Editorial

Generalist Physicians: A Modest Proposal

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An emphasis on "generalist physicians" (ie, GPs) is a major part of most serious plans to reform health care, but how should "generalism" be defined? For 25 years, the term *generalist* (or its predecessor, *primary care provider*) has referred to family physicians, general internists, and community pediatricians, based on the attributes of the service they provide—accessibility, comprehensiveness, coordination of care, continuity of care, and accountability.[1] As reasonable as this definition may sound, we believe it is time to reject it completely. This traditional definition is yet another example of the hubris of academic medical elitists who patronizingly attempt to define the "needs of the population." Instead, we propose a new definition of generalism based on patients' actual preferences.

In practice, the best way to assess patient preferences is by noting what patients do now in the current fee-for-service system, in which the vast majority of patients have a substantial choice in their medical care. The best criterion for deciding whether a particular discipline is "generalist" should be to note the proportion of the population who routinely see a physician from that discipline. Thus, for example, pediatrics is a *generalist discipline* because a majority of the population from birth to 18 years routinely see pediatricians, whereas oncology is a *specialist discipline* because only a small percentage of the population routinely see oncologists.

This patient-centered definition makes it clear that several types of providers who are currently thought of as specialists should actually be thought of as generalists. For instance, our nation's emergency department physicians take care of almost all of the population at some time: young or old, rich or uninsured, 24 hours a day—all are susceptible to injury and illness for which they choose to seek care at emergency departments. In an environment of guaranteed universal access to care, most of the conditions for which people currently visit emergency departments could be handled more appropriately and cost-effectively in other settings. However, such genuine health care reform remains many years away. If we focus on what patients actually do today, emergency department physicians should be considered generalists.

A similar argument holds for gynecologists and others who care for women exclusively. Many women consider their gynecologists as their physicians not only for Pap smears and mammograms but also for other problems, such as vaccinations or the evaluation of crushing substernal chest pain. Likewise, women's demand for epidural anesthesia for childbirth is rapidly making obstetric anesthesia a generalist discipline. Although midwives and some obstetricians and family physicians have insisted that deliveries without epidural anesthesia are occasionally possible, it is likely that within the next 20 years, delivery without epidural anesthesia will be considered as primitive as delivery without aseptic precautions. If virtually all women demand epidurals and if virtually all women get them, how can the physicians who provide them not be considered generalists?

Our new definition of generalism also allows reassessment of the priorities of current specialist disciplines. One example is radiology. Imaging technology has been one of the major achievements of modern medicine. From conception to death, every American is repeatedly imaged—from prenatal ultrasound to bone films after sports injuries to magnetic resonance imaging and nuclear scans as low back pain and cancer take their toll. Given patient demand for such imaging services, shouldn't radiology become a generalist field?

Emphasizing actual patient preferences also allows us to envision new medical disciplines that would serve the public better. Perhaps the best example is women's health. Although many disciplines, including family medicine, general internal medicine, and obstetrics and gynecology, currently claim to provide comprehensive care for women, some physician observers believe that, in the

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words of the executive director of the American Medical Women's Association,[2] "none are trained well in women's health" and women's needs therefore are not being met by the current system. Indeed, current efforts to reform medicine in the name of "evidence-based" practice may even worsen the situation by interfering with a woman's right to have a screening mammogram at age 40 or to have a routine ultrasound during pregnancy. In view of demands by urologists who focus on women's bladders, plastic surgeons who specialize in removing breast implants, and gynecologists who specialize in laparoscopic surgery, it seems clear that a first priority of responsible health care reform should be the creation of a new generalist discipline of women's health.

Another important new generalist discipline is thanatology, which is concerned with the care of dying patients. There is no disease process more universal than death. Furthermore, care for the dying consumes enormous resources, and there can be no doubt that most patients and families are dissatisfied by the overall experience of death in our current health care system. From a professional perspective, management of dying and death requires special skills, such as synthesis of multiple opinions about prognosis, coordination of a wide variety of clinical and social services, ethical and financial decision analysis, and, perhaps most challenging, sensitivity toward patients and their families. Moreover, given the large proportion of our health care spending that occurs in the final 3 months of life, well-trained thanatologists would provide an excellent opportunity to cut the costs of medical care. For all these reasons, the time is ripe for us to follow our British colleagues in developing this new discipline.

Our final nomination for a "new" generalist discipline may come as a surprise: general veterinary medicine. Of all generalists, veterinarians come closest to being able to manage all the patients in their community, whether they need immunizations, dietary advice, medication for parasites, instrumental delivery, or surgery for abdominal tumors. By nature of their role, veterinarians have been the pioneers of a concern for cost-effective care, developing reminder systems for preventive care, and euthanasia. These competencies will become increasingly important as US health care develops. Moreover, given the lowly status of generalism at most prestigious institutions, role models for human generalists are few and far between, so we need as many as we can get. If generalism is good for our pets, why not ourselves?

Alert readers may point out other new and emerging generalist disciplines, and we encourage them, for this list is only a start and should not be considered exhaustive. Rationales for the inclusion of many more generalist disciplines can and should be developed. Our point remains, however: patients and their preferences should come first. Generalism is too important to be narrowly defined.

References

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