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PERSPECTIVES

Genecialist manifesto: overcoming the "class struggle" in medicine

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Abstract: Generalists and specialists are often considered two completely distinct species, which culminates in the establishment of a concept of dichotomy. However, these dichotomy can at times fuel tension and even erupt into open conflict. In order to resolve this issue, the author herein proposes the concept of a "genecialist." The genecialist refers to a hybrid comprising elements inherent to both generalists and specialists. This potentially overcomes the multitude of issues associated with both generalists and specialists in the practical aspects of medicine. The coalescence of these two contrarieties may hold the key to improving the future of health care. Mediating and integrating both categories into one consolidated entity carries the potential to stem the tide of class warfare between generalists and specialists.

Keywords: genecialist, aufheben, generalist, specialist, asymmetry

Introduction

The dichotomy of having both generalists and specialists is omnipresent in many fields and is not restricted to physician occupations. One can observe that a growing number of health care professions, such as nurses and pharmacists, are increasingly becoming subdivided into specific specialties.[1,2] This type of generalist–specialist dichotomy is also a common phenomenon outside the field of medicine, such as in finance, journalism, or information technology.

The generalist–specialist dichotomy may, however, produce tension and even conflict in certain situations. Some specialists may complain of generalists "not doing enough" from their own specialty's perspective. A number of studies have demonstrated that the outcomes of certain conditions were better under the care of specialists, as opposed to generalists,[3,4] while others contested these claims.[5,6] On the other end of the spectrum, generalists may not approve of the way specialists see their patients, as they sense that specialists focus only on specific diseases or organs, and not on the patients as a whole.[7]

Friedrich Engels and Karl Marx wrote in their book, *The Communist Manifesto*: "Society as a whole is more and more splitting up into two great hostile camps, into two great classes, directly facing each other: Bourgoisie and Proletariat."[8]

Of course, one hopes that the relationship between generalists and specialists in medicine is not as hostile as the picture depicted by Engels and Marx; however, the concept of "splitting up into two" groups, the concept of dichotomy nurturing tension, or a sort of "class struggle" most likely exists in the field of medicine as well.

But what does this ultimately lead to? Doesn't this type of mutual criticism simply confuse patients, who may sense the tension between the two, often competing,

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contrarieties? This kind of detrimental dichotomy may potentially jeopardize the quality of health care as a whole, since it is the patients who suffer most from the disconnections and misunderstandings between generalists and specialists.

To overcome this problem, the author herein proposes a third pathway, namely, the concept of the "genecialist."

The genecialist refers to a hybrid comprising elements inherent to both generalists and specialists. He/she is a physician who can function as both a primary care physician (generalist) and as a specialist. The author proposes the integration and harmonization of both groups as a potential solution to overcome the numerous issues posed by the generalist–specialist dichotomy.

What is a genecialist?

The concept of the genecialist was conceptualized by referencing noteworthy philosophers in recent history who developed the process of dialectics, illustrated by Georg Wilhelm Friedrich Hegel's "aufheben," which articulated the tension between thesis and antithesis.[9] The concept of the genecialist was born in a manner similar to aufheben by exhaustive inquest into both generalists and specialists.

The genecialist represents him/herself as neither a generalist nor a specialist. In fact, the genecialist need not represent anything.

Representation, by definition, is a declaration of being a member of a faction. Generalists represent themselves as members of general medicine and specialists represent themselves as members of a given specialty. A sense of being in a faction is a declaration, stating that, "I am different from you." The declaration makes one isolated from others, who do not belong to that particular faction.

"Factionalization" is the true enemy that must be slain in order to effectively nurture a mutual understanding between ostensibly polar contrarieties (eg, men and women, West and East, white and black, doctors and patients, the examples are endless). This concept of dichotomy is detrimental to achieving mutual understanding, sympathy and empathy to others.

Thus, in this novel depiction of generalists and specialists, the difference is – to a certain extent – relative.

But are generalists and specialists really different? Or, perhaps even more importantly, should they be? A generalist is classically thought of as doing and knowing something about everything, but not everything about something. The classical image of a generalist is, therefore, a wide, short rectangle, covering a broad range of knowledge, but few in great depth. One might call this the Lake Okeechobee effect, referring to a large inland lake in Florida with extensive surface area, but which is at no point more than 2 meters deep. On the other hand, the classical depiction of a specialist is a rather tall, but narrow rectangle, covering only one field of specialty, yet with a very high level of expertise. Staying with the aquatic analogy, this might be represented by Oregon's Crater Lake, with a relatively small surface area but a great depth of up to 2000 meters.

In reality however, the author believes that the typical generalists and specialists adhere to neither of these analogies. Rather, most generalists I know can better be described as a triangle in terms of shape. In general, they are more than capable in many senses to function as primary care physicians, but they also often have in-depth capabilities in a specified field, which also makes them "special." This can be for a specific disease entity, or subspecialty such as expertise in rheumatologic diseases or infectious diseases. It can also refer to a particular setting of their respective duties, such as an emergency department, house calls, rural medicine, or occupational medicine, to name a few. These physicians may particularly stand out at procedures such as endoscopy or ultrasound. They may also excel at some cross sectional entities, such as evidence based medicine, narrative medicine, medical ethics, palliative care, clinical reasoning, or medical education. Many generalists do have "something," and therefore the rectangular analogy fails to do them justice; instead these physicians are more closely represented by a triangular geometry.

Likewise, many specialists I know do not fit the rectangular description. Although not enough to be called generalist perhaps, they do have some width and learn certain things related to their original specialty. Many surgeons are good examples. Some are good in the management of postsurgical infections, nutrition, pain management, and so on. They also fit more of a triangle description, rather than rectangles, as described above for generalists.

The difference between these two groups is merely in the width and length, which is comparatively relative, and not definitive.

Some experts are extremely good at even narrower contents. Some cardiologists devote themselves only to cardiac catheterization and do not bother doing echocardiograms, stress tests, or even electrocardiogram reading. These are "super-specialists," who are even better than ordinary specialists on select topics. Their triangle is narrower, taller, and sharper.

Now, if you consider the three distinct triangles constructed to depict the generalist, specialist, and super-specialist, you will find a relative gradient, not showing any definite dichotomy. This is similar to what you will find when looking at people with differing heights and weights.

There may be a generalist with a very, very wide coverage of a broad range of topics with relatively short height on his/her triangle. Some generalists may not boast such a broad range. For example, the majority of general internists do not see trauma patients, pregnancy-related problems, or pediatric cases.

A frequent topic discussed by generalists is "what is the minimum requirement to be considered a generalist?" Some might say "you must see pregnant women," or "you need skills in trauma care." Personally, I feel that such lines of questioning are irrelevant since the difference in the width of the triangle is merely relative.

The other side of the coin is true as well. If one caters to a greater number of gay patients, HIV may be a more common entity. Some may work at a Veteran's Affair Medical Center where most of the patients are men and smokers with many tobacco-related comorbidities. Are "generalists" in these settings "specialists," covering a much narrower spectrum of patients? It probably depends on how you categorize them but this in itself is an arbitrary process.

Structuralism, founded by Ferdinand de Saussure, Claude Lévi-Strauss, and others explained that every categorization is rather arbitrary and not definitive,[10] which is not unlike attempting to define the number of colors of a rainbow. The generalist–specialist dichotomy is – like structuralism rightly found out – all relative and arbitrary. If so, why separate them? Why do we not handle them collectively as one entity, to avoid the unnecessary and often confounding factionalization?

The concept I describe is not entirely original. Pickering described a very similar concept in the 1970s.[11] He stated:

> As TH Huxley said, 'Know something about everything and everything about something.' As a physician I hold a similar view. In my youth I became an expert on peripheral vascular disease. I remember with great satisfaction the patients I saved from vascular surgery, for example, hysteria, multiple sclerosis, prolapsed intervertebral disc. I saved them because I had also been trained in neurology. What chiefly terrifies me about medicine in the US is the danger to the patient of falling into the hands of a subspecialist, particularly one who uses questionnaires, for he starts with a presumed diagnosis and the patient is almost certain to become a disease and cease to be a person. A fortiori, should it happen to be the wrong specialist. I am equally terrified by the increasing practice of teaching general medicine by subspecialists. No surer method of eliminating the patient as a whole person could be devised.

This "knowing something about everything and everything about something" mentality is a key to becoming a genecialist.

Genecialists are those who have completed training in both general medicine and a subspecialty. But this is not enough. Genecialists must continue to practice in dual settings to remain current in both fields.

The genecialist must have something that makes him/her "special." This does not have to be a typical subspecialty such as cardiology or nephrology. For instance, I know of one primary care physician who is very knowledgeable about evidence-based medicine. He wrote a number of books on this topic[12–14] and is widely respected for his expertise. Prominence in one topic in which one knows (almost) everything is a condition to make the topic special to oneself, as well as to others. Still, this primary care physician calls himself a generalist. To me, he is a prime example of a genecialist.

The true value of "not knowing"

Knowing (almost) everything about something helps you in many ways. By "penetrating" through a certain field, you will paradoxically realize how much you do not know about many things involved in daily patient care.

Suppose we have 20 specialties in medicine (we have more of course, but this is merely for the sake of a thought experiment). If you are specialized in one of these 20 fields, because there are 19 more specialties in which you have no specialist expertise, you realize that the ratio of things you know to those that you do not know is 1:19, which means that the things you do not know outweigh the things that you do know by a factor of 19. You realize that there are so many things that you do not know because you have deep knowledge and skills only in a specific subject. Without specialist expertise, you will never understand the potential height that each specialty truly embodies. Without generalist expertise, you will not know how many subjects medicine truly covers. It is only when you have enough height and width in your respective triangle that you can truly come to the realization that you have many things that you have yet to learn. This encourages you to learn more, listen to others, and respect others, so that you can improve yourself. Again, the true value of becoming a genecialist does not reside in the knowledge you have. It is the awareness of knowing what you do not have that is the true value of being a genecialist.

By being a specialist, you notice the slight differences among similar cases, since you see many cases accumulated by consultation. At a glance, patient A with pneumonia may appear similar to patient B who also has pneumonia. But they differ from a specialist's view; A and B are treated differently, since they really are different. The judgment to differentiate between these two pneumonia cases is again arbitrary

according to structuralism. These subtle differences go unnoticed to the uninitiated, who do not have enough experience, namely nonspecialists. However, these differences may alter the way you treat your patients. For example, "I think that John has an unusual pneumonia, which might be a little difficult to treat. Why don't we consider extended treatment for this patient?" This happens often in my infectious diseases consultation service, but this kind of contingent judgment may not be described in a textbook or on PubMed.

I have noticed that some generalists mock a specialist because he/she did not follow evidence or guideline in a particular case. Evidence is, of course, not to be ignored. I am by no means against evidence-based medicine. However, there are things that evidence alone might not be able to tell you. A high level, sophisticated, randomized, controlled clinical trial may be useful in general, but may not be applicable if the patient in front of you is different from the ones enrolled in the trial, and it should be noted that this happens frequently. The absence of evidence is not the evidence of absence. Overreliance on evidence and ignoring one's experience is not evidence-based medicine and is more like evidence-biased medicine.

By being specialists and by seeing various types of patients, you are more likely to notice these subtle differences. This also leads to the appreciation of other specialists. For the sake of argument, let's say I have a colleague who is a cardiologist. This individual may not give beta blockers to a particular patient with a myocardial infarction, because there may be an underlying condition to preclude their use that he/she sees, which I do not have knowledge of. I may not be able to acknowledge the difference myself, but I will know the difference exists and this is what is important.

Obviously, many generalists also see things that I cannot. For example, one patient you have known for years may present with chest pain. The generalist may sense this pain is different from others in the past because, as a generalist, he/she knows the patient well and will be able to pick up on subtleties that I cannot.

Rich eyes see differences others cannot see. The genecialist knows there are such eyes. Becoming a genecialist is a very effective way to realize the existence of such eyes and avoid any unnecessary or otherwise confounding miscommunications.

Overcoming asymmetry

Having something "special" is good because you are somebody who can be relied upon. I acknowledge that sometimes primary care physicians feel understandably uncomfortable about not having something special about which others ask your opinion – a medical forte, if you will. This might produce a relationship with a sort of "laterality," since there will be a dichotomy of one entity calling upon the other, but by the same token not being called upon. Thorsen et al expressed the general practitioners' frustration at their dialogue being rather asymmetrical.[15] Should individuals become genecialists, the one-way communications hierarchy will be effectively lifted, resulting in individuals calling upon others and having the very same gesture reciprocated. There will be no asymmetry as we observe now.

Widening the "width"

The attributes of family physicians according to Rakel are shown in Table 1.[7]

Table 1 Attributes of the family physican*

- A. strong sense of responsibility for the total ongoing care of the individual and the family during health, illness, and rehabilitation.
- Compassion and empathy, with a sincere interest in the patient and the family.
- A curious and constantly inquisitive attitude.
- Enthusiasm for the undifferentiated medical problem and its resolution.
- Interest in the broad spectrum of clinical medicine.
- The ability to deal comfortably with multiple problems occurring simultaneously in a patient.
- Desire For frequent and varied intellectual and technical challenges.
- The ability to support children during grow and development and in their adjustment to family and society.
- Assists patients in coping with everyday problems and in maintaining stability in the family and community.
- The capacity to act as coordinator of all health resources needed in the care of a patient.
- Enthusiasm for learning and for the satisfaction that comes from mainlining current medical knowledge through continuing medical education.
- The ability to maintain composure in times, of stress and to respond quickly with logic, effectiveness, and compassion.
- A desire to identify problems at the earliest possible stage or to prevent disease entirely.
- A strong wish to maintain maximum patient satisfaction, recognizing the need for continuing patient rapport.
- The skills necessary to manage chronic illness and to ensure maximal rehabilitation after acute illness.
- Appreciation for the complex mix of physical, emotional, and social elements in personalized patient care.
- A feeling of personal satisfaction derived from intimate relationships with patients that naturally develop over long periods of continuous care, as opposed to the short-term pleasures gained from treating episodic illnesses.
- Skills for and a commitment to educating patients and families about disease processes and the principles of good health.
- A commitment to place the interests of the patient above those of self.

*These characteristics and desirable for all physicians, but are of greatest importance for the family physician.

There is a cautionary statement below this list, which states: "these characteristics are desirable for all physicians, but are of greatest importance for the family physician."[7]

Now, what Rakel may be implying is that idealistically all physicians should – but in reality do not – embody these characteristics. I think these attributes should be of great importance to all physicians and personally cannot imagine a physician who is exempt from having a strong sense of responsibility, compassion, empathy, curiosity, and so on. If the specialist leaves these attributes only to the family physician (or any generalist), it implies that the specialist is, will be, and must be, inferior to others in terms of those attributes. So the question is "have they left out these attributes?" I think the answer may be "yes." But a better question is "should they ignore these attributes?" I do not think so. Bringing these attributes to the so-called specialists will certainly enrich their practice, allow them to take better care of their patients and will result in less conflict with so-called generalists. With the acquisition of these virtues described by Rakel, I firmly believe that all specialists can be categorized as "generalists."

I know a number of so-called specialists who do possess all of these attributes described by Rakel. I know an American specialist in pulmonary medicine who has cared for her asthma patients for years, in a very compassionate and comprehensive way, who has gone out of her way to even provide instruction to her patients on how to buy an appropriate carpet or how to wash their pillowcases. There is also a Japanese rheumatologist whose care was thoroughly compassionate and never ceased to impress his patients. After years of dedicated care at one hospital, he decided to leave the institution and start a new practice in a distant locality. Some of his patients actually moved closer to this individual, simply to seek his care.

As an infectious diseases doctor, I see many HIV/AIDS patients. To me they are not merely a subset of patients that must be constantly observed for CD4s and viral loads. We have to extend our care to their anxiety, the lack of understanding by their family members, the fear of discrimination, cultural conflicts, concurrent problems such as the use of illicit drugs, or the problems of unsafe sexual practices. Compassion, dedication, comprehensiveness, continuity, and many other virtues described by Rakel are a must in HIV/AIDS care. There need be no distinction between a classic generalist and specialist in one's approach to HIV/AIDS care. In fact, our patients desperately need the watchful eyes of both generalists and specialists.

Integrity is the key for future medicine

Meza and Passerman propose the integration of narrative medicine and evidence-based medicine.[16] They do not consider these to be antagonistic concepts. However, they are not necessarily complementary. A good narrative guides physicians and patients to ask appropriate questions to resolve the patients' "narrative dilemma." This is the first step towards entering into evidence-based medicine. Unless you ask clinically appropriate questions that closely relate to the patient, a high quality search for evidence and detailed evaluation of articles will not result in the benefit or happiness of the patient. This type of integration is a representation of future medicine. Integrating all dichotomies will harmonize separate concepts as one, which will benefit all of the parties concerned. I would like to propose the same notion here with the concept of the genecialist to preemptively resolve any potential conflicts between generalists and specialists.

Immanuel Kant[17] explained that all natural scientists are categorized into two groups. One is interested in harmonization and integration, and the other is interested in specialization and disintegration.[17] Either view is possible and arbitrary, as explained in structuralism. More than likely, it is integration, rather than disintegration that has a greater affinity with the field of medicine. The concept of a genecialist is one such example.

Karl Marx tried to overcome the dichotomy and class struggle between the Bourgeoisie and Proletariats, rather unsuccessfully. He foresaw the latter would overcome and destroy the former in the class struggle, but that prediction turned out to be untrue. I would like to propose a better way to overcome our dichotomy in the field of medicine: the coalescence of both entities and aufheben to nurture a new concept of the genecialist, for better patient care. Workers of all medical fields, unite!

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References

1. Price A. Specialist nurses improve outcomes in heart failure. *Nurs Times*. 2012;108(40):22–24.

2. Pradel FG, Palumbo FB, Flowers L, Mullins CD, Haines ST, Roffman DS. White paper: value of specialty certification in pharmacy. *J Am Pharm Assoc (2003)*. 2004;44(5):612–620.
3. Boom NK, Lee DS, Tu JV. Comparison of processes of care and clinical outcomes for patients newly hospitalized for heart failure attended by different physician specialists. *Am Heart J*. 2012;163(2):252–259.
4. Grilli R, Minozzi S, Tinazzi A, Labianca R, Sheldon TA, Liberati A. Do specialists do it better? The impact of specialization on the processes and outcomes of care for cancer patients. *Ann Oncol*. 1998;9(4):365–374.
5. Donohoe MT. Comparing generalist and specialty care: discrepancies, deficiencies, and excesses. *Arch Intern Med*. 1998;158(15):1596–1608.
6. Smetana GW, Landon BE, Bindman AB, et al. A comparison of outcomes resulting from generalist vs specialist care for a single discrete medical condition: a systematic review and methodologic critique. *Arch Intern Med*. 2007;167(1):10–20.
7. Rakel ER. The family physician. In: Rakel ER, Rakel DP, editors. *Textbook of Family Medicine*, 8th ed. Philadelphia: WB Saunders; 2011:3–18.
8. Marx K, Engels F. *The Communist Manifesto*. The English edition of 1888. Amazon Services International, Inc.
9. Shimazaki T. Generation of Hegel's Dialectics. On simultaneous establishment with "Philosophy of Mind". Hitotsubashi University research series. *Social Science*. 1992;30:32–132. Japanese.
10. Uchida T. *Introductory Structuralism*. Tokyo: Bunshun-shinsho; 2002. Japanese.
11. Pickering G. The essence of medicine. Doctor-patient relationship: the impact of recent changes in medicine and society. The Waldenström lecture. *Acta Med Scand*. 1978;204(5):339–343.
12. Nago N. *EBM Practice Workbook. For better treatment*. Tokyo: Nankodo; 1998. Japanese.
13. Nago N. *EBM Practice Workbook. Part 2. Medicine we can do now*. Tokyo: Nankodo; 2002. Japanese.
14. Nago N. *Step up EBM Practice Workbook*. Tokyo: Nankodo; 2009. Japanese.
15. Thorsen O, Hartveit M, Baerheim A. General practitioners' reflections on referring: an asymmetric or non-dialogical process? *Scand J Prim Health Care*. 2012;30(4):241–246.
16. Meza JP, Passerman DS. *Integrating Narrative Medicine and Evidence-based Medicine: The Everyday Social Practice of Healing*. London: Radcliffe Publishing; 2011.
17. Maruyama M. *Thought and Behavior in Modern Japanese Politics*. Tokyo: London: Oxford University Press. 1963.