What is the future of generalism in medicine? There was a time when financial analysts predicted that 90% of U.S. health care would be organized as managed care built on a primary care, generalist model (1). In the wake of these predictions, residency positions in family medicine and other generalist disciplines grew rapidly. Hospitals and health systems bought or built practices and added so-called primary care capacity to their operations (2).

Today, however, the intellectual stratosphere and, more important, the medical marketplace resound with a very different language. Recent publications about generalism are resplendent with words like “crisis” (3), “distress” (4), “dissolution, disillusion” (5), “crossroads” (6), “prosperity and despair” (7), and “reconstruction, renewal, and renaissance” (8). The authors seem preoccupied with the notion that the generalist fields, while offering great value, need to change or may not survive (3–6, 9).

The picture is also grim for many generalist physicians and patients in the world of medical practice. The cost of care and the number of persons without health insurance continue to rise, creating obstacles to patients' receipt of recommended care. Now, we also know that more care is not necessarily better—in fact, when care is fragmented and probably redundant, more care may be worse (10, 11). In the meantime, generalist primary care physicians, while remaining committed to providing high-quality patient care, are struggling. Individual practitioners struggle with low reimbursement for their services, administrative burdens always seem to increase, and inflexible appointment schedules and brief visits satisfy neither patient nor provider (12, 13). Following a decade of increasing interest in generalist residency training, applications to residency programs designed specifically to produce generalists have fallen off dramatically (14).

An ever-increasing evidence base indicates that care organized around generalist primary care is the best (15). Despite challenging market forces that make it difficult for generalist physicians to practice the best possible care (2), large and small groups of talented providers, often organized into effective teams, continue to deliver comprehensive, generalist care. Thoughtful individuals devote considerable intellectual energy reviewing published scientific papers and commentary to find examples of generalist care that meets patient expectations and yields good outcomes. Others work on demonstrations and proposing solutions (4, 8, 9, 16, 17) that suggest answers to the question “Whither generalism in medicine, whither primary care?” The answers could lead to ways to improve and deliver more nearly ideal care to all Americans.

This supplement contains examples of intellectual energy devoted to proposing solutions. In the fall of 2003, the Robert Wood Johnson Generalist Physician Faculty Scholars program (18, 19), a program designed to promote academic development of talented junior faculty in generalist disciplines, asked current and past scholars and its National Advisory Committee to develop a series of white papers addressing different aspects of the future of generalism and ways to improve and deliver ideal primary care to all Americans. Ten groups of scholars, with each group including at least 1 family physician, general internist, general pediatrician, and senior advisory board member, developed proposals that were presented and critiqued at an annual meeting. Ultimately, 9 of these presentations became papers. The topics that emerged were not too surprising, ranging from generalist research to student interest in generalism to a variety of approaches to develop better systems, improve coordination, move to more “ideal” primary care, and develop more integrated “whole-patient” care.

This supplement contains the 4 papers that we, the supplement editors, believed best addressed the question “What is the future of generalism in medicine?” These papers address some of the critical elements that are widely recognized as necessary to produce more ideal care: integration (20), coordination (21), and the need for effective communication to achieve whole-person care (22). The fourth paper focuses on the challenge of creating a system of health care practice and medical education that works to make primary care specialties more attractive to students “short of a major overhaul of economic incentives in favor of generalist careers” (23).

A system based in primary, generalist physician practice is arguably the ideal system (15)—whether it is based in a large health care system or in smaller offices and networks. Indeed, primary medical care is essential, and patients want it (24). The papers in this supplement are noteworthy because they offer perspectives on the future of generalism in medicine from persons representing all 3 major primary care disciplines. Their perspective is idealistic and aspirational. In general, the articles contain suggestions that are reasonable ways to work within the existing system of care. They do not suggest changes that are simply not feasible given today’s political climate. The papers are particularly timely today, and they provide a welcome response to the need for innovative thinking and constructive policy formulation to help ensure high-quality care for the public by preserving and enhancing generalist practice.
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