From the North American Primary Care Research Group

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REVITALIZING GENERALIST PRACTICE: THE MONTREAL STATEMENT

"Today, the need for people-centered primary health care is greater than at any time in history"[1]

The challenges facing our health systems are immense. International efforts strive to meet the needs of aging populations, the rising prevalence of chronic disease and illness, and the changing impact of complex social factors (including health care) on individuals' experiences of, and capacity to manage, illness. The international community has pledged to renew its efforts to better align health care to a person-focused, individually tailored, goal-oriented model of health care.[1]

To date, primary care reform has focused on improving the integration of health services by strengthening coordinated access to multidisciplinary teams delivering continuous, comprehensive care,[2] the aim being to reverse the fragmentation of health care resulting from over-specialization.

But integration alone cannot guarantee the delivery of person-centered care: health care that recognizes its goal as optimizing an individual's health-related capacity for daily living, rather than the "command and control" of disease.[3] This tailoring of health care decisions about diagnosis and management to the individual's context often requires compromise between a biomedical, patient, and professional view of what constitutes "best" care.[4] Enhancing our capacity to appropriately and safely deliver such balance or compromise within modern medical practice is essential if we are to tackle emerging problems of treatment burden, overdiagnosis, problematic polypharmacy, and other forms of iatrogenic harm.

Research into patient and professional experiences of care demonstrate that delivery of person-centered, individually tailored care is currently challenged by the context of clinical practice.[5]

Whole-person individually tailored clinical decision making is the expertise of the medical generalist.[6] Medical generalism is a distinct form of clinical practice that is complementary to, but different from, specialist practice. Although both forms of practice are needed in today's health system,[7] the majority of patients require comprehensive generalist care (Box 1).[8,9]

However, a failure to recognize the differences between the definitions and monitoring of quality of care in primary care systems is contributing to a failure in person-centered care.

We describe the 4 key elements of best quality generalist practice that are needed to enable and ensure quality person-centered care, and suggest how these may be recognized within practice (Table 1). The 4 key elements are:

- The goals of care
- The data used in practice
- The tasks of practice
- Assessment of quality of care

We deliberately do not offer specific ways to measure each element as these will be context sensitive. Our Table, however, does offer a framework by which individual settings can review their own models of practice.

In Order to Deliver the Health Care Needed for 21st Century Challenges

We call on health systems, practices, and practitioners around the world to evaluate their current models of care against our stated criteria for best *generalist* care.

Box 1. Differentiating Specialist and Generalist Care[7]

Medical Specialists and Generalists Ask Fundamentally Different Diagnostic Clinical Questions When Making Decisions About Individual Patients

Specialist	
The specialist uses their detailed knowledge of and expertise in a specified area of biological (mal) function to ask, "could we diagnose this individual with condition X ?"	Best diagnostic practice is defined by the correct assessment of whether the individual has a particular disease/condition. It requires the clinician to collect appropriate clinical data and apply hypothetico-deductive logic to ask does this individual meet the diagnostic criteria for this condition? If no, the patient is discharged. If yes, an individual clinician may then explore this condition in the context of this patient's life and personal circumstances in order to decide between competing treatment options (adopting a person-centered approach to care in the specialist context).
Generalist	
The generalist uses their expertise in using multiple sources of data to interpret individual illness experiences to ask, "should we diagnose this individual with condition X ?"	Best care optimizes an individual's health-related ability to continue living their daily life: supporting a person to understand their illness (including the pros and cons of medicalization) and enhancing individual capacity to adapt and respond personally to that experience. Choosing diagnoses and treatment options on the basis of their likely impact on daily living, rather than solely their ability to instrumentally improve disease management.

Table 1. Defining and Identifying Generalist Best Practice–All Elements Must be Present

Defining Best Practice: Describing Quality Generalist Practice	Recognizing Best Practice: What You'd Expect to See in a Service Delivering Quality Expert Generalist Care
The goal(s) of care	
Best care optimizes an individual's health-related ability to continue their daily life.	Individually tailored care is ENDORSED by health systems, professionals, and patients. Individuals, practice teams, and organizational systems consistently and actively emphasize the value/importance of individual goal-related care. Individual health-related capacity for daily living is ENHANCED by health services. Contact with health services leaves patients better able to understand and to respond and adapt to their illness experience, resulting in enhanced capacity to manage daily living and health literacy; minimized illness burden.
The data used in practice	**Generalist practice is ENABLED by:**
Best care is informed by scientific evidence, together with patient accounts of experience, contexts, and preferences; and professional experience of illness and disease in this patient's particular context.[9] Scientific evidence is viewed not as "top of an evidence hierarchy" but rather 1 source of a wide range of data, information, and knowledge to be used in interpreting what is wrong and what might need to be done. Contact time with patients is designed to support access to, and use of, an appropriate range of data sources.	Informational continuity: accessible, appropriately completed, updated, and summarized records to provide patient context data Scientific data: readily accessible in formats that are suitable for patients and professionals, eg, guideline summaries, decision aids Patient-centered consultation spaces that enable both parties to exchange patient accounts of experience, context, and preference Professional-centered work spaces that provide opportunities outside of the consultation for the creation, use, and maintenance of locally constructed "mindlines," a term to describe "collectively reinforced, internalized tacit guidelines" constructed from brief reading, tacit knowledge, and interactions with professionals and patients; so creating "knowledge-in-practice-in-context."[10]
The tasks of clinical practice	
Best care recognizes the intellectual task of the clinician to integrate data, information, and knowledge; to construct a unique individual interpretation of illness experience; to safety-net/check that interpretation (including appropriate follow-up); and to empower the patient to own the decision process.	Clinicians are trained in, and confident to use, the skills needed for the intellectual task of using data to construct new context-sensitive knowledge about this individual. Clinicians and patients perceive that they work in an enabling context with adequate resources to support this form of practice (including prioritization of workload). Process of care is described with reference to the context in which clinical decisions are made and not just on the basis of the decision itself.
Assessment of quality of care/practice	
Quality of care is described with reference to the context in which clinical decisions are made and not just on the basis of the decision itself; and assesses whether context and care have ideally enhanced—certainly not undermined—health-related capacity for daily living.	Feedback and monitoring processes assess both the context of, and outcomes from, care from a person-centered perspective. Services support longitudinality[11] of care—to observe the impact of personalized clinical decision making—is evident. Clinicians and patients are supported to judge the quality of care (decision making) based on the goal/impact of the decision over time rather than any decision itself.

In so doing, to advocate and implement the changes needed to enhance the delivery of generalist care, *supplemented* by specialist disease management when appropriate for a given individual.

We call on the World Health Organization to incorporate recognition of the intellectual task of person-centered care in its 2018 statement on strengthening primary care[1] to recognize the delivery of generalist decision making as a quality indicator for primary care practice.

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AAFP From the American Academy of Family Physicians

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AAFP CREDIT SYSTEM RECONSIDERS FUNCTIONAL MEDICINE TOPICS

The AAFP Credit System will begin approving functional medicine topics in accordance with the credit system's eligibility requirements (https://www.aafp.org/cme/creditsys/about/eligibility.html) and topic-specific guidance issued by the AAFP's Commission on Continuing Professional Development (COCPD), effective immediately.

The COCPD's topic-specific guidance on functional medicine now says: "Activities and sessions eligible for credit are limited to those that provide clinicians with an overview or scope of functional medicine and the techniques that functional medicine practitioners use, so family physicians can educate interested patients about the topic."

"Activities and sessions for credit that are ineligible include those that teach clinicians how to perform techniques, modalities or applications of functional medicine in their clinical practices."

Members may claim CME credit for functional medicine activities and sessions that are certified for credit by the AAFP Credit System.

Background

The Cleveland Clinic's Center for Functional Medicine defines functional medicine as "a personalized, systems-oriented model that empowers patients and practitioners to achieve the highest expression of health by working in collaboration to address the underlying causes of disease."

In 2013, the AAFP's COCPD, which oversees the AAFP Credit System, recognized that CME provider organizations applying for credit for activities and sessions about functional medicine were receiving inconsistent credit determinations.

In response, the COCPD conducted a literature review on functional medicine, and based on this review, the group determined at the time there wasn't sufficient evidence to award AAFP credit to activities and sessions on the topic. So, a moratorium was placed on functional medicine in February 2014. That moratorium expired in 2016, at which time another evidence review was conducted and the COCPD extended its moratorium based on similar reasoning. This most recent moratorium expired in February of this year.

In anticipation of this expiration, the AAFP Credit System issued a call for comment on functional medicine in September 2017 to AAFP members, CME provider organizations, functional medicine stakeholders and other national accreditors. The request for feedback included a call for evidence on functional medicine's efficacy in the application of family medicine and any additional supporting evidence and/or literature.

The information received was objectively reviewed and summarized in a report by a third party and presented to the COCPD. That information, along with several literature reviews and results from the AAFP Member Survey, informed the commission's decision to lift the moratorium on functional medicine. The change went into effect after it was recently approved by the AAFP Board of Directors.

Family Physician Expert's Perspective

COCPD Chair Melody Jordahl-Iafrato, MD, of Tucson, Arizona, told *AAFP News* that although the moratorium has been lifted, activities or sessions covering functional medicine must comply with the AAFP Credit System's eligibility requirements and with the topic-specific guidance issued by the COCPD.

Under the newly issued topic-specific guidance, for example, Jordahl-Iafrato said a session that provides an overview of what functional medicine encompasses would be eligible for credit.

"This may include some examples of techniques, but not teaching how to do these techniques," she said. "However, a session that teaches how to treat a specific disease—such as neurological or gastrointestinal dis-