

Is this what we want?

By Jonathan M. Ross, M.D.

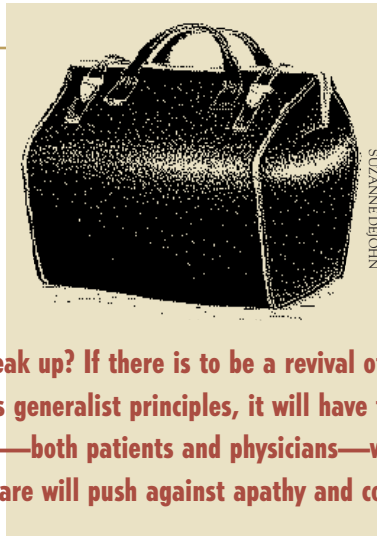
Eleven years ago, several colleagues and I published an article in the *American Journal of Medicine* about the future of general internal medicine. At that time, there was much interest in the role that generalist physicians could play in improving health care while constraining costs. We defined a generalist physician as someone who would be accessible to patients and be able to provide them with continuous, comprehensive, and personalized care.

Generalist physicians would have broad knowledge of diseases and therapeutics and would promote healthy behaviors and preventive strategies. They would also be able to explain to patients such emerging concepts as evidence-based medicine—care based on what research shows to be most effective—as well as individualized risk assessment and risk reduction.

Concept: But generalist physicians never emerged as the central concept of health care, partly because the health-care reform efforts of the 1990s fell short of their goals. At the same time, the medical profession was heading toward further subspecialization, not only for procedure-based specialties like radiology and surgery, but also for internal medicine-based specialties like cardiology and gastroenterology. And new specialists emerged: the hospitalist, the intensivist, the geriatrician, the palliative-care physician. In an effort to control costs, managed-care and other health-insurance companies began “homogenizing” generalist physicians, internists, family physicians, nurse practitioners, and physician assistants, lumping them together as generic primary-care providers (PCPs).

But ignoring the vastly different skill sets and orientations of such professionals only served to diminish the meaning of the generalist physician. Furthermore, medical services provided by PCPs were reimbursed at lower rates than services provided by specialists doing procedures. Such inequalities in remuneration reinforced the idea that generalists had less value than specialists.

Continuity: It’s hardly surprising, then, that medical students and residents, well aware of these developments, were increasingly disinclined to become generalists. They had medical school debt to pay off, among other reasons. To make matters worse, more physicians began entering primary-care specialties part-time, accepting lower wages than full-time doctors in exchange for less on-call duty and shorter



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workweeks. Continuity of patient care suffered as a result. Medical centers, which were already struggling to deal with limits on residents’ hours (residents now work a maximum of 80 hours a week, whereas they used to work 100 or more), must now also provide coverage for part-time physicians’ patients. In response, institutions have begun expanding the number of hospitalists, doctors who focus only on hospitalized patients, further fragmenting patient care.

This rise in specialization, decline in reimbursement for PCPs, and further separation of hospital- and office-based care portends the virtual extinction of the generalist physician. Who will know the whole patient? Who will be connected to the patient through wellness and illness? Who will provide “continuous, comprehensive, and personalized care”?

While efficiency and specialization can bring concentrated expertise that’s good for patient care, they can also result in a loss of the patient-doctor relationship, in unnecessary treatments or diagnostic tests, in increased rather than decreased costs, and in patients feeling abandoned in an impersonal system. The conflation of so many forces has created a patchwork system of care.

Is the vision we had in 1994 still valid? Do patients want the kind of physician we described instead of the fragmented care that is commonplace today? Is there a way to balance efficiency, specialization, lifestyle concerns, and repayment of medical school debt with generalist principles of care? Or is generalism a dying philosophy?

Challenges: Few political figures seem to understand these challenges. Academic leaders appear to be more interested in pursuing biomedical research than in exploring generalist principles of care. Pharmaceutical and insurance companies, as well as powerful interest groups and medical lobbies, benefit from the existing system and thus have little incentive to change. So who will speak up? If there is to be a revival of medical care that reflects generalist principles, it will have to come from individuals—both patients and physicians—whose desire and demand for good care will push against the apathy and complacency that are forces against change.

I hope that the humanistic impulse, which still characterizes medical students as well as physicians, will serve as a nidus for reconsidering what has happened to this country’s health-care system. We need political leaders to serve citizens rather than corporations. Our academic leaders must help us ask and answer this question: Is generalist medical care preferred by patients and is it better for them? If so, we need to do a far better job of teaching generalist medicine, fostering generalist careers, and rewarding generalist care both academically and financially. Is anyone interested in this question? ■

The “Grand Rounds” essay covers a topic of interest to the Dartmouth medical faculty. Jonathan Ross, an associate professor of medicine and of community and family medicine, has been practicing and teaching internal medicine at Dartmouth-Hitchcock Medical Center since 1983. He is the Department of Medicine’s associate chair for education and also oversees the department’s Morbidity and Mortality Conference, which was the subject of the cover feature in the Summer 2003 issue of DARTMOUTH MEDICINE magazine.