

# The gentle radical

## Ten reflections on Ian McWhinney, generalism, and family medicine today

Curtis Handford MD CCFP MHSc Brian Hennen MD CCFP FCFP

Ian McWhinney conceptualized and described the philosophical foundation of family medicine in a way that family doctors never fail to recognize.<sup>1</sup> At the core of Dr McWhinney's vision was the belief that the family physician was medicine's consummate generalist.

From the opening paragraphs of *A Textbook of Family Medicine*<sup>2</sup> to early work in the peer-reviewed literature,<sup>3-5</sup> the generalist theme is at the forefront. Dr McWhinney consistently articulates the general practitioner's unique value and skill necessitated by the realities of caring for an unselected patient population.

In this essay, using his words, our personal reflections, and the thoughts of others, we summarize 10 of Dr McWhinney's powerful insights into the family physician as a generalist and make the case that these insights have never been more relevant to family medicine, to our health care system, and to the health and well-being of Canadians.

### Generalism is a distinctive clinical method

*"General practitioner," if it meant a doctor who did everything—surgery, medicine and obstetrics—was becoming outdated.*<sup>3</sup>

Some portray the "true generalist" as the family doctor who does it all in every setting in the community: clinic, inpatient ward, labour floor, emergency department, and nursing home.<sup>6,7</sup> There are highly skilled practitioners, particularly in more remote settings, whose daily work might resemble this idealized concept of a generalist, but this impressive collection of clinical skills is not the essence of generalism. Generalism is not synonymous with comprehensiveness. As outlined by Dr McWhinney in one of his earliest works,<sup>4</sup> the generalist's "special competence" is the "detection of the earliest departure from normal" and it is enabled by several factors, as outlined in **Box 1**.<sup>4</sup>

Stephens affirms the generalist as the expert at evaluating undifferentiated problems with diseases presenting very early in their natural history when they are largely indistinguishable from minor, transient illness or illness with a strong psychological component.<sup>8</sup>

Such a task requires the generalist to harness his or her cumulative knowledge of the patient and the continuity of the doctor-patient relationship to sharpen clinical judgment and mitigate clinical uncertainty. It is this clinical method that defines the generalist. It is a skill that

### Box 1. Competencies contributing to generalist expertise

The following are competencies Dr McWhinney described as contributing to generalist expertise

- Skill in elucidating undifferentiated clinical problems
  - High incidence of transient illness
  - High incidence of emotional illness
  - Diseases are often seen early, before the full picture develops
- Personal knowledge of the patient (continuous relationship)
- Special knowledge of those parts of medicine that are relevant to his or her skill
- Long-term management of chronic disorders
- Treatment of emotional disorders in normal people

Data from McWhinney.<sup>4</sup>

every family physician must develop and use to care for his or her patients, regardless of the degree of comprehensiveness of specific clinical skills or practice settings.

### In Canada, family practice is the epitome of generalist clinical practice

*Of all branches of medicine, general practice is the most variable. Each practice is a reflection of the character of the practitioner, the type of patient he serves, and the district in which he works.*<sup>5</sup>

Family medicine has no predetermined limits to its scope. Some generalist disciplines, such as internal medicine and pediatrics, narrow their scope based on patient age. Others, such as obstetrics, limit their scope based on patient sex. Yet others, such as emergency medicine, narrow their scope based on acuity. Family physicians commit to work with any patient with any problem to the limits of their competence not only throughout the duration of a particular illness, but also in between illness episodes. A continuous therapeutic relationship of this nature is unique to family medicine.

*If [we family physicians] are to fill our place, it is crucial that our commitment be unconditional; patients should feel confident that they will never be told "this is not my field."*<sup>9</sup>

Cet article se trouve aussi en français à la page 33.

## Generalism has a scientific basis

*Many patients have illnesses that defy differentiation into well-known disease categories. 25-50% of illness in family practice remains undifferentiated, even after assessment.<sup>9</sup>*

Diagnoses of life-threatening conditions that should not be delayed make up the minority of cases in a generalist office. Clinical acumen and a sound differential diagnosis will assist the practitioner in determining which patients cannot safely wait before investigation or treatment of their symptoms. For most other patients, deciding how long to wait before pursuing a firm diagnosis is dependent on various patient and provider factors, including the doctor-patient relationship.

In a general practice, the prevalence of a specific disease will be much lower than in an emergency or hospital population. As a result, the predictive value of diagnostic tests is much lower and the value of such tests in the general practice setting is “markedly overestimated.”<sup>10</sup> Dogged pursuit of a precise diagnosis, looking to “rule out an organic cause” at all costs, might prove futile, wasteful, or even harmful to the patient. As technology advances, the costs and potential risks to the patient, such as risks of investigative tests and side effects of medications, increase considerably.<sup>2</sup>

To address the limitations of diagnostic tests in their practice setting, expert generalists employ the scientific “watch and wait” approach.<sup>11,12</sup> Purposefully and carefully allowing natural history to influence the pre-test likelihood of disease is soundly based on principles of clinical epidemiology. The generalist approach is “neither greater nor lesser than that of the specialist, just different.”<sup>13</sup> According to Rosser and colleagues, “If more people understood the concept and skilled appreciation of watchful waiting in family practice, the more valued would be the excellent family physician.”<sup>10</sup>

## Generalists are often diagnosticians, sometimes curers, but always healers

*To be a healer is to help patients find their own way through the ordeal of their illness to new wholeness.<sup>9</sup>*

Many patients leave a consultation with their family physicians accepting diagnostic and prognostic uncertainty. Others fear what might be lurking beneath or the prospect of living indefinitely with their symptoms. As the number of chronic diseases in a particular patient increases, the number of potential symptoms also increases, as does the iatrogenic burden from the medications these patients are inevitably prescribed.

Easing the patient’s suffering is an important part of the generalist’s work. In addition to the patient’s

physical symptoms, there is also fear of the unknown, frustration about reduced function, guilt about burdening others, and overall increased stress in the patient’s daily life. Patients’ personal habits might also be contributing to their problems. Skillful incursion in these areas is the domain of the healer. Done properly, it can be in and of itself a powerfully therapeutic intervention.

Generalist leaders must impress upon policy makers that overemphasis on measurable physician performance indicators will come at a cost. If physicians are reduced to assembly-line technicians, much of the real healing work of the person-centred generalist will be in jeopardy.

## Society increasingly expects specialist attention, perhaps at their peril

*Many of us live in societies that value excellence. The idea of excellence, however, is the development of a single talent to its utmost limit .... In deciding to be generalists, family physicians have renounced one-sided development in favor of balance and wholeness. They do pay a price for this: in lack of recognition by a society that is itself unbalanced.<sup>2</sup>*

Specialization was born in the industrial revolution and initially had more of an economic application. Focusing labourers to perfect one aspect of the manufacturing process had obvious effects on productivity and, therefore, economic benefits.<sup>14</sup>

Highly trained specialists are necessary in medicine, but they must be used appropriately. Whereas increased numbers of generalists is associated with improved population health outcomes, increased numbers of specialists has a neutral or opposite effect.<sup>15</sup> The medical industry, media, and public personalities perpetuate a myth that if one has an unresolved symptom or an uncured disease, it is because he or she has been denied the best specialist or the latest test. This message fosters an unrealistic expectation and demand for services that society simply cannot afford.

*Generalism requires societal embrace of an untidy, indefinite, lethargic and risky practice of medicine .... Homo sapiens has come to expect certain salvation, not uncertain palliation.<sup>12</sup>*

## Demands on generalists are constantly shifting

*For most of this century, the typical primary care professional has been a generalist practitioner.<sup>16</sup>*

The generalist has been, up to the 20th century, a solo practitioner in office-based practice. In Canada this landscape shifted considerably toward group practice and multidisciplinary teams. Contributing to this shift

is the trend for more patient care to happen outside of hospitals, with sicker patients increasingly being cared for in the community.

Although the precise effect of such shifts remains to be determined, working in teams would appear to have advantages for everyone, in particular the patient. However, there are some risks. We must ensure that care is not fractionated within primary care teams with each team member being responsible for only one small piece of the patient's care. The generalist physician remains ultimately responsible for the whole person and must manage and coordinate the total treatment activity of the entire team.

### Generalists face challenges, including from within family medicine

*By virtue of special interest or training, a physician may have knowledge that is not shared by colleagues ... the important point is that this should not lead to fragmentation.<sup>2</sup>*

There is considerable interest among new family medicine graduates in pursuing additional training in enhanced-skills, third-year fellowship programs. The College of Family Physicians of Canada has recently formed groups of family physicians with enhanced competence in focused areas of practice. Some of the approximately 20 special interest groups are proposing certificates of competence in their interest areas.

One qualitative study of family medicine residents<sup>17</sup> showed that residents believed that "specialization" was a solution to the "burden" of managing a broad scope of practice. We know that of the 77% of those family physicians who received Certification in emergency medicine from the College of Family Physicians of Canada who are still practising emergency medicine, 59% are practising emergency medicine exclusively.<sup>18</sup>

Starfield and Gervais<sup>11</sup> express concern that specialism within generalism risks creating increased demand for specialist, disease-oriented care as opposed to whole-person, patient-centred care. They argue that enhanced-skills training within family medicine should focus on issues central to the work of the generalist including areas such as unexplained symptoms and difficult patients.

### Generalist skill needs to be modeled for learners to engage

*To make ourselves effective teachers ... we must learn to analyze, describe and justify the many intuitive judgments we make in the course of our day's work.<sup>19</sup>*

There are enormous opportunities in medical generalism for both faculty development and other valuable and

meaningful scholarly pursuits such as writing essays and letters to journals, challenging residents to develop sound research questions, and having proven research teams competing for grants.<sup>20</sup> Faculty must excite learners, particularly family medicine residents, about the essence and value of their craft: competence in dealing with undifferentiated illness, evidence-based clinical evaluations, balancing the use of watchful waiting, judicious use of investigations, and knowledge of generalizable research findings. Faculty ought to tackle head-on what Ian McWhinney called common *myths* about generalists<sup>16</sup> with which our learners inevitably wrestle: that they have to "know everything"; that the specialist will always "know more"; that specializing will eliminate uncertainty; that new science always leads to more useful information; and that error is usually caused by lack of information.

### Family physicians require particular learning to be effective generalists

Each defining element of the generalist (**Box 1**)<sup>4</sup> can be part of an organized learning process for medical students and residents and even doctors in professional development workshops. Examples could include how common illnesses present before declaring themselves: the pain before the rash in an outbreak of shingles; the fever and sweats of a possible infection declaring themselves as the first signs of lymphoma, as uncommon lymphoma shows itself during a management plan of watchful waiting. Similarly they could include a debate on how to recognize and manage new emotional stress in a typically healthy young parent. Each element deserves particular consideration in a series of learning competencies that strengthen the generalist capacity of the young physician.

### Family physicians are expert clinicians, not specialists

*We are not specialists, unless the term becomes meaningless.<sup>9</sup>*

There has been much debate<sup>21,22</sup> about whether family medicine should be regarded as a medical specialty. In Canada the issue for the most part is one of professional status. In some jurisdictions there is also a considerable financial benefit to being identified as a specialist.

All specialists have boundaries around who they serve, whether it is by patient age or sex, illness acuity, organ involvement, or a need for technology. Family doctors have no such boundaries. Are they specialists? No. They are generalists: expert clinicians, masters of the undifferentiated clinical presentation, managers of uncertainty, healers, collaborators, scientists, and role models. They are portable and adaptable. Now more

than ever the sustainability of our health care system depends on their unique knowledge, skill, and attitude. 🍁

**Dr Handford** works in the Department of Family and Community Medicine at St Michael's Hospital in Toronto, Ont, and is Assistant Professor in the Department of Family and Community Medicine at the University of Toronto. **Dr Hennen** is Professor of Family Medicine at Dalhousie University in Halifax, NS.

#### Competing interests

None declared

#### Correspondence

**Dr Curtis Handford**, St Michael's Hospital, 410 Sherbourne St, Toronto, ON M4X 1K2; telephone 416 867-3728; e-mail [curtis.handford@utoronto.ca](mailto:curtis.handford@utoronto.ca)

**The opinions expressed** in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

#### References

- McWhinney IR. The importance of being different. *Br J Gen Pract* 1996;46:433-6.
- McWhinney IR. *A textbook of family medicine*. Oxford, UK: Oxford University Press; 1997.
- McWhinney IR. General practice and family medicine. *Can Fam Physician* 1972;18:111-2.
- McWhinney IR. General practice as an academic discipline. *Lancet* 1966;1(7434):419-23.
- McWhinney IR. General practice. Some practical suggestions for reform. *Lancet* 1961;1(7177):604-7.
- Ladouceur R. What has become of family physicians? *Can Fam Physician* 2012;58:1322 (Eng), 1323 (Fr).
- Gutkin C. Focusing on generalism. *Can Fam Physician* 2012;58:352 (Eng), 351 (Fr).
- Stephens GG. The intellectual basis of family practice. *J Fam Pract* 1975;2:423.
- McWhinney IR. *A call to heal. Reflections on a life in family medicine*. Regina, SK: Benchmark Press; 2012.
- Rosser WW, Slawson DC, Shaughnessy AF. *Evidence mastery: evidence-based family medicine*. Hamilton, ON: BC Decker; 2004.
- Starfield B, Gervais J. Family medicine should encourage its clinicians to subspecialize: negative position. In: Buetow S, Kenealy T, editors. *Ideological debates in family medicine*. Hauppauge, NY: Nova Science Publishers; 2007. p. 107-19.
- Lee RV. The jaundiced eye: generalism in general. *Am J Med* 1995;98:304-6.
- Pruessner HT, Hensel WA, Rasco TL. The scientific basis of generalist medicine. *Acad Med* 1992;67:232-5.
- Saul JR. *Voltaire's bastards: the dictatorship of reason in the west*. New York, NY: Vintage Books; 1993.
- Shi L, Macinko J, Starfield B, Wulu J, Regan J, Politzer R. The relationship between primary care, income inequality and mortality in US states: 1980-1995. *J Am Board Fam Pract* 2003;16(5):412-22.
- McWhinney IR. Primary care: core values in a changing world. *BMJ* 1998;316:1807-19.
- Beaulieu MD, Dory V, Pestiaux D, Pouchain D, Rioux M, Rocher G, et al. What does it mean to be a family physician? Exploratory study with family medicine residents from 3 countries. *Can Fam Physician* 2009;55:e14-20. Available from: [www.cfp.ca/content/55/8/e14.full.pdf+html](http://www.cfp.ca/content/55/8/e14.full.pdf+html). Accessed 2013 Dec 6.
- Varner C, Ovens H, Letovsky E, Borgundvaag B. Practice patterns of graduates of a CCFP(EM) residency program. A survey. *Can Fam Physician* 2012;58:e385-9. Available from: [www.cfp.ca/content/58/7/e385.full.pdf+html](http://www.cfp.ca/content/58/7/e385.full.pdf+html). Accessed 2013 Dec 6.
- McWhinney IR. Problem solving and decision making in primary medical practice. *Can Fam Physician* 1972;18:109-14.
- Reeve J, Blakeman T, Freeman GK, Green LA, James PA, Lucassen P, et al. Generalist solutions to complex problems: generating practice-based evidence—the example of managing multi-morbidity. *BMC Family Practice* 2013;14:112.
- Bailey T. Is family medicine a specialty? Yes [Debate]. *Can Fam Physician* 2007;53:221-3 (Eng), 225-7 (Fr).
- Hennen B. Is family medicine a specialty? No [Debate]. *Can Fam Physician* 2007;53:221-3 (Eng), 225-7 (Fr).

\*\*\*