According to health policy leaders, overspecialization of the health care workforce is at least partly responsible for the current health care crisis. As a result, proposals for solutions to the crisis are almost uniformly grounded in the resurrection of generalism in medicine. However, such proposals project a newness of generalism that ignores the history and universality of the generalism—specialism debate in medicine. As the following discussion illustrates, the debate is not unique to this time or place in history. Nor is the solution as simple as increasing the relative proportions of physicians who provide primary care, as many debaters have led us to believe. How arguments supporting the current revival of generalism in medicine differ from those in the longstanding debate has implications for whether changes in health manpower policy will have sustainable effects.

HISTORY OF THE DEBATE

The 1966 publication of the Millis commission report on medical education sparked the current revival of generalism in medicine, with claims that excessive specialization of the workforce was not in the best interest of physicians or patients. However, alarm over excessive specialization of the physician workforce is not by any means new. Discussions of the correct balance of generalists and specialists in medicine occurred in earlier civilizations. The Greek historian Herodotus offered an example through a telling perspective on the state of health care manpower in ancient Egypt:

Medicine is practised among them on a plan of separation, each physician treats a single disorder and no more: thus, the country swarms with medical practitioners, some undertaking to cure disease of the eye, others of the hand, others again of the teeth, others of the intestines, some those which are not local.

In contrast to medical practice in Egypt, the Hippocratic conception of physician work from ancient Greece was reflected in the practice of generalist medicine. The patient, not the disease, was to be treated, and to treat the patient well, the physician was to examine him or her as a whole, not merely the organ or body part in which the disorder was located. The Hippocratic formula for getting a case history called for an inquiry into the background of the patient's life, from antecedents, occupation, temperament, ...

to the patient habits, his regimen, pursuits: his conversation, manners, taciturnity, thoughts, sleep, or absence of sleep and sometimes his dreams, what they are and when they occur;—to his picking and his scratching,—to his tears, ... from these as well as from his symptoms 'we must form a judgment.'

Galen, who served as court physician in the Roman empire, further promoted Hippocrates' ideas on the strength of generalism in approaching the patient:

treatment of the disordered part, as if it could be isolated from the living unity of the whole man is one of the deplorable consequences of atomism or mechanism in medical theory.

While evidence of a debate between generalists and specialists in medicine occurred even in earlier Western civilizations, continuing division of labor throughout the course of history made the generalist perspective difficult to maintain. The writings of Montaigne from eighteenth-century France support specialization of the physician workforce with analogies from other professions. Montaigne proposed that the generalist approach to patient care may even be harmful:

As we have doublet and breeches-makers, distinct trades, to clothe us, and are so much the better fitted, seeing that each of them meddles only with his own business, and has less to trouble his head with than the tailor who undertakes them all; as in matter of diet, great persons for their better convenience and to the end that they may be better served, have cooks for the different offices, this for soups and potages, that for roasting, instead of which if one cook should undertake the whole service, he could not so well perform it, so also as to the cure of our maladies. The Egyptians had reason to reject this general trade of physician, and to divide the profession; to each disease, to each part of the body, its particular workman, for that part was more properly and
with less confusion cared for, seeing the person looked to nothing else. Ours are not aware that he who provides for all, provides for nothing; and that the entire government of this microcosm is more than they are able to understand. They counterpoise their own divinations with the present evils; and because they will not cure the brain to the prejudice of the stomach, they injure both with their dissentient and tumultuary drugs.  

Dostoyevsky’s characterization of the Russian physician workforce in *The Brothers Karamazov* offers yet a different perspective on the debate. He criticizes both generalists and specialists as responsible for overspecialization of patient care. His reminder that with specialization comes more aggressive marketing of health care services and a rise of alternative medicine is particularly relevant to our contemporary health care environment.

‘And then what a way they have of sending people to specialists! ‘We only diagnose but go to such-and-such a specialist, he’ll cure you.’ The old doctor who used to cure all sorts of disease has completely disappeared. I assure you now there are only specialists and they all advertise in the newspapers. If anything is wrong with your nose, they send you to Paris: there, they say is a European specialist who cures noses. If you go to Paris, he’ll look at your nose: I can only cure your right nostril, he’ll tell you, for I don’t cure the left nostril, that’s not my specialty, but go to Vienna: there there’s a specialist who will cure the left nostril. ‘What are you to do? I fell back on popular remedies . . . ’

While these historical examples offer ample evidence that some of the ideas in the current debate are not new, it is difficult to imagine a historical precedent for the rapid evolution of American medicine from a generalist to a specialist culture during the last several decades. While early recognition of the consequences of such a rapid change in health care manpower raises the hope that the trend is reversible, another lesson for the debate from the history of undergraduate liberal arts education suggests that the trend may be relentless.

The current debate over generalist values in medical education is remarkably similar to the debate over the value of a liberal arts education that raged in U.S. universities in the 1940s. The concept of liberal arts education evolved from the Aristotelian ideal of the educated person, who was “critical” in all or almost all branches of knowledge. Great thinkers of the Renaissance adopted this ideal, which survived for centuries as the aim of a liberal education, although this ideal was never actually accomplished. According to Van Doren, because such great Renaissance thinkers as Leonardo, Pico, and Bacon could not succeed in their presumed dream of knowing all there was to know about everything, then certainly lesser men should not presume to try. The alternative of achieving expertise in one field while others attained expertise in theirs became self-evident.

This new specialist paradigm led to a more comfortable academic community where an authority need compete only with experts in his or her field. As Van Doren explains, after World War II the liberal curriculum was discarded almost everywhere.

The convenient device for accomplishing the change consisted of a divided and subdivided university, with separate departments like armed feudalities, facing one another across a gulf of mutual ignorance . . . . The original belief that an educated person should be ‘critical’ in more fields than his own no longer existed. The university’s separate worlds ceased to talk to one another. The “uni” in the university also became meaningless as the institution, possessing more and more manpower as government funds were pumped into it for research, turned into a loose confederation of disconnected ministates, instead of an organization devoted to the joint search for knowledge and truth.

While these various perspectives clarify that the debate over the value of generalism and specialization in medicine is not new and will continue long after the current health care crisis, how academic institutions will evolve in the short term is less clear. The threat of fragmentation in departments of internal medicine reminds us of Van Doren’s lesson and argues that calls for a ‘renaissance in generalism’ should be regarded with skepticism.

**UNIVERSALITY OF THE DEBATE**

While historical lessons from great literature and from the course of liberal arts education in nonmedical institutions suggest that specialization in medicine may be relentless, one need not turn to the past for examples of the phenomenon. It is apparent in all contemporary spheres of health care, at home and abroad, among generalists as well as among subspecialists.

The imbalance of generalists and subspecialists is often considered a phenomenon that is unique to our entrepreneurial health care system in the United States. Critics of U.S. overspecialization frequently use comparisons with other developed countries as justification for more control over the specialty distribution of physicians. However, closer supervision of specialty distribution in those countries has not completely eliminated problems with predicting and maintaining the correct balance of physicians. In France, where there is tight control over specialty distribution, differences in the amounts of respect and financial remuneration accorded generalists and specialists are still problematic. In Britain, acknowledgment that specialists who maintain narrow interests are less threatening to other narrowly focused specialists illustrates that accommodating specialists into a community may be easier than accommodating generalists, regardless of the health care system.

Comparisons in the cost and effectiveness of care between generalists and specialists are increasingly prevalent, not only in the United States but also in other health care systems. For example, in The Netherlands, where the primary care workforce is reim-