

Generalist Physician Initiative

An RWJF national program

SUMMARY

The *Generalist Physician Initiative* (October 1991 to June 2001) challenged schools of medicine to increase the supply of generalist physicians—specifically general internists, general pediatricians and family practitioners—that they were training.

The program was designed to address a steady decline during the 1980s of medical school graduates entering generalist practice (the percentage fell from 32 percent in 1980 to 14.5 percent in 1992). Thirteen schools of medicine participated in the full program.

The University of Missouri-Columbia (UMC) School of Medicine served as the national program office. Jack Colwill, M.D., professor and chair of the UMC Department of Family and Community Medicine during the program (and then emeritus professor) served as program director.

Key Results

- The *Generalist Physician Initiative* helped the medical schools create a variety of external partnerships that added value to their programs, including partnerships with HMOs and state [Area Health Education Centers \(AHECs\)](#).
- The *Generalist Physician Initiative* helped catalyze educational reform in medical schools that had had little educational change in two to three decades. Those changes included:
 - Elevating generalist faculty into major leadership roles.
 - Instituting new administrative structures to coordinate generalist activities.
 - Increasing the number of generalist faculty.

Among the changes the schools carried out to promote generalism were:

- Changing the admissions process to target more students with generalist potential, along with increasing the number of generalists on admissions committees.
- Developing high school and college undergraduate recruitment programs.

- Redesigning undergraduate medical education to include the primary-care community experiences, generalist-oriented clinical medicine courses and generalist [clerkships](#).

Key Assessment Findings

As part of the evaluation of the *Generalist Physician Initiative*, the national program office compared the 15 *Generalist Physician Initiative* schools with 45 schools that had applied to, but had not been accepted into, the *Generalist Physician Initiative*. The assessment showed that:

- The *Generalist Physician Initiative* schools had succeeded in elevating generalist faculty into leadership roles in the medical schools, in reorienting their undergraduate medical school curricula toward primary care education, in activating networks of community-based educators and in improving the overall quality of medical school education.
- The schools had less success in influencing the design of residency programs, due in part to their patient-service demands and the school's lack of immediate direction of the residency programs.
- The *Generalist Physician Initiative*—as measured by the Association of American Medical College's Graduation Questionnaire—increased their output of generalists by approximately 39 percent during the course of the program—from a baseline of 26.4 percent of graduates in 1988–1991 to 36.7 percent of graduates in 1999. By 2000, there had been a decline in generalist graduates to 32.8 percent of all graduates, so the final increase was 24 percent.
- However, the data failed to demonstrate any difference between *Generalist Physician Initiative* schools and the schools that applied for but did not get program funding.

The national program office director and deputy directors speculate that the marketplace demand for generalists during the 1990s influenced all medical schools and may have blunted the particular effects of the *Generalist Physician Initiative*.

According to Gerald T. Perkoff, M.D., "Market forces have more to do with career choice than do the needs of the system, and certainly more than philosophies." The original Robert Wood Johnson Foundation (RWJF) Program Officer Michael Beachler concurred: "Health care system forces, unleashed in the early 90s, were more powerful than any grant program."

Participating Schools

The *Generalist Physician Initiative* included a one-and-a-half year developmental stage and two three-year implementation stages. The following 13 schools of medicine completed the entire project (see Program Results reports linked to the school names):

- Boston University School of Medicine, Boston.
- Case Western Reserve University School of Medicine, Cleveland.
- Dartmouth Medical School, Hanover, N.H.
- East Carolina University School of Medicine, Greenville, N.C.
- Georgia Medical College, Augusta, Ga.
- Allegheny University of the Health Sciences (which became MCP Hahnemann), Philadelphia.
- University of Massachusetts Medical Center, Worcester, Mass.
- University of New Mexico School of Medicine, Albuquerque, N.M.
- New York Medical College, Valhalla, N.Y.
- Pennsylvania State University College of Medicine, Hershey, Pa.
- State University of New York at Buffalo Medical School, Buffalo, N.Y.
- University of Texas Medical Branch-Galveston, Galveston, Texas.
- The [three Virginia medical schools](#) that applied as a consortium—University of Virginia School of Medicine, Charlottesville, Va. Virginia Commonwealth University Medical College, Richmond, Va. and Eastern Virginia School of Medicine, Norfolk, Va.

Funding

The RWJF Board of Trustees authorized the program for up to \$32.7 million.

THE PROBLEM

A shortage of generalist physicians has been a national concern since the 1950s. In response to these concerns, family practice developed as a new specialty in the 1960s. In the 1970s, family practice residency programs expanded rapidly, and a number of programs in internal medicine and pediatrics developed primary care tracks.

RWJF, which was established as a national philanthropy in 1972, supported these efforts in its early grantmaking through its *Primary Care Residency Program* (1973–1981) and the *Nurse Faculty Fellowship Program* (1977–1982).

RWJF also authorized the *Teaching Hospital General Medicine Group Practice Program* (1979–1985) to help reorganize academic general internal medicine into a model that reflected the primary care principles of continuity, coordination and access.

However, despite federal support for primary care training programs that worked to institutionalize many of RWJF's investments, primary care did not become the national norm in health care, as hoped.

Underlying economic trends and other forces continued to favor specialty training, research and care, and U.S. medical school training reflected this bias. By the 1980s, medical school graduates' interest in the generalist specialties was waning.

A 1989 survey of the nation's governors indicated that 48 states were experiencing severe shortages of primary care physicians, particularly in rural areas. By 1992, only 14.5 percent of medical school graduates indicated on the Graduate Questionnaire of the Association of American Medical Colleges (AAMC) that they planned generalist careers.

This finding contrasted substantially with the guideline set by the Council of Graduate Medical Education (COGME) in a 1992 report that recommended that U.S. medical schools aim at graduating 50 percent of its students into generalist practice to address workforce shortages.

A number of complex factors—both internal and external to the medical school—seemed to be causing the supply problem.

External factors included:

- Lifestyle preferences of students.
- The structure of the financing of undergraduate and graduate medical education (primarily the high level of educational debt incurred by many medical students, which often necessitates more lucrative specialist career choices).
- A physician reimbursement system that favored specialists.
- Societal norms that career choices are made by the individual rather than government regulation.
- Cultural norms that appeared to favor specialization over generalism.

Internal factors—over which medical schools could have direct influence—included:

- Medical school admission policies.
- The lower status of generalists among other faculty members.
- Clinical training of medical students and residents that emphasized acute care in the hospital over the more generalist-oriented ambulatory care setting.

A small number of medical schools undertook specific actions that proved effective in increasing the production of generalists. These steps included:

- Changing medical school admission policies to increase opportunities for qualified applicants from underserved areas.
- Increasing the exposure of medical students to training in ambulatory settings such as community clinics and generalist physician role models.
- Modifying the content and structure of residency programs.

In addition, HMOs, private insurers and state governments began showing greater interest in creating a more favorable environment for the production of generalist physicians. HMOs began working with academic medical centers to provide medical students with ambulatory training as well as information about generalist career opportunities.

Health system payers (Medicare, Medicaid, health insurance companies) concerned about access to, and the high cost of, health care, also encouraged interest in reforming the financing systems that had historically favored specialists over generalists.

CONTEXT

In keeping with its earlier efforts in primary care, RWJF created a multifaceted grantmaking strategy in the 1990s to reduce distribution and supply barriers to basic health services.

In addition to increasing the number of generalist physicians, RWJF sought to develop strategies to increase the capacity of existing providers to furnish basic health services and to improve the distribution of primary care providers in high-need areas. The initiatives that complemented the *Generalist Physician Initiative* included:

- *Preparing Physicians for the Future: Program in Medical Education*, launched in 1990, to support changes in the structure and content of medical education. (See [Program Results](#).)
- *Generalist Physician Faculty Scholars Program*, launched in 1993, to strengthen generalist faculty by improving their research skills and capacity. (See [Program Results](#).)
- *Practice Sights: State Primary Care Development Strategies*, launched in 1991, to strengthen state efforts to recruit and retain primary care providers through such strategies as the creation of recruitment centers, *locum tenens* programs and loan repayment programs. (See [Program Results](#).)
- *Generalist Provider Research Initiative* launched in 1993, to support policy and analytic studies in generalism, along with serving as a way to provide information to shape the policy levers that affect specialty choice. (See [Program Results](#).)

PROGRAM DESIGN

In July 1991, the RWJF Board of Trustees authorized the launch of the *Generalist Physician Initiative* to challenge schools of medicine to increase the supply of generalist physicians—specifically, general internists, general pediatricians and family practitioners.

Authorized for up to \$32.7 million over a seven-year period, the *Generalist Physician Initiative* included a one-and-a-half year developmental stage and two three-year implementation stages. Eighteen projects (developed by 20 schools of medicine, with three working in a consortium) received developmental grants.

To proceed from one stage to the next, the participating medical schools had to achieve certain benchmarks identified by the national program office and the national advisory committee.

Fourteen projects met the benchmarks and proceeded into the first implementation stage; 13 of them proceeded through to the second implementation stage.

The national program office encouraged each school of medicine to set a numeric goal for increasing the numbers of its graduates choosing generalist practices, using as a guideline the COGME's 1992 report that recommended that U.S. medical schools aim at graduating 50 percent of its students into generalist practice to address workforce shortages.

To modify the medical school culture to support generalism, the *Generalist Physician Initiative* encouraged the schools to develop institution-wide strategies that included interventions in each of four areas:

- Medical school admissions
- Undergraduate medical education
- Residency training
- Practice entry and support.

Recognizing that most medical schools would need to expand their educational programs beyond the walls of their institution, the *Generalist Physician Initiative* also encouraged participating schools to develop external partnerships. These partners could be:

- Practicing physicians
- Hospitals
- Community health centers
- State government's third-party payers

- Managed care organizations
- Regional foundations
- [Area Health Education Centers \(AHECs\)](#).

To encourage high-level leadership and institutional buy-in, each *Generalist Physician Initiative* grant was made to the dean of the medical school.

Most of the participating schools established an organizational structure to implement the *Generalist Physician Initiative* and to promote generalist efforts. These administrative units took a number of forms, including:

- Appointing associate deans for primary care.
- Placing offices of generalist education within the dean's office.
- Establishing freestanding centers for primary care.

THE PROGRAM

National Program Office

RWJF established a national program office at the University of Missouri-Columbia (UMC) in the fall of 1992. Jack M. Colwill, M.D., professor and chair of the Department of Family and Community Medicine during the program (and then professor emeritus) was appointed program director. Colwill is recognized as one of the first educators to emphasize interdisciplinary training for students.

Gerald T. Perkoff, M.D., Curators Professor Emeritus of Family and Community Medicine at UMC and Robert L. Blake, Jr., M.D., the William C. Allen Professor of Family and Community Medicine, UMC, were the program's deputy directors.

Carrie Paden, M.P.A., joined the program as Administrator. The University of Missouri and the Department of Family and Community Medicine provided space and accounting support for the *Generalist Physician Initiative*.

In collaboration with RWJF staff and the national advisory committee (see below), national program office staff helped determine the project selection criteria and process, create progress benchmarks and review proposals.

Colwill, Perkoff and Blake were each assigned schools for which they provided individual consultation and technical assistance, including yearly site visits, throughout the projects.

During the implementation period, the national program office sponsored six meetings for *Generalist Physician Initiative* participants to create a forum for representatives from the three primary care disciplines to discuss educational programs.

The national program office also earmarked funds for dissemination projects, primarily the preparation of a supplemental issue of *Academic Medicine* and a series of mini-grants to support specific *Generalist Physician Initiative* program goals aimed at promoting faculty development efforts and dissemination between schools. (See [Overall Program Results](#).)

The national program office created the first RWJF national program office website, designed and used by *Generalist Physician Initiative* schools for joint communication, along with annual directories with contact information for participating faculty.

National Advisory Committee

A national advisory committee, made up of 16 recognized leaders in medical education, assisted RWJF and the national program office in developing parameters for the site selection process, in reviewing proposals and in ongoing technical support for grantees during the program. (See [Appendix 1](#) for a list of members.)

Chaired by Samuel Thier, M.D., then president of Brandeis University, the national advisory committee recommended *Generalist Physician Initiative* grant recipients to RWJF at each stage of the program.

Thier, an expert in the areas of national health policy, medical education and biomedical research, has served as president of the Massachusetts General Hospital and the Institute of Medicine. As of the date of this report, Thier was president and CEO of Partners HealthCare System.

Project Selection

Selection criteria favored those schools that:

- Had key leaders in place.
- Were prepared to collaborate with external partners.
- Had matching support from the medical school or from external partners.
- Had developed a technically and politically feasible plan.
- Were able to evaluate the effectiveness of their strategies.
- Were prepared to sustain their initiatives after RWJF funding ended.

Some 86 schools applied for *Generalist Physician Initiative* funding. The national advisory committee recommended to RWJF that 18 projects receive planning grants.

The Planning Phase and Implementation Phase

Eighteen projects (including 20 schools, three that applied collaboratively) received developmental grants of approximately one and a half years in length apiece. Sites then applied for implementation grants and after proposal review and site visits by national advisory committee members and national program office staff, 14 projects (at 16 schools) received implementation grants of approximately three years in length. Four schools were not funded for implementation.

At the conclusion of the first three years of implementation, the national advisory committee recommended that the University of Nevada School of Medicine be dropped from the program. Though the school had piloted a number of curricular changes in undergraduate medical education, resistance to a key program—a third year family medicine [clerkship](#)—had slowed implementation significantly.

Consequently, only 13 projects (at 15 medical schools) completed the six-year implementation program. See the 13 Program Results linked to the schools' names. The schools with a * completed the entire program:

- [Allegheny University of the Health Sciences \(which became MCP Hahnemann\), Philadelphia.](#)*
- [Boston University School of Medicine, Boston.](#)*
- [Case Western Reserve University School of Medicine, Cleveland.](#)*
- [Dartmouth Medical School, Hanover, N.H.](#)*
- [East Carolina University School of Medicine, Greenville, N.C.](#)*
- [Georgia Medical College, Augusta, Ga.](#)*
- [Louisville University School of Medicine, Louisville, Ky.](#)
- [Morehouse School of Medicine, Atlanta.](#)
- [New England University, College of Osteopathic Medicine, Biddeford, Maine.](#)
- [New York Medical College, Valhalla, N.Y.](#)*
- [Pennsylvania State University College of Medicine, Hershey, Pa.](#)*
- [State University of New York at Buffalo Medical School, Buffalo, N.Y.](#)*
- [Tufts University School of Medicine, Boston.](#)

- [University of Massachusetts Medical Center, Worcester, Mass.*](#)
- University of Nevada School of Medicine, Reno, Nev.
- [University of New Mexico School of Medicine, Albuquerque, N.M.*](#)
- [University of Texas Medical Branch-Galveston, Galveston, Texas.*](#)
- The [three Virginia medical schools](#) that applied as a consortium—University of Virginia School of Medicine, Charlottesville, Va. Virginia Commonwealth University Medical College, Richmond, Va. and Eastern Virginia School of Medicine, Norfolk, Va.*

Communications

The primary communication products of the *Generalist Physician Initiative* were the numerous published articles and presentations by the faculty of participating schools about their programs. (See each site's Bibliography.)

In addition, national program office staff published a report, a book chapter and five articles about aspects of the program, including a descriptive article in the September 1997 issue of *Academic Medicine* written with Michael Beachler, the first RWJF program officer for the *Generalist Physician Initiative*.

The national program office also sponsored a supplement to *Academic Medicine*, published in January of 1999, which included articles from many of the *Generalist Physician Initiative* schools about their projects. national program office staff also made 49 presentations about the *Generalist Physician Initiative* at national meetings.

To facilitate communication among the participating schools, the national program office sponsored annual meetings during the implementation stages and launched the first RWJF national program office website for the project, which included listservs for a number of *Generalist Physician Initiative* working groups. (The website was closed in December 2000.)

The project also used a separate grant (ID# 032842) to fund activities aimed at promoting communication between the *Generalist Physician Initiative* schools, including travel funds for 21 *Generalist Physician Initiative* faculty to visit other *Generalist Physician Initiative* schools and a series of mini-grants beginning in 1997. (See the [Bibliography](#).)

OVERALL PROGRAM RESULTS

Assessment

In lieu of a formal evaluation, the national program office compared the 15 *Generalist Physician Initiative* schools with 45 schools that had applied to, but had not been accepted into, the *Generalist Physician Initiative*.

To complete the analysis, the national program office matched each non-*Generalist Physician Initiative* school with schools participating in the program based upon the following characteristics:

- Percentage of graduates entering generalist specialties between 1989 and 1991.
- Class size.
- Federal research dollars.
- Public/private ownership.

Assessment Findings

- The *Generalist Physician Initiative* schools had succeeded in elevating generalist faculty into leadership roles in the medical schools, in reorienting their undergraduate medical school curricula toward primary care education, in activating networks of community-based educators and in improving the overall quality of medical school education.
- The schools had less success in influencing the design of residency programs, due in part to their patient-service demands and the school's lack of immediate direction of the residency programs.
- The *Generalist Physician Initiative*—as measured by the Association of American Medical College's Graduation Questionnaire—increased their output of generalists by approximately 39 percent during the course of the program—from a baseline of 26.4 percent of graduates in 1988–1991 to 36.7 percent of graduates in 1999. By 2000, there had been a decline in generalist graduates to 32.8 percent of all graduates, so the final increase was 24 percent.

Some of the schools achieved larger increases: Eastern Virginia Medical School increased from 32.9 percent during the 1989–91 period to 54.6 percent during 1999 and 2000, a 66 percent increase.

- However, the data failed to demonstrate any significant difference between *Generalist Physician Initiative* schools and the schools that applied for but did not get program funding.

Outcome Generalist Medical School Graduates			
	1988-91	1999	2000
<i>Generalist Physician Initiative</i> Schools	26.4%	36.7%	32.8%
Non-Program Schools	26.7%	36.7%	32.6%

The national program office director and deputy directors speculate that the marketplace demand for generalists during the 1990s influenced all medical schools and may have blunted the particular effects of the *Generalist Physician Initiative*.

Interventions made by *Generalist Physician Initiative* schools were paralleled by interventions in other medical schools. Schools used [Title VII funding](#) and other grant programs to assist in increasing their output of generalists.

Eleven states mandated that their medical schools increase generalist output. The states of New York and Pennsylvania implemented grant programs modeled after the *Generalist Physician Initiative* for all medical schools in the state. In addition, several of the schools that had been turned down for *Generalist Physician Initiative* funding went on to implement their proposed programs in generalist education.

According to Gerald T. Perkoff, M.D., "Market forces have more to do with career choice than do the needs of the system, and certainly more than philosophies." The original RWJF Program Officer Michael Beachler concurred: "Health care system forces, unleashed in the early 90s, were more powerful than any grant program."

Overall Results

- **The *Generalist Physician Initiative* helped the medical schools create a variety of external partnerships that added value to their programs.** For example:
 - The University of Massachusetts Medical Center's partnership with Fallon Clinic, a large HMO in New England, provided students with educational opportunities in managed care settings and helped focus primary care and managed care research projects.
 - Case Western Reserve and the Henry Ford Health System in Detroit jointly developed the school's new Primary Care Track, which included clinical education rotations at Henry Ford.
 - The three Virginia schools of medicine worked in collaboration with the Virginia Legislature to establish project goals, implement a statewide workforce monitoring system and begin a recruitment effort aimed at attracting medical school applicants oriented toward generalist careers.
 - Penn State and East Carolina worked in close collaboration with their state's [Area Health Education Centers \(AHECs\)](#).

- **The *Generalist Physician Initiative* helped to catalyze educational reform in medical schools that had had little educational change in two to three decades, according to the program director.** *Generalist Physician Initiative* schools made significant modifications in medical school educational structure, including:
 - **Developed recruitment programs for prospective generalists focused both at the college and high school levels (approximately half of the schools did this).**
 - Some schools actively marketed themselves as "primary care schools" to applicants.
 - Others (such as East Carolina, MCP Hahnemann, Pennsylvania State, the Virginia Consortium, Georgia Medical College, the State University of New York at Buffalo, and the University of Texas at Galveston) developed programs of recruitment at rural colleges and at rural high schools.
- **Changed the admissions process to target more students with generalist potential, along with increasing the number of generalists on admissions committees.**
 - Most of the schools (e.g., New York Medical College and Pennsylvania State University) indicated they were giving preference to applicants whom they believed were more likely to become generalists.
 - Two schools (Case Western Reserve University and MCP Hahnemann) conducted studies of their admissions processes to determine predictors of generalist specialty choice.
- **Redesigned the four years of undergraduate medical education to include the primary care community experiences, generalist-oriented clinical medicine courses and generalist clerkships.**
 - All schools developed early primary care experiences for first- and second-year students—frequently linked to expanded introduction to clinical medicine courses.
 - Each school recruited community-based physicians, many of whom assumed teaching responsibilities. In the clinical years, each participating school expanded primary care clerkship in the third year and developed primary care electives in the fourth year.
 - Many schools developed a two-month-long family practice clerkship in the third year. Alternatively, Dartmouth developed a primary care clerkship cooperatively taught by the three disciplines. In most settings, the family practice clerkship was based with community physicians throughout the region.
 - Clerkships in internal medicine and pediatrics typically moved one month of their three-month clerkships to the ambulatory setting.

- Some schools (MCP Hahnemann University, Pennsylvania State University, Dartmouth and New York Medical College) significantly restructured their overall clinical curriculum to focus upon what the generalist needs to know.
- **Made modest curricular changes in residency education.** Most participating schools committed themselves to:
 - Increase the size of primary care residency programs.
 - Reduce the number of subspecialty fellowships.
 - Create more positions in primary care.
 - Boston University established an academic Department of Family Practice and established a family practice residency.
 - All schools increased the scope of ambulatory experience for residents. Two schools (the University of Massachusetts and Pennsylvania State University) provided continuity rotations in which residents worked in community clinic settings with local internists and pediatricians as preceptors.
 - In addition, a number of the schools (Pennsylvania State University, Virginia Commonwealth University and the University of Virginia) developed interdisciplinary conferences for generalist residents to address topics of common interest to each of the three generalist disciplines.
 - However, only two schools (Case Western Reserve University and Dartmouth) developed primary care tracks to provide a more focused training program for generalist interns.
- **Developed a variety of means to provide community support for physicians' entry into generalist practice.** Among them, participating school instituted:
 - **Tuition and loan forgiveness assistance** (Seven schools: the University of Massachusetts, Georgia Medical College, Boston University, East Carolina University and the three schools of the Virginia Consortium).
 - **Assistance in practice placement** (Several schools (including MCP Hahnemann, Pennsylvania State University and the three schools of the Virginia consortium).
 - ***Locum tenens* experiences for residents** (Four schools: East Carolina University, the University of New Mexico, Dartmouth and the University of Texas).
 - **Community-based residencies in family practice** (Two schools: (Pennsylvania State University and New York Medical College).
 - **Increased reimbursement for community-based preceptors from an HMO** (New York Medical College).

- **Through its Innovations in Residency Education Awards mini-grant program, the national program office helped support innovative projects in graduate medical education at several *Generalist Physician Initiative* schools.**
 - For example, in 1998, the national program office awarded \$25,000 two-year mini-grants to East Carolina University School of Medicine and Eastern Virginia Medical School.
 - East Carolina used the grant to develop and validate a clinical practice exam that would assess the primary care resident's skill levels.
 - Eastern Virginia used the grant to facilitate the development and implementation of a collaborative approach to teaching evidence-based medicine to its Family Medicine, Internal Medicine, Pediatrics and combined Family Medicine/Internal Medicine residents.
- The total amount awarded through the mini-grant program came to almost \$100,000.
- **Virtually all educational programs established under the *Generalist Physician Initiative* were still operational two years following the initiative.**

LESSONS LEARNED

1. **Making the grant awards to medical schools rather than to departments helped to promote interdisciplinary collaboration, but the tendency of the individual disciplines to operate independently, especially in residency education, did not disappear.**

At many of the *Generalist Physician Initiative* schools, the three generalist disciplines found themselves working closely together in pre-doctoral education—especially at the first- and second-year level. However, grants to the deans' office had relatively little impact on residency education.

These programs still are functionally controlled by their respective departments and are regulated by the respective residency review committees. The distance of some residency programs from the medical school also made coordination difficult.
(National Program Director)

2. **A matching funds requirement is important for institutionalization of educational programs.** By making a financial commitment, the medical schools were better able to "own" the cultural changes engendered by the project. (National Program Director)
3. **Annual meetings were an invaluable resource for institutions participating in the *Generalist Physician Initiative*.** No other forum for networking among the generalist disciplines exists. Many of the *Generalist Physician Initiative* project directors were

disappointed that these meetings could not continue beyond the end of the program.
(National Program Director)

4. **A website with listservs greatly enhances communication among participating institutions in a national program.** Today, the importance of a website goes without saying, however, listservs are important features that are not always included. In the early 90s, however, the *Generalist Physician Initiative* broke new ground with the first RWJF national program office website, and one that included listservs. (National Program Director)
5. **Changes in the external health care environment create challenges—and unexpected opportunities.** The 1990s saw the rise of managed care, the demise of the Clinton health care plan and financial instability and change in ownership of many health care organizations. The *Generalist Physician Initiative* schools were not immune and were experiencing bankruptcies, mergers and significant leadership changes both within the medical school and within its partner organizations. However, out of the chaos came opportunity.

For example, when MCP and Hahnemann combined into one medical school, its new leaders completely reoriented the medical school curriculum around generalism, an opportunity that might not have happened but for the merger. (National Program Director)
6. **While simple, numeric outcome measures give focus to complex programs, they will not reflect the nuances of systems-change efforts.** By setting tangible goals, the medical schools in the *Generalist Physician Initiative* could easily track their improvement in producing generalists, and the numeric goals helped motivate the schools to continually improve their programs. On the other hand, changes made in the culture of medical education could not be easily captured in numbers. (RWJF Program Officer/Hassmiller, Deputy Program Director/Perkoff)
7. **If you establish numeric goals, be clear about what you are measuring.** The schools in the *Generalist Physician Initiative* differed—and there was no clear agreement among the national program office staff—on whom to count as a generalist graduate. Ultimately, it was left to the schools to define their own parameters. (Deputy Program Director/Perkoff)

AFTERWARD

At the schools that completed the implementation phase, most of the educational programs begun under the *Generalist Physician Initiative* have been institutionalized and the organizational structure to enhance primary care continues.

However, many schools have expressed a concern that the number of graduates entering generalist specialties is now declining. In 2000, medical school graduates indicated less

interest in primary care than the previous year, according to the AAMC Graduate Questionnaire.

To explore this and other issues related to the role of primary care in health care delivery, RWJF sponsored an invitation-only meeting, "The Future of Primary Care," October 3–5, 2001 in Glen Cove, N.Y. About 40 leaders in the field, including generalist physicians, primary care nurses, educators and policy-makers, presented background papers and discussed the broad issue of how quality health care will be delivered as the U.S. population continues to age and become more diverse.

A book of proceedings from the meeting was scheduled for publication in late 2002. The *Annals of Internal Medicine* journal published several articles based on conference papers in a supplement, [February 4, 2003, volume 138, #3](#).

RWJF commissioned a volume in its Series on Health Policy, *Generalist Medicine and the US Health System*. It was published by Jossey-Bass in 2004. Program director Colwill wrote the opening chapter.

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Reviewed by: Robert Crum and Molly McKaughan

Program officers: Michael Beachler and Susan Hassmiller

APPENDIX 1

Generalist Physician Initiative National Advisory Committee

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

(Includes all members who served at any time during the project.)

Samuel O. Thier, M.D. (Chair)

President and CEO
Partners HealthCare System
Boston, Mass.

Robert B. Johnson

Executive Director
Grady Memorial Hospital
Atlanta, Ga.

John Ball, M.D.

Executive Vice President
American College of Physicians
Philadelphia, Pa.

William Kerr

Director
University of California, San Francisco,
Medical Center
San Francisco, Calif.

Roy Butler

Commissioner of Medicaid
Kentucky Cabinet of Human Resources
Frankfort, Ky.

David Kindig, M.D., Ph.D.

Director
Programs in Health Management
University of Wisconsin-Madison
Madison, Wis.

Jocelyn Elders, M.D.

Director
Arkansas Department of Health
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Bernard Lo, M.D.

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Associate Editor, Health Affairs
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Robert Graham, M.D.

Executive Vice President
American Academy of Family Medicine
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Howard Rabinowitz, M.D.

Professor and Vice Chairman
Department of Family Medicine
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David Greer, M.D.

Dean
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Providence, R.I.

Edward J. Stemmler, M.D.

Executive Vice President
American Association of Medical Colleges
Washington, D.C.

Lawrence Haspel, D.O.

Executive Vice President
Olympia Fields Osteopathic Hospital and
Medical Center
Olympia Fields, Ill.

Samuel Warburton, M.D.

Corporate Medical Director
Aetna U.S. Health Care
Hartford, Conn.

Thomas S. Inui, Sc.M., M.D.

President
Fetzer Foundation
Kalamazoo, Mich.



Modena Wilson, M.D., M.P.H.
Academy of Pediatrics
Chicago, Ill.

APPENDIX 2

Glossary

Area Health Education Centers (AHECs)—a system, funded through a combination of state and federal funds, that strives to eliminate disparities in health and health care, especially in underserved communities, by providing community training for health professionals in these areas. Nationwide, there are more than 170 individual AHECs, and two-thirds to three-fourths of the medical schools in the United States benefit directly or indirectly by the services that are provided through the AHEC network.

Clerkship—an educational experience for students in medical school that provides a series (via rotations) of supervised, hands-on training experiences in the fundamentals of various disciplines. Academic credit is usually given.

Continuity clinics—clinical educational experiences for residents in which they are assigned to a particular clinic for a certain period of time (for example a half-day per week for the three or four years of their residency training). During this time they provide primary care for their own panel of patients, with faculty physicians available for guidance and consultation.

Locum tenens—a program that temporarily places physicians in the practices of an absent colleague.

Preceptorship—an experience for a medical student or other student not in a professional training program (i.e., an undergraduate or high school student) in which the student follows a physician through the workday in order to get a sense of what is involved in that particular doctor's work. This is typically not a hands-on experience, but is, rather, observational.

Title VII—Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex and/or national origin.

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"The 1st Annual Meeting of the RWJF Generalist Physician Initiative," January 5–8, 1995, Ft. Lauderdale, FL.

"The 2nd Annual Meeting of the RWJF Generalist Physician Initiative," January 9–11, 1996, Key Biscayne, FL.

"The 3rd Annual Meeting of the RWJF Generalist Physician Initiative," January 9–11, 1997, Key Biscayne, FL.

"The 4th Annual Meeting of the RWJF Generalist Physician Initiative," January 8–10, 1998, Key Biscayne, FL. Attended by 200 people.

"The 5th Annual Meeting of the RWJF Generalist Physician Initiative," January 7–9, 1999, La Jolla, CA.

"The National Symposium for Primary Care Education for the 21st Century: Lessons from National Initiatives," September 24–26, 1998, Baltimore. Co-sponsored by the *Generalist Physician Initiative*, the Kellogg Foundation and the Health Resources and Services Administration. Attended by 400 people.

"The 6th Annual Meeting of Generalist Physician Initiative, *Meeting the Challenge of Primary Care in the New Health Environment*," January 7–10, 2000, Tucson, AZ. Attended by participants in the *Generalist Physician Initiative* medical schools and in seven partner initiatives.

PROJECT LIST

Reports on the projects managed under this National Program are listed below. Click on a project's title to see the complete report, which typically includes a summary, description of the project's objectives, its results or findings, post grant activities and a list of key products.

Full Project Reports

- [Back to Basics: Shifting from Specialty to Generalist Medicine](#) (April 2007)
- [Focusing on Primary Care at the University of Massachusetts Medical Center](#) (July 2003)
- [Increasing the Number of Primary Care Physicians in Underserved Areas of Pennsylvania—the *Generalist Physician Initiative*](#) (July 2003)
- [Philadelphia Medical School Turns to Educating Generalist Physicians](#) (July 2003)
- [Recruiting, Educating and Supporting Primary Care Physicians for Rural Virginia—the *Generalist Physician Initiative*](#) (July 2003)
- [Training Generalists Physicians for Underserved Rural North Carolina](#) (July 2003)

Short Project Reports

- [Doubling the Interest in Primary Care Careers at New York Medical College—the *Generalist Physician Initiative*](#) (July 2003)
- [Increasing Graduates Who Practice as Generalist Physicians in New York—the *Generalist Physician Initiative*](#) (July 2003)
- [Increasing the Number of Generalist Physicians Practicing in Underserved Communities in Texas—the *Generalist Physician Initiative*](#) (July 2003)

- [In New Hampshire, a National Role Model for Generalist Education \(July 2003\)](#)
- [Medical College of Georgia Encourages Students Toward Generalist Careers \(July 2003\)](#)
- [More Generalist Physicians for Underserved New Mexico \(July 2003\)](#)
- [Path to General Medicine Residencies Leads Through the Community \(July 2003\)](#)