Generalism and rural Canada

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By all means, if possible, let [the young physician] be a pluralist, and — as he values his future life — let him not get early entangled in the meshes of specialism.[1]

We salute those dedicated practitioners providing surgical services to Canadian rural populations. They are truly the heart of all rural health care, and this issue of the *CJRM* is for them.

Without an operating room (OR) most rural hospitals can offer primary care, basic hospitalizations and triage — important, but inadequate, as laboratory resources crumble, precluding any kind of secondary care. Given Canada's geography, how far then must rural patients travel to get even the most basic of secondary care?

The problem with Canadian rural heath care is that our medical system is squeezing out the generalist — both in family medicine and surgery.

Two characteristics define the rural workforce: 1) community importance in determining needs, and 2) the work of jack-of-all-trades or generalists. This holds true for most of the rural workforce but is quite evident in health care. We see these 2 characteristics in any rural OR — in the broadly trained nurses, the GP-anesthesiologist, the GP-surgeon or the fellowship surgeon with skills in many disciplines.

And what is a generalist? The intellect naturally specializes and, by contrast, the artist within, integrates. The generalist is found somewhere on the spectrum between these 2 poles, the location continually varying. The generalist is best suited to deal with sick humanity while, at the 2 poles, the specialist and the artist serve the medical generalist. This argument is found in reading Osler, who might agree that the hallmark of generalism is one or several "defined competencies." A defined competency is the partial practice of a discipline — "defined" in the sense of being circumscribed but also in the sense of matching a social need; "competency" in the sense of a capable skill set. A defined competency implies the best of what physicians have always done — devoting themselves to healing, responding to social needs, research, teaching, understanding limits and lifelong learning.

Defined competencies link, for example, the fellowship general surgeon pinning hips with a family doctor performing cesarean sections. Ideally, the competency is defined by the needs of the community and supported by the entire medical system. The needs of rural communities are unavoidable. Unfortunately, system support vanishes as differentiation of our medical workforce accelerates. Without validation of defined competencies at all levels of the medical system, especially nationally, the generalist's lot is doomed. Inevitably, rural surgeons are among the most vulnerable.

Rural Canada needs the generalist with defined competencies, constantly fluctuating between the primary, secondary and tertiary levels of care. Those who advocate for tightly compartmentalized levels of secondary care or those who want family medicine to be a primary care specialty are not just denying centuries of careful generalist medical practice, they are abandoning a large part of what defines Canada.

Reference

1. Osler W. Internal medicine as a vocation. *Med News* 1897;71:660.