

## COMMENTARY

## A Generalist's Perspective

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I have no idea what is the right topic for an SGIM president's address—even though I've heard about 30 of them over the years. I want to thank Nicki Lurie for using my phrase, "Don't get mad, get data!" for her SGIM president's address in 1998. Otherwise, I would have used that adage today—but it's really better that she did. The beauty of her doing so is that it was when she and I were clinical scholars at UCLA that I coined that phrase, describing her converting her righteous indignation about the closing of clinics for the poor in Los Angeles into a data collection effort to study the impact of the clinic closing on health outcomes. This was massively more helpful than just getting mad. So although I coined the phrase, I feel *she* owns it—and I am delighted that she got the Calkins Public Policy Prize at this SGIM annual meeting for such work. And I know she would want me to add to that advice, "And then act!" So for the president's address about "Don't get mad, get data!", I refer you to her presidents' address of 1998.

Some presidents' addresses start, or at some point, allude to the president's family, especially the parents. I had amazing parents, and I honor their memory. Indeed, it is their visions and hearts within me that make me who I am. But for you listening in the audience today, as John Eisenberg used to ask about research, "So what?" What good is that to you, right? It hardly helps you for me to tell you to go out and get great parents with a strong sense of social justice. So I will not talk about my parents.

Rather, I want to talk about generalism as a way of seeing things, a special perspective. I want to argue

that it doesn't matter whether you are in an outpatient clinic, in an ICU, on the wards, in the classroom, in the community, as an organizational leader, or in a policy role, we are unified by our generalist vision. I wish I could speak now in boldface italic, but I can't. So I'll say it again: *It doesn't matter whether you are in an outpatient clinic, in an ICU, on the wards, in the classroom, in the community, as an organizational leader, or in a policy role, we all share our generalist way of seeing things.*

When do we recognize that we have a distinct generalist perspective? It varies. Some of us recognize it early on—some, like me, not so early. How do you know if *you* are a generalist?

It reminds me of the medical school application process. If you don't have some reservations about going to medical school, you are crazy. And if you admit that to the medical school interviewer, you are crazy.

Similarly, if you don't have some doubts about being a generalist, you are crazy. But if you let that stop you from being a generalist, you could be making a serious mistake. Many good things can be done without complete certainty, and our time is finite; we don't get to experiment with our lives forever. Of course, as generalists, we are used to having to act without complete certainty and dealing with very finite time.

When does the generalist vision start? Soon after we decided we wanted to be a physician and got the opportunity to go to medical school, we started deciding what kind of physician we wanted to be. We ultimately chose to be generalists. I'd like to dwell on that "decision" for a few minutes. But first, please raise your hands if you

struggled at some point with the decision to become a generalist rather than a sub-specialist. (And if you didn't struggle—if you didn't wonder—you didn't raise your hand, and you're crazy.)

Our careers have developed in different settings and at different times, but I suspect most of us, though not all—I know some exceptions—had at least some period of doubt about becoming a general internist. For me, in medical school and in my traditional internal medicine residency, it certainly seemed that specialization was more highly valued than generalism—academically, socially, and financially. Like all of you here, I was a good student, which meant, of course, I was responsive to cues in my environment about what a good student should do and what a good student should be. The cues in medical school and residency were that the question was not *whether* I would become a subspecialist but *what kind* of subspecialist. I liked the biology of differential gene expression, and thought hematology and oncology would be very interesting—but the clinical practice seemed terribly depressing. I found the history and physical exam of the practice of rheumatology great fun, and the biology was fascinating, but would I miss the action of acute care? I enjoyed the highly evident physiology and its manipulation in medical and cardiac intensive care units, but ultimately it seemed a little too mechanical—too much that was just hydrodynamics, plumbing, and wiring. I loved the beautiful subtlety of neurology, but it seemed a bit glum—the diseases were largely awful. I loved the emergency department (or, as it was quaintly called at Boston City Hospital where I was a

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resident, the “Accident Floor”); there was always a new surprise and problem to deal with and very very interesting people. But then I never saw them again. Now you all recognize I was exhibiting the proclivity for generalism, although I didn’t recognize that. To me, the problem still seemed to me to finally discern *which* of these subspecialties, or others I considered, would be the right subspecialty for me. I guess I was too concrete in interpreting my environment.

Why am I telling you all this? Because in case some of you are still struggling along these lines, or in case you meet a confused young physician struggling in this way, as an example, I want to share how I escaped my own determination to become a subspecialist and responded to my generalist within.

Two opportunities saved me. As a senior resident I was pivoting like a spinning top, not sure which subspecialty fellowship to apply for, and I was asked to be chief resident. I had an additional year of learning from patients and reading related topics with real responsibility when I was a single chief resident—back in the days when the chief resident ran the medical service. It was great in so many ways for me, but I won’t recount that now, other than to say that if you see a young resident Harry Selker struggling, or a young harried struggling resident, offer him or her an out if you can, to allow completion of their incomplete professional development in which they hopefully will eventually recognize they were meant to be a generalist. It turned out that one year was not sufficient remedial time for me, and another opportunity to avoid clinical subspecialization landed in my lap, the opportunity to subspecialize *academically* rather than clinically: two years as a Robert Wood Johnson clinical scholar. The position ideally suited me. I found that the enjoy-

ment of inference that had made genetics interesting to me (Who has ever really seen a gene? It’s all inference.) also could be found in clinical epidemiology. Using cool inferential analytic methods, one could come up with insights about clinical care that otherwise could not be seen. And also, the analytic methods allowed me to better understand public health and policy issues, which became of great interest to me. So my advice to you is, if you have the opportunity to help a confused yet self-unrealized generalist find themselves through a non-clinical *academic subspecialty*, encourage them to do that.

Ultimately, I realized that although emergency cardiology is a great area for research (in which I still work), as a clinician, I really liked the *whole person* a lot more than just their left ventricle. I liked the fun of being a “real doctor” who could deal with constipation as well as cardiac tamponade—and recognize the difference without a Swan-Ganz catheter (and without a colonoscope). Yet, to be honest, it took quite a few years to truly accept that in myself. I mainly blame myself for this confusion, but I bring to your attention one contributing factor: Everyone around me hallowed the subspecialty role, and even society seemed to respect the super-specialist more than the generalist. I had no countervailing examples. So, be an example of a happy, fulfilled generalist so you will inspire those as confused as was I.

Now let’s turn back to the perspective of the generalist. What is special about generalism? (Irony noted.) Ultimately, it’s what we see when we look around. Some physicians will look at an overweight person and see an opportunity to do their new minimally invasive gastric banding procedure; some will see the need for a drug; some will see

an opportunity for integrated teaching and careful medical care; and some will also see an individual’s physiology, psychology, and social context. We generalists see all of that—and then many more details as we delve into the care of this person. We see the individual’s characteristics integrated and *in context*. This is an unalterable part of our vision. And just as it is not necessarily good or bad to be an introvert or extrovert, to be a detail person or a big-picture person, or a feelings-based person vs. a rationally based person, we should not judge our generalist proclivities to see the broad picture—or others’ proclivities to focus on a narrower portion. Rather, we should cherish it, as it is not only satisfying to us, it is crucial to our patients and to society. It is a gift, just like intelligence, creativity, musical ability, or a good jump shot. What is silly, and what is a waste, is to not use that gift. Fortunately, as gifts go, it’s a good one. (Say, compared to my gift of compulsivity, a more mixed gift!) So, in seeing our patients, we see more than just one attribute or organ. In our research, we tend to see more than just one aspect of what’s going on, and we do our research in complex real-world settings. As educators, we see the need for more than just the transmission of facts and procedures. As committee members, we see more than just narrow administrative and policy issues. As leaders, we see the need to include the wide range of stakeholders, not just the powerful. In all these cases we see contexts and the web of influences that create the whole.

To drive home the issue of this being an intrinsic characteristic, I would like to make an analogy to the Myers-Briggs Personality Inventory. How many of you have done a Myers-Briggs evaluation? Please

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raise your hands. Then you know that this personality profiling instrument categorizes you by your intrinsic proclivities. What I find more interesting than the actual personality categories is that these categories are reliably discernible at all. We each have natural ways of thinking that dominate our perspective and our interpretation of data—we have very distinct and set ways of seeing things and ways of being. For example, one of the polar scales in the Myers-Briggs assessment is between introversion and extroversion. There are endogenous differences between introverts and extroverts. If an introvert goes to a party where there are lots of people (or an SGIM annual meeting), by the end of the evening, the introvert will be exhausted—but at the end of the evening the extrovert will be energized. This is just an intrinsic quality of each person. This means that we are not completely plastic to become what is most highly valued by others, but rather we should leverage our own tendencies. Having your personality analyzed and categorized by the Myers-Briggs test is an experience that helps you understand that a proclivity for generalism is intrinsic and should not be ignored. You are who you are—and the sooner you realize that you are a generalist, with or without a good jump shot, the better you will feel and do.

So, say now that you understand that by some stroke of luck, genetics, parents, and traits—oh, and education—you are a generalist. What can you expect? What's the deal with this perspective thing of which I speak?

We general internists focus on patient care, education, research, and social justice. And in each, we take the broad view. However, the words “dilettante” and “generalist” have the same number of letters; might we be mistaken for dilet-

tantes? I want to emphasize the difference: A dilettante is someone who, as an amateur or out of casual interest, enjoys the arts or engages in a field not as a profession. In contrast, engagement in multiple areas is part of our profession. Generalism itself is our professional *specialty*. My President's Columns over the past year in *SGIM Forum* may start to give a sense of this breadth. I wrote about the clinical role of the generalist, health and social policy, advocacy, physician payment, leadership, SGIM's mission, and magic wands, among other things. This diversity is an under-representation of the interests of a typical generalist, but it makes a point: We see the patient, but we also see the context of relationships, society, policy, and our role as a change agent. And we are intense about these all—this is not the casual interest of the dilettante.

In this, because it has relevance to conversations about the subspecialization of general internal medicine, such as represented by hospitalists, gerontologists, and others, I want to again emphasize something I said earlier. In politics, it is said that what you see depends on where you stand. In *generalism*, I propose it is the *opposite*: What you see does *not* depend on where you stand. Whether you stand in the clinic, the hospital, the community, in leadership or policymaking roles, or many other roles, what you see is the generalist's view—the foreground, the background, and the links, all together. My first year as a faculty member was at UCLA in the Division of General Medicine at Cedars-Sinai Medical Center. There, the Division had responsibility for the general medicine clinics and wards and also for the MICU. The idea was that rather than anesthesiologists, pulmonologists, or cardiologists, excellent ICU care would benefit from the integrative vision of

the generalist. I think this was exactly right. Do not let yourself be separated by where you stand—we all see the same integrative vision, and we should stick together.

That said, I do want to dwell a moment on the role of the general internist as primary care physician, a great example of the contribution of our generalist perspective.

I want to return to a story I told in one of my columns in *SGIM Forum* about “Jane,” a woman in her 40s who volunteered for a clinical research study where a protocol-based colonoscopy detected an adenomatous polyp. This led to her being referred to a series of specialists and receiving 55 medical visits over the ensuing one-year period. She underwent many imaging studies, tests, procedures, and several operations, only one of which was clearly indicated. (It was, in retrospect, unnecessary; the colectomy showed that the polyp already had been successfully removed by colonoscopy.) Her life was completely disrupted, huge amounts of money were spent by her and her insurers, and yet arguably nothing ultimately helpful was done.

This was bad for Jane and bad for society, but it was a natural consequence of our current medical care system. There are many reasons for such cascades of evaluations, tests, and procedures leading to waste and often net harm. However, in my mind, key among the causes for Jane was the lack of a primary care physician to act as her advisor and advocate as she tumbled down the medical cascade. Indeed, in the past, Jane had primary care physicians, but when she moved years before she never got another one—feeling that even if well-meaning they often were not available for her when she wanted access and that the visits were too short to illustrate to her the value of

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primary care. So in the middle of this cascade, this very bright woman didn't even think about having a primary care physician who might have advocated for a less specialty-driven path of evaluations and interventions.

In our daily practice, we all know that our ability to provide personalized primary care of this sort is severely compromised by many circumstances, and while we are disappointed, we are not surprised by what happened to Jane. Why is this the case? It's not the intent of general internists, or other primary care clinicians, to short-change patients in terms of time, attention, or access—but that is the case. In fact, this is the direct result of policy decisions made by the government, payers, and our profession. And I am happy that SGIM is working hard to address this through our National Commission on Physician Payment, chaired by Steve Schroeder, which includes general internists who play a wide variety of professional roles in the health care system, who, I trust, will bring to their deliberation the generalist's perspective.

But that isn't the end of the story. Recently I saw Jane and realized that her affect was a bit flat, which I had noticed before. But also I had noted just the opposite at times: very animated engaged enthusiasm. I wondered if I'd missed what a generalist should not have missed—a bipolar mood disorder. Indeed, I had her evaluated, and she is now on lithium and doing better. I wondered if I might have detected this earlier—it's certainly possible. But it also points out that our patients are continuing stories, not single-organ single-occurrence chapters. I've had the breathtaking privilege of having the same patients for 27 years. The unfolding of their lives, including but not limited to their medical conditions, has

greatly enriched my life—besides maybe having done some good for them. This is also true in our other roles, such as in policy leadership roles. You heard this morning how in New Orleans, Karen DeSalvo's work evolved and changed focus over the seven years since Hurricane Katrina, and I am sure you will hear that tomorrow in the talk that JudyAnn Bigby will give from her perspective as Massachusetts secretary of Health and Human Services.

As has been very evident at this meeting, our integrative vision naturally leads to concerns about social justice. Of course, we here live in the penthouse of planet Earth; we are so very lucky, and we know that 99% of our accomplishments are due to the great luck of the place and time of our birth, which clearly were not in our control. How do we pay back to our planet that so gifted us? Each of us will need to arrive at his or her own conclusion, but one thing that characterizes the generalist perspective is that we see the links between individuals' life experiences in the context of the bigger societal picture. So we care not only for the health of our patients but for all people, and we care about education not only of medical students and young physicians but of all people. We understand that access to high-quality health care and education are massive drivers of health—and these are major targets of our vision.

I had an experience yesterday that reminded me of this need. My daughter, who teaches high school science in New Orleans for Teach for America, called me and asked me if I would speak to one of her students about control variables in experiments. Kate was trying to explain it, but it was not going as well as she wanted. She reminded me that, when she was young, she and I would go on walks, and she would learn about science by my asking

her questions that she would answer. Could I do this for this young teenager? Also, he didn't have a father who was available to him, and she thought that my chatting with him as a dad would be nice for him. I was honored. He and I talked about his desired experimental variable: comparing diesel fuel to unleaded gas to a mix of diesel and gas. He thought he could compare them using a Porsche and a Lamborghini—or maybe a Camry vs. a Land Rover. We talked about that and about an experiment Kate had done with the class in which an egg was sucked into a milk bottle. (I asked, "How would you test that with a golf ball?") I told him he had quite a knack for science. Apparently this conversation mattered for him. Who knows what long-term impact that conversation will have? Who knows what long-term impact some of our medical teaching—say about cigarettes—will have? Folks, it's all general medicine.

Lastly, I have to comment further about my daughter, and my son Paul, and my wife Mary. Apparently our kids learn from us—we certainly learn from them, and we learn from trying to support them however we can. My daughter, age 23, and my son, age 25, still call me many days for questions, like Kate's, that I just mentioned, or Paul's, about his budding business. It is these relationships that tether and inform me about the processes of life and make me a better human and physician. My wife, a fantastic hospice nurse, shares her experiences with me, from which I learn immensely—and she tolerates my nuttiness and my generalist tendency to link things to everything—except to time! Spend your attention and love in these relationships, as well as with your patients and colleagues, and you will be a better generalist.

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