Working Group on Generalism
Summary of Recommendations
for Community Feedback
Feb 3, 2021 4-5pm

Why teach Generalism?

"Canadians need a robust generalist workforce as the backbone of the health system working collaboratively with specialist colleagues in order to improve their health overall, but also to improve the effectiveness of the health delivery system."[1]

With continued advancement and the increasing complexity of medicine, the creation of subspecialties was a natural progression to address this complexity.[2] But with diminished interest in generalist career paths, there are ongoing calls to renew generalist curricula within medical schools.[1-7] A strong generalist-supported health care system leads to improved health outcomes.[8] Generalist physicians are necessary to address the patient care needs for broad sections of our populations in rural, remote and urban centres.[3] Enhancing a generalist curriculum has been directly tied with the ability to ensure the meeting of societal needs for more generalists.[9-11] For those not selecting a generalist career plan, the skills associated with the philosophy are still relevant to their future subspecialty focus and their full understanding of the generalist approach can enhance intra-professional communication, further benefiting patient care. A curriculum grounded in the principles of generalism curriculum will better prepare *all* our students for the future health care needs of our communities.

For more information regarding the work of the Working Group on Generalism, including more complete background information, and review of current curriculum please see the complete report.

Final Recommendations

The Working Group on Generalism submits the following recommendations:

Build structural/administrative supports

1. Augment the number of generalist physicians within the leadership structure. A curriculum grounded in the philosophy of generalism must be developed by generalists.
    a) Generalist physicians (including those at distributed sites) should be encouraged and supported to apply for **senior leadership roles** (for example, at the Associated Dean level).
    b) Ensure **generalism representation on all committees** – UMECC, Med 1/2, Med 3/4, Progress, CASP, PFEC, Admissions, etc.
    c) At the Med 1 and 2 levels, a **target of a minimum of 50% of the unit head positions** should be held by generalists. Component head positions should target generalists whenever the subject area is relevant to generalism.
    d) All leadership positions require adequate support. For example, the **financial support** for unit and component head positions at the DMNS campus is currently tied to academic

departments. The ability to recruit generalist faculty as leaders is limited by the relative funding structure and availability of the generalist departments. **Administrative support** should also be considered and planned for. Finally, undergraduate leadership roles often have a lesser perceived within departmental structures. This requires senior leadership and departmental chair support to adjust the **perceived and absolute value** to be equivalent to postgraduate roles.

2. Address supports required by community teachers
    a) Address **infrastructure support** needs. Community generalist teachers may need extra exam rooms, additional computers, etc. to support learners in their spaces.
    b) Ensure appropriate and consistent **administrative support** to distributed teaching communities.
    c) Create **protected time and secure funding** for community generalist teachers throughout the Maritimes. Community generalist teachers cannot complete this work "off the side of their desks" and it needs to be acknowledged as a core part of their practice as physicians.

Enhance recruitment of distributed generalist teachers

3. **Engagement and Mentorship**
    a) Encourage Academic Department Heads to **establish relationships** with existing and potential faculty members across the distributed environment.
    b) **Identify potential generalist teachers** and making them feel welcome and part of the Dalhousie community.
    c) Identify young physicians early in practice who could be potential teachers and **pair them with a more experienced teacher** who can provide support and encouragement.

4. **Education**
    a) Identify and develop **faculty development** for community generalist teachers accessing information from ongoing needs assessments to ensure they have all the skills and tools required to be successful teachers.
    b) Facilitate **layered learning** throughout distributed settings, leveraging generalist resident teaching of medical students.

Embed objectives/competencies relevant to generalism within the curriculum

5. Adopt a **generalism framework** to guide curricular development. *See Appendix 1.*
6. Utilize a competency framework that reflects generalism competencies.
    a) Reflecting on the shift in medical education towards the utilisation of competency-based educational models, we should ensure that any framework selected reflects generalism

competencies. The **AFMC Entrustable Professional Activities**[12] reflect competencies that align with the principles of generalism and the working group supports their adoption.

b) Additionally, the Undergraduate Medical Education Committee of the College of Family Physicians of Canada have recently updated **CanMEDS-Family Medicine Undergraduate (CanMEDS-FMU)**[13] which can be used to support the development of more specific/detailed competencies. This document outlines Key and Enabling generalist competencies across the CanMEDS roles from a family medicine perspective. These competencies also align with EPAs and can be utilized in full or in part to establish generalism competencies either across the undergraduate curriculum or within focused areas. For example, if gaps are identified within the curriculum, CanMEDS-FMU may be a useful starting point for the development of new objectives.

7. Add a formal introduction to the "**Philosophy of Generalism**" early within the curriculum. Students should be formally introduced to the philosophy of generalism early in training. The working group proposes this could appropriately fit within Skilled Clinician, ProComp 1 or Foundations. It would be important to emphasize its relevance to clinical practice.

8. Adopt some **symptom-based lectures** rather than systems-based lectures alone. Patients present with symptoms rather than systems. Incorporating some symptoms-based lectures will assist students in developing an approach to the undifferentiated patient and the development of the broad differential diagnosis (for example, chest pain that could be cardiovascular, respiratory, gastrointestinal, musculoskeletal, or psychological in origin).

9. Case development/Review

    a) Create a **Case Review Committee** to conduct ongoing quality improvement of cases. This committee could offer expertise and support to unit heads in case development/review, apply lens'/tools to ensure all priority areas of the curriculum refresh are consistently applied, review for evidence of hidden bias, and facilitate the creation of the 'case family' (see below). This committee should include medical education specialists and generalist faculty.

    b) Create a "**Case Family**" to increase opportunities to understand family context and continuity of care. A significant proportion of the current cases are set in a family medicine setting. The working group recommends leveraging this context by creating a 'case family', with family members presenting throughout the curriculum across different units, emphasizing continuity and the importance of understanding the familial context and its influence on health and wellbeing.

    c) **Increase the scope of the Integration Unit**. The current objectives for the Integration Unit are to develop "an approach to common problems faced by frail older patients and patients with cancer as well as have a management plan for patients approaching the end of life." These patient types are often more complex, permitting students to draw on what they have learned in their preceding units. Students, however, are missing opportunities to gain approaches to other complex conditions and multi-morbidities common within generalist practices including the interplay between cardio/cerebrovascular disease, diabetes, heart failure, mood disorders, etc. By shifting some of the content of the current integration unit to other units, the objectives of Integration Unit could reflect other complex presentations

        - These should include cases that emphasize **uncertainty** and the **undifferentiated patient**. Current case presentations within the Med 1 and 2 curriculum pre-identify

the diagnosis. The working group recommends that some cases should include early undifferentiated symptom-based presentation, the case proceeding without a definitive diagnosis or solution, normalizing the need to manage uncertainty and tolerate risk, and broadening clinical reasoning skills and the patient-centred approach. Including cases with uncertainty, ambiguity and a lack of definitive solutions will more closely reflect authentic presentations in generalist practices.

d) Alternatively, establish **"Integrative cases"**.

These could be introduced in several different ways:

I. Periodic (every 2-4 weeks) cases summarizing learning from the preceding weeks
II. Case of the Month – an undifferentiated patient presentation, permitting the development of a complex patient presentation, drawing on all preceding units.

e) **Standardized simulated family in clinical skills**.[25] Introducing a simulated family into a Skilled Clinician session would permit students to develop the skills of understanding a patient within their individual, family and social contexts. This could also be an opportunity for other priority areas to enhance skill development, for example interactions with priority communities, etc.

10. Develop mechanisms to teach and monitor the "**Hidden Curriculum**"

a) Creating positive messaging about how the philosophy of generalism, the practice of family medicine and other generalists promotes good patient care.

b) Generalist disciplines and Student Affairs should partner to create regular career development sessions.

c) Students should be introduced to the concept of the hidden curriculum and how to identify it. In clerkship, create a session to debrief and reflect upon evidence of the hidden curriculum witnessed.

11. Develop and promote **faculty development** to support teachers in their explicit teaching of the principles of generalism. This should be developed and delivered by generalists.

Enhance exposure to Generalists

12. Increase the number of generalists, especially family physicians and including those in distributed sites, teaching lectures.

a) A **minimum of 25% of lectures should be delivered by generalists within the first 3 years**. A target of 40-50% could be considered in subsequent years.

b) There may be topics in which **co-teaching** is selected to both model the collaboration between generalists and sub-specialities and to demonstrate the value both types of providers have in the provision of health care.

c) The consideration of the **asynchronous** (pre-recorded) delivery of some lectures, may facilitate the ability to recruit generalist lecturers, including those at distributed sites. Students are commonly reviewing lectures after they are delivered, and in some situations, find more value in the asynchronous review. Using more asynchronous learning

opportunities will allow students to review and consolidate material further in advance of their tutorials.

13. At a minimum, **maintain the current percentage of generalists facilitating tutorial groups** within Med 1 and 2. While the working group does think it is important to ensure broad exposure of generalists as tutors, it suggests the focus should be placed on the enhancement of exposure in lectures (recommendation 12) and in leadership positions (recommendation 1). Without these gains, any augmentation of generalist tutorials will reinforce the hidden curriculum that generalist facilitators are not seen as clinical experts.

    a) As an exception, we do recommend **increasing the number of generalist tutors within Skilled Clinician 1. Generalist physicians are best suited to teach these skills. We also recommend a small increase in the number of generalist physicians tutors in Skilled Clinician 2**. For example, at least one session per unit per group could be paired with a generalist tutor.

14. **Leverage the use of residents from generalist disciplines to teach**, creating near peer learning opportunities. Students find greater safety in being taught by residents, being closer to in training as 'near-peers'. This also provides more teaching opportunities for residents, encouraging them to include teaching as part of their professional responsibilities upon completion of their programs.

    a) A non-mandatory **mentorship program** pairing residents from generalist disciplines with interested medical students could further enhance near-peer interactions.

15. Increase the **Family Medicine Med 1 Experience (FMEX) from 6 weeks to 12 weeks**. Longitudinal experiences enable learners to understand how illness develops over time.

16. **Augment the number of rural/distributed clinical experiences**

    a) **Rural Week** - Increase the number of weeks in distributed/rural sites by lengthening rural week or adding additional rural weeks, one per year. While the creation of rural week was a critical addition to the curriculum, it's current brevity may now feed into a hidden curriculum of devaluing the importance of rural practice.

    b) **Block Based Clerkships** – While the goal of most block-based clerkships within tertiary care centres is to expose student to generalist experiences, the nature of the practices within these settings cannot match the generalist experiences that students have within distributed communities. All disciplines should explore some opportunities for rotations outside of the tertiary care centres. This needs to be balanced with the learning needs of postgraduate learners (but creates opportunities for resident teaching and layered learning). A goal of 10% of each learners' clerkship weeks at distributed site would parallel recommendations for postgraduate learners.

    c) **LICD expansion** - Increase the number of LICD spots for students. The Family Medicine Project Charter has set a goal of 30% of all Dalhousie medical students to be placed in an LICD program.

17. Increase the number of available **electives in generalist specialities**. The ability to augment electives is linked to the recruitment of distributed community teachers outlined above and the enhancement of relationships with communities to ensure students have appropriate supports and the majority of electives at distributed sites would have a generalist focus.

Issues for Further Consideration

Recognizing that it is not the intent to alter the systems-based structure of the curriculum, the working group does find that this framework may be more challenging in introducing some of the concepts of the undifferentiated patient. The working group respectfully suggests that in future curricular redesigns, a shift to a non-systems-based, non-discipline-based framework, such as **domains of care**, may better align with the generalist approach. The current LICD objectives framework could be considered as a template:

- Professional and education
- Procedural skills
- Care of the adult
- Care of the child and adolescent
- Care of the elderly
- Care of indigenous populations
- Care of diverse, marginalized and vulnerable populations
- Maternity care and care of the newborn
- Mental health and behavioural medicine
- Palliative care and end of life care

"Part of the way of dealing with this is to stop trying to think of medical education as a series of systems or disciplines; it is really thinking of it as a more holistic process and series of care pathways which will involve a range of conditions which happen to present in different ways. It is re-thinking how you package the experience."

Professor Sir John Tooke, Vice Provost (Health), University College, London[7]

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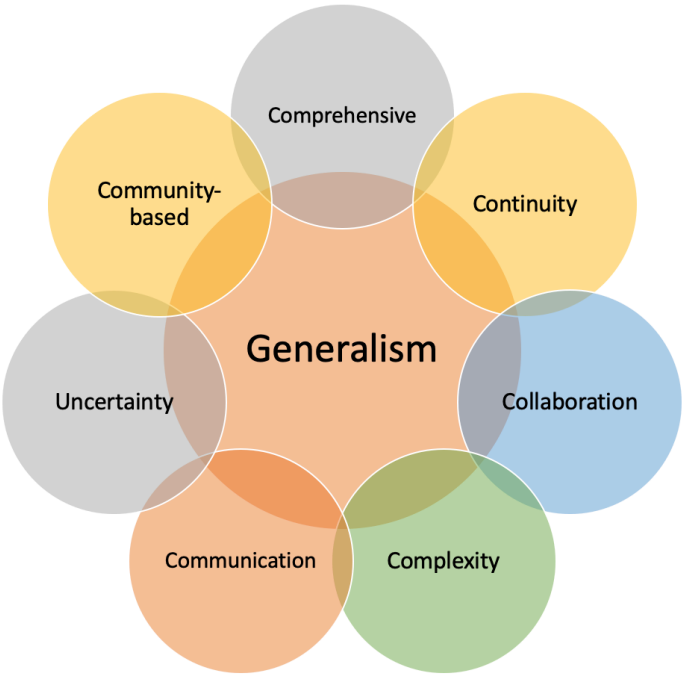
Appendix 1

Dalhousie Generalism Curriculum Framework



Comprehensive - a generalist curriculum emphasizes the value of broad, holistic, integrated, patient-centered care and maintains this continuity of responsibility for patients care over time to support and promote healthy outcomes. It demonstrates how the patient's context (family, community, social determinants of health) influences well-being.

Continuity – a generalist curriculum creates opportunities for students to follow a set of patients over time, developing meaningful patient–physician relationships and a deeper understanding of the progression of illness.

Collaboration – a generalist curriculum emphasizes the importance of inter- and intra-professional collaboration and team-based care.

Complexity – a generalist curriculum presents patient's health issues that reflect multi-morbidity, chronicity and complexity of care.

Communication – a generalist curriculum promotes the patient-centred clinical method, demonstrates effective inter- and intra-professional communication which reflects the value of the generalist role and addresses the hidden curriculum.

Uncertainty – a generalist curriculum offers students opportunities to assess patients presenting in the early, undifferentiated stages of their disease process, and permits the development of adaptive expertise in the management of uncertainty and risk.

Community-based – a generalist curriculum offers learning opportunities across a diverse set of communities, particularly outside of tertiary care centres where the majority of patients seek medical care.

Adapted from:

- Kelly M and Power L. Key Elements of a Generalist Curriculum. **Proceedings from the College of Family Physicians of Canada Undergraduate Education Retreat on Advancing Generalism, January 15, 2020.** Mississauga, ON: College of Family Physicians of Canada; 2020
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Working Group on Generalism
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