Editor's Notes

The Generalist-Specialist Tension within American Medicine

By Stephen Jackson, M.D.

Within our American health care sector, the base of primary care/ generalist (family practice, internal medicine and pediatrics) practice has eroded so substantially that it now comprises merely one-quarter of our physicians, despite the ongoing efforts by our health policy wonks and medical school deans to reverse this trend. In stark contrast, most European countries have a long history of a generalist foundation that accounts for about three-quarters of practicing physicians.

The benefits to society of a generalist-predominated health service are alleged to include better access to health services; improved preventive care; expanded "specialist" services by generalists who *purportedly* afford equivalent quality, efficiency and effectiveness in evaluating and managing complex co-morbidities; and enhanced continuity and personalization of care. One might argue that *if* generalists were able to perform all of these beneficial functions concomitantly, *then* "unnecessary" testing, procedures and consultations would be contracted, and therein minimize health care costs. Our nation's current compensation schemes, it is claimed, have driven up costs by incentivizing procedures and technical interventions, that is, encouraging the deployment of specialty services.

Regrettably, reimbursement for generalists is approximately half (or less) of that of specialists. This economic reality cannot but significantly influence the decision making process of a young physician (many of whom, upon completing medical school, already are in six-digit debt) to choose to pursue a higher compensated specialty. Moreover, there also are non-economic and quasi-economic factors that have contributed to this diminishing output of generalists: increased administrative expectations related to quality improvement initiatives; intensified record keeping demands; status deprivation; professional dissatisfaction; lifestyle and quality of life preferences; difficulty in remaining thoroughly competent in the face of an expanding knowledge base across the broad spectrum of internal medicine and pediatrics; and the usual liability issues plaguing all of medicine. It is indeed startling to note that only one-tenth of first year internal medicine residents remain in general internal medicine!

But, the generalist *surgeon* also seems to have become an endangered species. Each year about 1,000 general surgeons complete their residencies, a number that has remained stable since the early 1970s. However, only 30 percent continue to practice as general surgeons, the remainder entering the surgical subspecialties. As with internal medicine, these are ominous figures, especially so for small urban and rural hospitals that rely on well-rounded general surgeons for trauma, surgical emergencies and a broad spectrum of operative procedures.

Imagine the typical hospital of a decade from now: largely a giant ICU with in-house intensivists and hospitalists managing the medical side, and in-house general/trauma surgeons managing the surgical aspects of patient care.

Yet, today, even in this country, we are challenged, not just by the shortage of generalists, but by a dearth of specialists as well. In many communities it is increasingly difficult for hospitals and medical staffs to provide comprehensive panels of specialists on-call at all times. Why, despite an apparent surfeit of these specialists, is this the case? Well, there are many reasons, and, once again, not strictly limited to economics. Certainly, as specialists age, they reach a point in their lives where night and weekend call responsibilities come to exceed their ability, motivation or willingness to continue with an "on-call" lifestyle. Younger physicians these days are demanding a more reasonable, less stressful and more normatively healthy quality of life, one in which personal and family needs are better addressed, and where deprivation (delayed gratification) of the routine amenities of a contented life no longer is acceptable or tolerable. Also, some specialists, after a variable number of years of practice, do not need the added income from call because they have become well enough compensated by busy practices, often independent of hospital activities. Moreover, they don't want to have these lucrative practices interrupted at inconvenient or inopportune times by emergencies associated with being on-call. Furthermore, some specialists become so sub-specialized that, at some point of their careers, they simply no longer have retained the comprehensive skills of the "generalist" specialist.

Inadequate compensation stemming from patients with no insurance or government insurance degrades the payment mix needed to ensure adequate specialist backup staffing of emergency departments. Then add the organized and illegal refusal of insurers to pay noncontracted specialists fairly and reasonably for services rendered that otherwise would not have been available to their policy-holders ("balance billing" issues). Hospital stipends or other forms of financial support may provide a temporary patchwork solution to ensure on-call coverage, but even what might seem to constitute a reasonable level of compensation may no longer be persuasive or attractive to specialists.

Furthermore, most hospitals have a limited ability and a withering willingness to pay for specialty coverage. After all, should hospitals be expected to expend their own revenue to finance this element of our crumbling national healthcare sector? Understandably, the maxim "no margin, no mission" applies to non-profit hospitals as well as for-profits.

As a final point, let us contemplate where ethics and professionalism fit within this simmering cauldron? Do specialists have an ethical obligation to service the emergency needs of the communities in which they live and/or work? Can medical professionalism survive our commercialized health care market?

Committee Appointments

Active and resident members who are interested in becoming more involved in the CSA and would like to start by serving on a committee need to contact Michael W. Champeau, M.D., President-Elect, at m.champeau@comcast.net or the CSA office at (800) 345-3691 or csa@csahq.org by February 1, 2008, indicating interest in the following divisions and committees. For more information about the committees and the two divisions, call the CSA office or refer to the CSA Bylaws at **http://.csahq.org/pdf/csa_bylaws.pdf**.

Divisions

Educational Programs
Legislative and Practice Affairs

Standing Committees

Committee on Bylaws
Committee on Finance and Administration
Committee on Peer Review
Committee on Public and Professional Communications

Special Committees

Committee on Physicians Health and Well Being