become qualified generalists in the Commonwealth countries.

The rapid rise of specialisation in the post-war years sowed the seeds of generalism as both a counter-culture and a balancing force to ameliorate the excesses of medical specialisation.[5] In 1947, the American Academy of General Practice was formed to advocate for the advancement of general practice in the United States.[6,7] In 1951, there was renewed interest to form a college of general practice in the United Kingdom. Despite fierce opposition from the incumbent royal colleges representing specialists, the effort was successful and the Royal College of General Practitioners was formed in 1952. This inspired the

formation of state-based organisations of general practitioners in Australia, which were directly affiliated with the British College. In 1958, these organisations decided to come together to form the autonomous Australian College of General Practitioners.[8] In 1969 it received a Royal Charter and became the Royal Australian College of General Practitioners (RACGP) and completely replaced the British-affiliated colleges.[9]

The tide that carried generalism continued to rise in the late 1960s and the early 1970s. In 1969, the American Board of Family Practice was established in the United States, giving formal recognition to family medicine as an independent discipline of generalist physicians that is on par with all other specialties of medicine.[10] In 1972, the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) was formed with member organisations in 18 countries. Today, membership stands at 118 member organisations in 131 countries.[11] Advocacy for the generalist physician had become a worldwide movement. Despite these milestones, which seem to indicate rapid growth and development of the generalist physician, there remains a pervasive sense of regret among advocates that we had not fulfilled the promise of a return to generalism in medicine.[12,13]

The eternal triangle of the plough, town and gown

The nature of generalism is such that its proponents in the medical profession come from different settings of practice. Diversity is both a weakness and strength. Unfortunately, in the history of generalism, the divisiveness among advocates dominated the movement and we often failed to leverage the potential synergy that could be tapped to promote generalism.[14] The 'plough, the town and the gown' has been used to describe the three main affinities of generalist advocates.[15] The plough represents rural generalists who champion the needs of rural communities, which are often not well served by the medical profession. The town represents the urban generalists who are increasing in numbers but find their practice curtailed by the fragmentation of care caused by specialisation. The gown represents the academic generalists who are substantially educators and researchers. They are usually affiliated with medical schools, teaching hospitals and professional bodies.

The plough feels that the town and gown are privileged. The town feels that the plough and gown are impractical. The gown feels that the plough and town should be better schooled. While this generalisation may be exaggerated, their common passion for generalism is strong. Unfortunately the tension between the sectors dissipates energy and focus, to the detriment of their common cause.

Intergenerational Issues

Generalists of different age groups may share the same passion and agenda. However, their experiences vary widely, leading to significant differences in perspectives on many common issues. Three generations of generalist advocates have been described.[16]

Generation One are the pioneers or revolutionaries who struggled with the medical establishment that favoured specialisation. They emancipated general practice and established parity with the specialties of medicine. They sowed the seeds of general practice teaching in the medical schools and made inroads into academia.

Generation Two are the settlers who nurtured the teaching of general practice in medical schools in the early years. They started residencies and vocational training programs in the new generalist discipline of family medicine.

Generation Three are the offspring of these training programs.[17] They are the people of the new land of generalism, trying to adapt their inheritance to the shifting landscape and changing climate.

A fourth generation has been described. They are the latest iteration of generalists who have moved out of the confines of traditional roles and settings. They have expanded across the spectrum of the healthcare system and thrive in new niches. There is an inevitable difference in perspective and a gap in understanding between the generations.

The older generations carry the scars of old battles that were won and lost. They are concerned that the painful lessons from the past have been forgotten. They see the risk of compromise and lament the loss of passion for continuing the struggle. They are worried that the enthusiasm to adapt to niche areas of practice undermines generalism. The younger generation felt constrained by the traditional roles and the weight of the emotional baggage of history. They have a different appreciation of what constitute risks and opportunities.[18] They appreciate the need to train as generalists but are prepared to work in care settings that may limit their scope of practice. While there is disagreement in perspectives, all generations are united in their pursuit of greater space for the generalists.

Identity crisis

Despite the decades of advocacy for generalism, the definition of generalism itself remains contentious. The definition of organ-based, disease-based, age-based and even setting-based fields of medicine is easy. A narrowed-down description of a broad and diverse field such as generalism is challenging.

In the early days, specialists were recruited from GPs. Residencies for specialist training were then introduced and soon graduates from medical schools were recruited directly into these specialists training programs, without first becoming GPs. By default, GPs became doctors who lacked further training which led to the perception that generalists were inferior in status to specialists. This combination of factors led to diminishing number of young doctors entering general practice.

By the early 1950s, the situation became so bad that leaders in general practice began to call for efforts to elevate the standard and status of general practice through structured training programs that were equivalent to the specialist programs. This led to the paradoxical situation where generalists sought to define themselves as specialists.

Around the late 1950s, the term 'family practice' emerged as a proposed name of the new specialty of general practice. Family practice was officially recognised as a specialty in the United States in 1969 and the doctors who completed the residency training in this new specialty were called family physicians. Many still feel that the introduction of the term family physician made it harder to define the generalist.[19,20]

In 1961 primary care was first used to describe general medical care in the community.[21] Kerr White who was credited with coining the term 'primary medical care' and 'primary care physician', explained that he had intended for this term to be a substitute for general practice and the GP. In an interview in 1998, he expressed regret in hindsight. He said that the term 'generalist physician' would have been a better term for the intended meaning.[22]

Another emerging trend was the diminishing scope of practice by doctors trained as generalists. The eroding boundaries led to efforts to understand and safeguard the comprehensive scope of work that generalists do.[23] The generalists most troubled by this trend were those with the widest scope of practice, namely doctors with hospital privileges and those who practice in rural settings, which requires both hospital privileges and credentialing for procedures.

In Australia, many GPs in rural practices felt that not enough was being done to address issues faced by generalists practising in rural communities, and this ultimately resulted in the formation of the Australian College of Rural and Remote Medicine in 1997. In 2005, the Queensland state government announced its recognition of the rural generalist, which is defined as a medical practitioner who provides general medical care in the hospital and in clinics in the community. They are also credentialled to perform certain procedures independently, without the requirement of specialist supervision.[24]

There is a plethora of terms and definitions describing generalists. The terms GP, family physician, primary care physician, generalist physician, rural generalist and urban generalist have all been used to describe doctors who practise and advocate for generalism. It is ironic that a fragmented group of generalists are advocating for better integration as a solution for care fragmentation caused by specialism. This confusing array of terms has led to diminished influence.[25] This in turn has triggered efforts to define generalism itself.

Among some of the more confusing attempts at definition was the Commission on Generalism set up by the Royal College of General Practitioners and the Health Foundation in 2011, tasked to define generalism in the context of general practice.[26] At the end of a long process, it concluded that 'a generalist approach is widely applicable across healthcare, from general practice at one end of the spectrum, through to the highly specialised services found in secondary or tertiary care at the other'.

A more robust attempt at definition was achieved by advocates from the 'plough', who defined generalism in the context of rural medicine and issued the Cairns Consensus Statement on Rural Generalist Medicine in 2014.[27] It recognises and encourages generalists in other care settings but does not extend the definition to include them.

A study by the Australian Primary Health Care Research Institute to understand the place of generalism in primary care concluded that there is no agreed definition of generalism and that generalism in primary healthcare is not well conceptualised.[28]

In 2011, the College of Family Physicians Singapore issued a position statement defining family physicians as generalists who had acquired competencies in six defined areas through a structured and accredited training program in family medicine. It recognises the diverse settings of practice.[29] In 2013, its constitution was amended to recognise this new and broader definition.[30]

Attempts at defining generalism will continue. Perhaps we should recognise that narrow and specific definitions are futile, even harmful to our common interest, and accept generalism as a broad-based discipline dedicated to contextualising care to the person and the person's social and physical environment. Our commonality is our broad-based training and the application of our competencies to help patients in an increasingly complex and fragmented healthcare system.

The power of money

Money is the root of many things, including the rise of specialists over generalists. In almost every country, specialists command better pay and higher prestige, compared with generalists. This is mainly attributable to the way healthcare is funded.

Healthcare financing is a dominant force that shapes the healthcare delivery system, the practice of medicine and the training of doctors. The positive correlation between specialisation of medicine and the increasing cost of healthcare was recognised as early as the post-war years.[31] In the beginning, much of this increased cost was justifiable. As better and more effective treatment options become available, additional resources were needed and division of labour through specialisation of the increasingly complex tasks was a rational strategy. However, at some time in the past decades, the tipping point for diminishing returns was reached. There is evidence that increased funding of specialised medicine is no longer cost-effective and is often associated with lowered

quality of care.[32] There is also increasing evidence that healthcare financing and specialisation are now entangled in a positive-feedback loop. Increased financing drives increased specialisation and vice versa.[35,36]

Under such financial pressures, medical education and vocational training favours specialisation. In Australia, specialists earn almost twice as much as GPs and there are concerns that this makes generalism unattractive and distorts the workforce in favour of specialists.[35] In many countries, the medical training is funded largely through personal debt, which has to be repaid on entering the medical workforce. This drives medical students to choose future careers in specialist fields with better prospects of repaying debt and acquiring the things that a young adult needs in a material world. The cost of medical education had been rising rapidly and this exacerbates the trend.[35,36]

Political activism

Politicians around the world know the importance of healthcare in ensuring success during elections. In one survey in the United States, 77% of voters said that it is an important issue in determining who they will vote for. It was ranked second in importance, beating other issues such as terrorism, immigration, the environment and economic inequality.[37] The importance of healthcare as an issue of voter concern seems to be increasing in the United States.[38] In Australia, voters consistently ranked healthcare as the most important non-economic election issue from 1990 to 2013.[39] The weight of public opinion is therefore very important in shaping healthcare policies.

The mass media, which shapes public opinion, is enchanted with medical breakthroughs in high-tech academic health centres. The lay person is often unaware of the harm caused by the over-specialisation of medicine. Convincing politicians and the electorate on the benefits of generalism should therefore be the focus of the effort to promote greater generalism. This is supported by history.

The 1845 attempt to form the first college of general practice was initiated by Thomas Wakley, who founded *The Lancet* in 1823 and entered parliament in 1836. Together with other advocates, they lobbied politicians of the day for support and were nearly successful, except for the even stronger political pushback by their opponents.[1] In the United States, the successful advocacy for generalism in the 1960s was largely due to the effort of GPs who organised themselves into a state-based political movement that lobbied state legislators and the leaders of medical schools.[2]

Conclusion

The road to generalism is fraught with difficulties. Significant progress had been made over the decades through the effort of successive generations of advocates. Much more could be done if we learn from history.

We must recognise that it is an ongoing journey and we should build on past successes as we forge towards the next milestone. Constant re-inventing of the wheel without learning from the past is wasteful. Our failure to continue the good work of the past might even make us complicit in perpetuating the harms of today's distorted healthcare system.[40]

We should recognise and embrace the diversity of generalists and the varied settings in which we practice.[41] As in all diverse communities, we need to accept our differences and focus on our common goals. The rapidly changing landscape of general practice will create different perspectives and opportunities for different generations.

The older generation should appreciate the different circumstances of the younger. The younger generation needs to understand their heritage and build on the legacy created by the seniors.

We should be mindful of the powerful effects of healthcare financing in shaping the healthcare system, and harness its energy to support generalism. There are seasons in time that favour the advocacy of generalism and we should be prepared to seize the day.

The 10-year period between late 60s and early 70s was a favourable season because it was a time when people were re-discovering the interconnectedness of things and the sentiments of that time favoured counter-culture.[42] We may be at the threshold of another favourable season in the history of generalism.

The ageing population and the rise of complex chronic diseases are putting tremendous pressures on specialist-centric healthcare systems around the world.[43] This is widely perceived to be unsustainable and political leaders are desperately seeking solutions.

Once again, as in the late 60s, generalism is seen as the key to a sustainable and equitable healthcare system for the world. The healthcare system is largely shaped by government policy and funding. History has shown us that significant milestones in the progress of generalism were achieved by the political activism of advocates in the past. We should learn from history and continue to engage the government and the public to promote generalism as the key to healing our fragmented healthcare system.

Author

Kheng-Hock Lee MBBS, MMed (FM), FCFP, FAMS, Associate Professor, Duke-NUS Graduate Medical School; Head and Senior Consultant, Department of Family Medicine and Continuing Care, Singapore General Hospital; Singapore. lee.kheng.hock@sgh.com.sg

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