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Generalism in healthcare: ethical challenges in the 21st century

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Healthcare provision in the 21st century heralds a new understanding of the concept of generalism. The underlying themes include empathy and engagement in patient care and an appreciation of limits as generalists, as well as professionalism. Generalism requires the “integration of healthcare services” as we work across “professional and organisation boundaries”. The approach respects patient autonomy, especially as patient expectations rise. Patients value a holistic approach to care. Generalism supports cost-effective care across the health system.¹

While Family Medicine has traditionally been regarded as a generalist discipline with a breadth of focus and holistic health care, traditional specialist disciplines have depth of focus in a narrow field of health care. Although the dichotomy between specialist and generalist care has been the usual approach to conversations about health care, there is a growing understanding that generalist principles operate along a wide spectrum and exist in many other medical disciplines, including internal medicine, paediatrics and family medicine. In reviewing the challenges that have evolved with respect to generalism, I will discuss those identified by the Royal College of Family Practitioners, in addition to a few others.¹

Specialist-generalist relationships

The rise of patient autonomy (and the growing intolerance of uncertainty) in patients is driving them to access specialists as a point of entry into the healthcare system, which conflicts with the difficult relationship that has existed between specialists and generalists for decades. As a point of departure, most members of society acknowledge that both specialist and generalist approaches are necessary in health care.² Despite this understanding, there is a long history of a challenging relationship between generalists and traditional specialists in various disciplines. A primary care-specialty care interface has developed, and this is fuelled by government policy and healthcare funders alike. Since the 1990s, a growing emphasis on primary care at health policy level in South Africa has exacerbated the conflict. Medical funders, in the process of maximising cost-effective care, actively manage boundaries between primary and specialist care via referral networks, prior authorisation for referrals, referral guidelines and specialty “hotlines”.³ A number of

guiding principles may be considered in the context of conflictual generalist-specialist relationships, such as patient welfare and best interests, mutual respect and integrity, and the appropriate and prudent use of health resources. Ultimate responsibility for the patient lies with the referring doctor who must continue care after the specialist intervention has ended. Doctors have a “primary ethical duty to care well for patients”. This creates an obligation to “avoid self-defeating acrimony, and seek rather to define the principles that will guide generalist-specialist relationships towards the best interests of patients”.³

The expansion of services by other professions

Pharmacists have expanded their services in recent times to include over-the-counter diagnosis and treatment, as well as screening. While preventative health care and screening are always encouraged in the medical profession, diagnosis and treatment in an open-plan pharmacy, in the absence of a physical examination, is a matter of great concern. This practice is gaining in popularity, especially after hours and on weekends, when it may be difficult to access generalist medical care. Clearly, pharmacists are playing a role in fulfilling unmet health needs. Furthermore, many pharmacists in South Africa find that limiting their practice to dispensing only underutilises their training.⁴ However, such practices have the potential to result in adverse events for patients when medication is prescribed in the absence of a medical examination. History taking across the counter in the presence of other customers also breaches the rules of privacy and confidentiality which are sacrosanct in the context of the traditional doctor-patient relationship.

Generalism and evidence-based medicine

Patient management in clinical medicine has increasingly included reference to the growing body of scientific knowledge at the disposal of healthcare practitioners when providing evidence-based health care. Undergraduate and postgraduate programmes at health science institutions include evidence-based medicine (EBM) as a major component of their curricula. However, applying EBM principles in clinical practice can be quite challenging. Given the paucity of research conducted in the primary healthcare sector, several important questions need to be addressed, i.e. “Do we have an adequate base of evidence to work with in traditional generalist medicine?” “Is this evidence based on research in resource-depleted settings?” How do we know when we are presented with false or misleading ‘evidence’?”

In his controversial, but stimulating book, *Bad pharma: how drug companies mislead doctors and harm patients*, Ben Goldacre describes numerous trials which involve commonly prescribed drugs, like statins and antidepressants, where, according to him, the industry has deliberately misled the profession with inaccurate information. He describes the failure to publish negative trials as the “cancer at the core of EBM”.⁵ The False Claims Act in the USA has resulted in a number of lawsuits against the industry in the last two years.⁶

GlaxoSmithKline recently settled a \$3-million lawsuit for misbranding drugs and failure to provide safety information on rosiglitazone.⁶ Amgen is set to pay a whopping \$24.9 million to the USA government for “kickbacks” that were paid to switch patients onto their anti-anaemia drug, Aranesp®.⁷ Clearly, by definition, EBM must be based on good evidence. It is the responsibility of generalists, specialists, researchers, sponsors, medical funders and the pharmaceutical industry to ensure that good science and good ethics underpin research on medical and other interventions.

Ethics and the use of social media by health professionals

The Internet has made the rapid and widespread exchange of information possible among people. Some practitioners use twitter, facebook or blogs for patient communication or to market their practices. Currently, there are no guidelines in South Africa that explicitly deal with social media use by the profession. The American Medical Association developed a set of guidelines for doctors and medical students in 2010 which highlighted important principles with regard to the use of social media, such as maintaining confidentiality and patient privacy online, ensuring that appropriate boundaries are maintained in the electronic doctor-patient relationship, and taking heed of reputational risk that can result from content that is posted online. It is critical that doctors and medical students separate a personal online presence from a professional presence. To ensure this, privacy settings should be maintained on personal websites and other social media.⁸ Generalists function in a context in which they have more regular and personal interaction with patients. Hence, it is particularly important that professionalism is maintained if social media are used to interact with patients.

Electronic health records

The evolution of electronic health records is closely linked to social media in health care. While electronic records have the potential to be beneficial in terms of improved patient care, efficacy and safety, and in preventing duplicate prescribing and drug interactions, the system is not without risk. This includes data privacy and security, stigmatisation and discrimination, secondary use of data and additional costs. Secondary use of patient data is a matter of great concern. It is unclear if medical funders use patient data on their databases for research or to allow access to academic institutions or research organisations. It is well established that electronic scripting data which are submitted to some pharmacies could be sold to data mining companies, who in turn, might sell this data to the pharmaceutical industry. Companies in the latter often use these data to extrapolate the prescribing habits of

generalists and specialists to decide which doctors should be chosen to receive special entertainment, holidays abroad and sponsorship. Insurance companies, the police and employers have the potential to access electronic data. The principle of autonomy creates the obligation that patients ought to have control over who can access their records and who can see their data.⁹ While electronic records are important and beneficial in advancing healthcare provision in the 21st century, generalists should be aware of risks that pertain to data security and privacy.

Conclusion

Generalist medicine is increasingly being recognised as being critical to health care in South Africa. The discipline faces many challenges. It is important that these challenges, and their consequent opportunities, are addressed. Relationships between generalists and specialists must be enhanced via regular interaction and communication to enhance mutual respect, and to promote interdependence and build integrity in the profession.

Relationships with other healthcare providers, such as pharmacists and allied health professionals, should be enhanced to avoid the duplication of tasks and the blurring of professional roles and responsibilities. If an evidence-based approach is to be used in generalist care, it is important that the evidence base is strong, and that current literature is critically appraised and poor evidence recognised. Responsible use of social media and electronic health records by role players in the healthcare profession must be encouraged and guided by the profession and the Health Professions Council of South Africa. Medical undergraduate training should be regularly reviewed to assess the extent to which the training of healthcare professionals is based on the principles of generalism. Ultimately, we need to remember that the patient is central to our debates and conflicts. Our first responsibility should always be the patient's welfare and best interests.

Conflict of interest

I declare that I have no financial or personal relationships which may have inappropriately influenced me in writing this paper.

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