UCL Press

Chapter Title: What is generalism and why is it important?
Chapter Author(s): Sophie Park, Kay Leedham-Green and Tanya Cohen

Book Title: Generalism in Clinical Practice and Education
Book Editor(s): Sophie Park, Kay Leedham-Green
Published by: UCL Press. (2024)
Stable URL: https://www.jstor.org/stable/jj.9128000.9

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at https://about.jstor.org/terms



This book is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License (CC BY-NC 4.0). To view a copy of this license, visit https://creativecommons.org/licenses/by-nc/4.0/.



UCL Press is collaborating with JSTOR to digitize, preserve and extend access to *Generalism in Clinical Practice and Education*

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

Part I: Core concepts

Part I contains five chapters. These aim to provide the reader with a conceptual understanding of what generalism is and why it is important. Chapter 1 introduces an overarching philosophy of practice. Chapter 2 explores how generalism can manifest as a team process across multiprofessional contexts. Chapter 3 presents a critical patient perspective. Chapters 4 and 5 describe how generalist knowledge is constructed and used within clinical practice and research.

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

1
What is generalism and why is it important?

Sophie Park, Kay Leedham-Green and Tanya Cohen

Introduction

Generalism is an inclusive and holistic form of clinical practice that, due to its innate breadth, remains poorly defined or understood. The concept of generalism, however, is increasing in prominence as healthcare systems worldwide respond to the rising complexity of population health needs and other challenges, such as ensuring sustainable and equitable access.

One of the core strengths of generalism is its adaptability: the ability to move flexibly to accommodate particular contexts or individual patient needs. Although we provide examples of generalism in practice throughout the book, these are not intended to describe one 'right' way to do generalism. Rather, by providing you with a rich description of how a problem *might* be negotiated, we hope you will think critically about how you could use a similar approach (or not) in your own practice. Throughout the book, we emphasise the importance of critical reflexivity: the ability to question and be curious about yourself and others, and to use this to inform how and when you choose to act in particular ways. When we describe a clinical example, there is almost always more than one possible way to approach it. We invite you to consider explicitly (for example, 'thinking aloud') what influences or shapes *your* intention and preference for a particular option. How does this align or differ from the preferences of a colleague, peer or patient, and why? This process includes thinking about ways of knowing, doing, learning and organising clinical practice. Also, the value systems that inform what 'good' looks like in relation to each of these. We celebrate a multiplicity

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

of approaches, and throughout the book share ways of moving with agility between forms of knowledge and ways of doing. This critical curiosity enables us to value not only biomedical excellence but also a wide range of other important and valuable ways of knowing; to examine their relevance to the current situation or challenge; and to select this knowledge to inform practice and ways of doing.

The Health Foundation in 2011 highlighted generalism as a way of thinking, a distinct paradigm of clinical practice (1) which is:

> at root, a way of thinking and acting as a health professional and, more than that, a way of looking at the world. It is possible to be a generalist in any specialty or profession and, equally, it is possible to work as a General Practitioner without being a true generalist. The essential quality is that the generalist sees health and ill-health in the context of people's wider lives, recognising and accepting wide variation in the way those lives are lived, and in the context of the whole person.

The work of a generalist is dynamic, scoping their focus and attention, accruing knowledge about a patient and their community over time, and using this to inform decisions about how, when and why to implement (or not) an element of healthcare at a particular moment in time. What is clear is that, when done well, generalism is beneficial for patients, clinicians and broader healthcare ecosystems. The situated, conditional and dynamic nature of generalist work, however, means that it is inherently politically and ethically challenging, creating both rewards and frustrations for patients and clinicians alike.

A reductive definition of generalism risks oversimplifying something that is innately complex; therefore, we begin by proposing an integrative philosophy of practice and then discuss how generalism might be enacted clinically through a set of guiding principles. This philosophy was co-produced with our co-authors: patients, academics and practitioners with international perspectives. It has arisen from our meetings with them and their writing. We hope it will give you a framework on which to hang your reading as you continue through the book.

A philosophy of generalism

We have constructed this philosophy as ways of being, knowing, judging and doing (Figure 1.1). These categories reflect the philosophical domains

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms



Figure 1.1 A philosophy of generalism for clinical practice. © Sophie Park and Kay Leedham-Green

of ontology, epistemology, axiology and praxis which are also discussed in relation to research practices in Chapter 4. We have created an illustrative example for each section. If you prefer starting with a tangible example rather than theory, you might wish to read the examples first.

Rather than jump straight into this philosophy of generalism, we invite you first to reflect for a moment on your own philosophy of practice. Do you identify with a particular professional group? How do you perceive that profession in relation to others, and yourself in relation to patients? What types of patients and patient problems fit within your professional remit? From what perspective and by what means do you judge the quality of the care that you provide? What do you look for when updating and researching your practice, or teaching others? How do you identify, prioritise and address patient and population health needs, including future needs? What do you do if your patient or their problem

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

is beyond your remit? How and when do you collaborate? How does the organisation of health and social care in your context enhance or inhibit your profession, and how will your profession respond to future challenges or be shaped by future contexts?

Ways of being

Generalists are inclusive and holistic practitioners who are able to work with all types of patients and problems. They can support people at all stages of life who may have undifferentiated symptoms, minor or major illnesses, chronic conditions, and complex, situated and contextual issues. They are sustainable clinicians attending to patient health as well as disease and they work to address population health inequalities.

A generalist focuses on the person – 'What does this person need now?' – rather than on their own area of expertise or preferred approach. This may seem an obvious place to start a clinical interaction, but an expansive clinical remit has implications. Seeing health needs from the perspective of people rather than a clinician's own specialised skill set means that generalists work comfortably with symptoms and illnesses that may pass without ever coalescing into a named disease. A generalist might be the first person to diagnose a major illness, but they also treat people with everyday health needs that may not have an associated specialty, but nonetheless matter to people. Generalists see symptoms, illnesses and diseases as dynamically enmeshed with people's life circumstances: the poorly nourished baby, the teenager with a sexually transmitted disease, the arthritic carer. This is where generalists lean in and engage rather than disengage. And, because a generalist sees a person within their life context and life narrative, they attend to potential future concerns and wellbeing rather than focusing solely on today's 'presenting complaint'. This invites secondary questions within a consultation: 'Why have they come today?' 'Why has this person become unwell, and what can be done about that?' and, perhaps, 'Why might this person become unwell in the future and how can this be navigated?' or even 'What does "well" look like from this person's perspective?'

Example 1.1: Jay the trainee (identifying as a generalist)

Jay spent much of his undergraduate and early postgraduate training in urban hospitals, seeing a constantly revolving set of patients, either acutely unwell in the emergency room, admitted to the

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

wards, or in clinics being assessed for complex procedures and treatments. Jay was always curious about the people he met and often frustrated that they had not accessed help at an earlier stage, or had underlying or additional issues addressed. Jay still remembers a young homeless person on his cardiology rotation, admitted for infective endocarditis after using an unclean needle, discharged back on to the streets after a heart valve replacement without further support. The operation itself was a success, but the impact on the person less so. This is when Jay decided to become a generalist.

Ways of knowing

If a clinician is going to work with all types of patients and all types of patient problems this requires a very special approach to knowledge. Although most generalists would call themselves 'lifelong learners' with a 'can do' attitude, they cannot know everything. Generalism therefore requires clinicians to have an awareness of, and a humble and open attitude to, not knowing. But how does a generalist know what to do, when they do *not* know? Observing a generalist in action will quickly reveal that they rely on what we term 'distributed expertise'. This means they acknowledge, construct and implement a wide range of knowledge forms as needed and work with the knowledge and expertise of others. For example, if a menopausal patient attends because their hormone replacement therapy is not working as they had hoped, a generalist might further explore the patient's expectations and experiences; consult local prescribing guidelines and spend some time looking up the benefits and side effects of alternative combinations with the patient at their side; if they feel unsure, ask a colleague with a special interest for their opinion or make a referral; or, if they are unable to meet their patient's need today, share a reliable information resource and invite them back. This approach to knowledge means that generalists are not only able to consider all types of problems, but they can accommodate a particular person's situation *and* adapt to continuously evolving therapeutic guidelines and population health needs.

Generalists adopt personalised approaches to complex problems. This requires generalists to integrate and implement 'situated knowledge' (knowledge that is unique to a person or place) with other forms of knowledge. Examples of situated knowledge include what someone's home life is like, how their situation has changed over time, or what

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

opportunities exist for teenage parents in a local area. Situated knowledge is not written down in any textbook, and therefore takes time to build and connect. Biomedical and other forms of clinical knowledge need to be connected with situated knowledge for each to be effectively implemented. Generalists, therefore, benefit from continuity with people and with places, so that they can construct and use situated knowledge.

Ways of knowing are dependent upon how we use language or attribute meaning to particular terminology. For example, the word 'complexity' might be used by a specialist to mean an atypical or technically complicated condition or 'patient case'. In contrast, 'complexity' might be used by a generalist to mean interconnected or situational factors, making a patient situation unique or challenging to manage using monolithic or linear guidelines.

Finally, because generalists work with complex problems such as multimorbidity in addition to diseases with established guidelines, they embrace multiple knowledge forms and different types of evidence. For example, a flare-up of chronic pain might require different lenses (medical, anatomical, psychological, behavioural and/or sociological), with the final approach negotiated through curiosity, listening and relevance.

In summary, generalists reflect on what is *not* known as well as what is; they embrace distributed expertise (acknowledging and implementing the expertise and knowledge of others); they construct situated knowledge through continuity with people and places; and they integrate multiple knowledge forms, applying different lenses to complex problems.

Example 1.2: Fiona the health visitor (using distributed expertise)

Fiona originally trained as a midwife but decided to move across to health visiting as she felt she could make more of a difference to a child's start in life by seeing families longitudinally at home. She said that one of the things she learned is that you can never know the answer to every question a new parent asks, from 'Which is the best type of nappy?' to 'How can I leave my abusive partner safely?' For simple questions, she tries to help people find information and supports them in reflecting on its relevance and quality. Where she

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

identifies a potentially serious problem, she discusses it with her team and/or refers onwards. Where there is no simple answer, she explores the problem and its context with curiosity, sharing information and resources as needed, and helps the person construct an informed plan that fits their specific situation. With these strategies for finding and using knowledge and expertise, Fiona feels able to operate safely and effectively whatever the question.

Values

The ways of being and knowing outlined above are not separate from generalist values; rather, they arise *from* their values. Focusing first and foremost on what matters to people, rather than a clinician's own field of expertise, arises through a generalist value system. This does not mean that other value systems are wrong; they are complementary. A generalist's value system not only defines their clinical approach, it also defines how they judge what 'good practice' looks like, and how they position themselves in relation to others. For example, can the quality of generalist care be adequately measured through biomedical markers of disease control? Is there a place for more complex patient-defined and patient-reported measures? Is the disease-based knowledge of a clinician more important than the knowledge that a person brings about their own body, experience and context?

Exploring what someone values, how they judge what good is, and how they position themselves in relation to others, gives clues as to their value system. We argue that generalists value things like inclusivity, curiosity, continuity, collaboration, adaptability and participation; they invite multiple perspectives when judging what 'good' is, including the perspectives of patients and communities alongside the perspectives of clinicians and academics. They position themselves *with* colleagues and patients: sharing knowledge, sharing decisions, asking for and integrating the perspectives of others.

Example 1.3: Participatory and person-centred approaches

Marta is a social worker and trainer. She is currently working with her local library service which is being converted into a flexible community space for people with complex needs. It will have a

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

social space, a garden and a creative space in addition to the current quiet reading and lending space. Marta has been asked to support the mixed team of librarians, administrators, social workers and mental health professionals who will deliver the new service. Her goal is to ensure that it is constructed around the needs of the people who will use it. Her main challenge, she says, is working with professionals who are often entrenched advice-givers. Marta includes service users in her workshops to help the group develop curiosity and respect for others and a shared sense of purpose. Today Marta has invited representatives from a local community group for people with learning disabilities. They will work with her team to co-create a design brief and evaluation strategy for the social space together with a team leader from a neighbouring area where a similar service has already been set up.

Ways of doing

Generalism is enacted in ways that are rarely straightforward or procedural. Of course, generalists need to be familiar with national consensus guidelines and procedures, but they often need to adapt or select approaches so that they are relevant to a particular situation. Generalism is a mindful and skilled navigation of multiple points of possibility: exploring broadly, connecting diverse types and sources of knowledge, involving people in clinical reasoning and decisions, and implementing those decisions in ways that are dynamic and responsive.

We have distilled the ways of doing generalism into four overarching principles: expansive exploration, connecting knowledge, participatory processes, and adaptive implementation (Figure 1.2). These principles underpin the practices described throughout this book. Each principle can be used equally within clinical encounters, educational and academic activities, and within policy, innovation and improvement. In this chapter, we present a brief overview of how these principles might be applied within clinical practice (explored further in Part IV, Chapters 15–18) and some wider implications.

Expansive exploration

Within generalist clinical practice there is a broad spectrum of legitimate clinical attention within an encounter. Attention can be directed to, for instance: a single disease; multiple diseases; symptoms of ill

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms



Figure 1.2 Principles of generalism. © Sophie Park and Kay Leedham-Green

health with an absence of disease; prevention of ill health and well-being support; management of long-term conditions; the interface between health and social care; or historical and economic challenges shaping a patient's social determinants of health. Stott and Davies in 1979 examined over one hundred UK general practice consultations (2) and identified four key categories of focus: management of presenting problems, modification of help-seeking behaviours, management of continuing problems, and opportunistic health promotion. Iona Heath defines further subtle gradations of clinical focus: stress, illness, disease (possible to manage locally), and disease requiring referral to other services or teams (3). Clinicians have tended to focus their clinical attention on confirming or excluding the presence of disease. It is, she argues, legitimate to give attention to any or all of stress, illness and disease within a generalist clinical encounter, engaging at

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

the boundaries and intersections between each. This can be explicit ('I am stressed, please help'), or implicit: a patient bringing something to a consultation as a potential disease, which becomes re-problematised within the clinical interaction as an illness, or stress, while remaining a relevant and legitimate concern for both to recognise and attend to. Part of the role of the generalist is to act as a gatekeeper, and indeed gate-opener, to specialist and community services. The efficiencies and effectiveness of a healthcare system are further amplified if generalist interactions also involve discussing the boundaries and intersections between stress, illness and disease. What needs to be classified as a disease at this point in time, and what requires a different lens? Explicitly involving people in these decisions avoids over-medicalising or over-investigating them; instead, treating them with respect and thereby minimising harms and maximising benefits. This process is fluid and dynamic and clinicians must think critically and explicitly about the value and consequences of constraining the focus of a consultation or broadening and collaboratively refocusing its scope. This broader scope of practice and the fluid and real-time negotiation of issues enable a more balanced sharing of power (both clinician and patient bring relevant elements of knowledge).

Scoping the potential focus or 'spotlight' of clinical attention is complex and value-laden and has significant implications for resource allocation. Sometimes investment in expansive exploration rather than narrowing the focus of attention can mean longer-term efficiencies: for example, signposting to community services for people experiencing social isolation, or considering trauma and/or distress rather than dismissing or overtreating idiopathic pain. Depending on the circumstances, available time and patient expectations, some wider considerations might be explicitly discussed, while others might be implicit but inform how a clinician focuses their questions or examination.

We are not suggesting that it is possible or necessary to broaden the scope at every encounter. The generalist is, however, constantly selecting *with* the patient what to focus on within an interaction: collaboratively and creatively exploring, agreeing and formulating the problem or focus *together* before seeking possible solutions or next steps. Instead of positioning the patient as bringing problems or 'presenting complaints', or even as 'being a problem' if their complaint does not feel relevant to a clinician's field of expertise, generalists collaboratively negotiate where to focus clinical attention with their patient.

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

Example 1.4: Kamal and Dr Jay (a generalist consultation)

Kamal has COPD and chronic knee pain following an operation a few years ago. Kamal has come to see Dr Jay about a flare-up in chronic knee pain which is keeping him up at night. Dr Jay asks Kamal about himself while he examines the joint. Kamal explains that he has retired early to care for his father who has dementia. Dr Jay asks Kamal why he thinks his pain has flared up, and what he thinks might help. Perhaps a medicines review is needed, or a behavioural approach such as walking every day and keeping a pain diary, or understanding today's pain in the context of carer fatigue and applying for respite care, or a combination of all three. Kamal explains that he hasn't been taking his painkillers as he distrusts them. He agrees that the pain isn't helped by being cooped up all day with his father. He thinks walking might help and this was suggested by his surgeon, but he can't leave his father alone. He doesn't want respite care as his dad would be too stressed, and in any case, he can't afford to go anywhere. Dr Jay explores Kamal's concerns about analgesia and deprescribes the strong painkillers his surgeon had given him. Kamal agrees to try simple analgesia before bed every day for a week to see whether that helps and to come back if it doesn't. Dr Jay describes a new service at the library which includes a dementia-friendly social space and advice service for carers. Kamal agrees to take his dad along and try it out. Dr Jay reflects and writes a note to check up on Kamal's mood the next time he visits. Dr Jay sees Kamal next at his father's care-planning appointment. Kamal's mood appears brighter. He has joined a network of carers via the library and both he and his father have had their financial and social support reviewed. His knee is still sore, but no longer wakes him at night.

Attending to what is *not* said, as well as what is, can help shape a clinician's understanding of where people locate their distress and broaden the range of acceptable solutions considered. In the example above, Kamal did not directly express distress about his role as a carer but this was held by Dr Jay as potentially relevant and he 'opened a gate' to a community service. Generalists not only attend to what people might

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

explicitly expect from an encounter but also explore what is missing or unmet. Thus, a generalist might just as readily suggest referral or access to a resource for a patient in need (despite their not previously having articulated or acknowledged this as a problem) as discuss with a patient why an investigation might not be clinically informative.

Expansive exploration might feel like opening a Pandora's box of unsolvable problems, and proactive care might feel like more work despite longer-term efficiencies. Broadening the scope of clinical attention does not mean that the generalist must deal with or action all problems at all times. Naming something as 'a problem' can in itself provide therapeutic value or become a catalyst for change beyond the consulting room. An example might be asking a patient what they could do about a housing or relationship problem. There is extraordinary skill inherent in this process, and when done well, it can open up a range of contrasting, vivid opportunities to those actively involved. The focus shifts from 'What can I identify that I can solve?' towards a more collaborative and inclusive approach to problem identification and acknowledgement: 'What will help this patient, and can I support them with this?' This requires both clinician and patient to accept that not all identified problems might have an immediately available solution, and not all problems are solvable by the clinician or patient, but they can still discuss issues that are beyond their own scope of direct action, and use their interaction to establish what they can do together and what each can work on independently or with others (for example, multidisciplinary team, community resources, lawyer) supplementing what can be achieved within the consultation.

Participatory processes

Navigating generalism's broad clinical remit is challenging and requires the participatory engagement of patients, carers and others. Generalists work in a potentially infinite problem space and people often come with undifferentiated or diffuse symptoms. There are various hypothetic-deductive diagnostic strategies that aim to help generalists work safely within this space. John Murtagh (4) proposes systematically considering the most probable, dangerous and easily missed diagnoses, and whether the patient is trying to communicate a psychosocial problem. Norbert Donner-Banzhoff argues that including or excluding every possibility through direct questioning and hypothesis testing is unfeasible and actually unhelpful in generalist contexts: the range of potential problems is too high and the frequency of positive findings too low. He examined hundreds of consultations in

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

the general practice setting in Germany (5) and found that there is a practical reason why generalists work more collaboratively with their patients. It is only by giving patients and carers the opportunity and encouragement to describe everything they find worrisome, changed, or both, that the generalist can hope to narrow this infinite problem space to the point where hypothesis testing becomes productive. He describes a process of inductive foraging (extended active listening) and triggered routines (for example, to characterise a symptom or check for 'red flags') which occur before a diagnosis is even considered. If hypothesis testing or triggered routines start too early in the interaction, they become counterproductive as the clinician is forced into deductive mode before the problem space is sufficiently narrowed. In generalist contexts, more participatory and patient-centred approaches result in better clinical reasoning.

This collaborative process of identification, appreciation and integration of why a patient has come can also strengthen a patient's agreement and use of the management plan and contribute to a stronger and more trusting relationship, enhancing future continuity of care. In using an explicit 'think aloud' approach to reasoning, the clinician is sharing the boundaries of their decision-making rationale, enabling the patient to be more confident about re-attending if something unexpected arises and making visible areas of dissonance which might need further attention. If there is unaddressed dissonance, this can disrupt opportunities for future care. For example, if a patient feels that a clinician offered inappropriate advice, 'missed' or 'dismissed' symptoms, it can reduce trust and confidence and a patient's willingness to seek help if symptoms persist or to agree to suggested actions in the future. Understanding which lens(es) the patient is using to make sense of their experiences, alongside critical awareness by the clinician of their own preferred or familiar lenses, can help map out a far wider range of potential sense-making opportunities and approaches (Figure 1.3).

Participatory processes are not without challenges. There are potential pitfalls in distributing power and decision-making responsibilities between clinicians, patients, carers and others. For example, if the balance is tipped heavily towards the patient's experience, the clinician may find it hard to move the conversation beyond emotional suffering. Or, if decisions are transferred completely to the patient, they may feel overwhelmed or burdened with the responsibility to make a 'good decision'. Instead, the frame and focus of clinical interactions need to remain agile, with the clinician holding a space in which both patient and clinician can explore and develop. This requires mutual

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

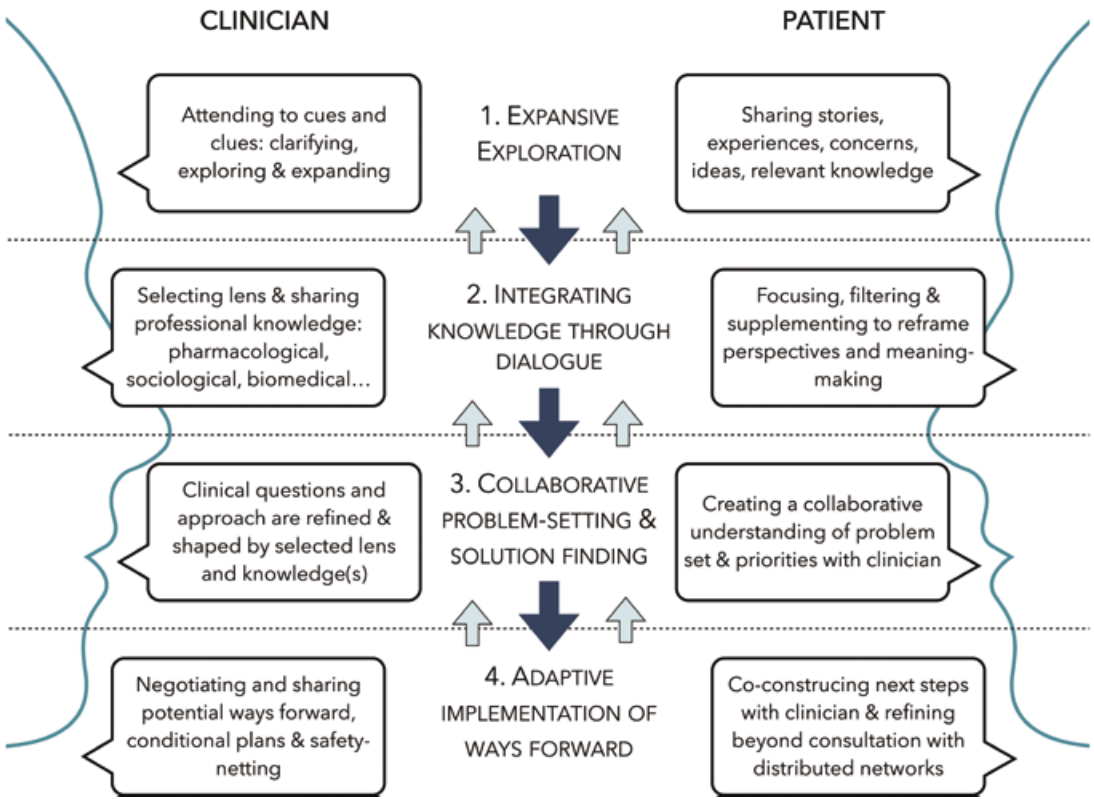


Figure 1.3 Generalist problem-setting. © Sophie Park

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

engagement, trust and curiosity in decision-making. A generalist may need to help a patient balance short-term gains with longer-term complications. For example, a patient might benefit from a referral for insomnia therapy but want sleeping tablets. This is commonly described as the difference between needs and wants: the latter being an easy or transactional short-term 'win', but unhelpful in the context of a relationship which values continuity, trust and long-term care. When done well, sharing knowledge and responsibility can be refreshing to both patient and clinician, as both become actively engaged in the decision-making process. Tim Rapley describes how the process of sharing power, knowledge and decisions is not confined to a one-off consultation event, but a distributed continuum over time beyond the consultation (6). A patient might welcome the opportunity to pause a decision so that they can read selected information and discuss sense-making and options with others. Similarly, a clinician might benefit from discussing a patient's unmet needs with colleagues or engaging in further reading themselves before suggesting a course of action.

Connecting knowledge

Patients and clinicians are human beings; however, both can lose sight of one or other element of the 'human' and their 'being'. Treating clinicians and patients as human beings involves an integration of lenses. The 'human' lens focuses attention on the physical body, the disease object, or the biomedical science relating to the disease pattern. The additional focus on 'being' explores the situated nature of being human: their experiences, their circumstances, their context, and their relationships with others. In Chapter 15, Graham Easton writes about the importance of storytelling within clinical interactions. In the example above, Dr Jay invites Kamal's story by simply asking him about himself. Listening to, engaging with and navigating another's story is key to human empathy. Rebecca Solnit in her book *The Faraway Nearby* describes how stories enable us to put ourselves into another's place: to put ourselves in another's story, or to tell ourselves their story (7). Enabling a space within a consultation to listen and exchange knowledge as two human beings invites a broader range of ideas and issues as relevant and/or interrelated.

Connecting disparate forms and sources of knowledge presents generalists with a problem: they are no longer focusing on a single type or set of knowledge (for example, biomedical), but balancing a range of interrelated knowledge forms. Knowledge is no longer fixed and boundaried but dynamically constructed and ever-expanding. They must connect

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

and navigate this wider knowledge space during a clinician–patient interaction, with each participant shaping the nature of the dialogue and the potential outcomes. Part of the expertise of the generalist is in recognising which knowledge sets are relevant and where that knowledge is incomplete. Acknowledging such gaps, knowing when to pause, or how to connect with other resources and people to enhance a person's care requires humility and explicit vulnerability.

Adaptive implementation

Working with ongoing uncertainty requires adaptive approaches to the implementation of potential ways forward, including revisiting decisions if symptoms persist or change. Many people's problems never cross clear diagnostic or interventional thresholds but remain in a zone of uncertainty. Generalists apply practical wisdom, balancing when to act with when to wait and see. The threshold or 'cut-off' shaping whether or when something is medicalised, held for future review, or explored in other ways will vary, depending on how well the clinician and patient know and trust each other, and their respective experiences, concerns and preferred approaches (8). The relationship between patient and clinician becomes more important, requiring mutual trust and openness to enable an effective exchange and co-production of how to proceed.

Adaptive implementation presents challenges, particularly for relatively inert clinical systems and educational curricula. Clinical education has typically been about producing clinicians who implement evidence-informed solutions to predetermined problems. Similarly, systems and processes are often set up to constrain options to fixed guidelines. This may be entirely appropriate for a simple infection or isolated problem. Complex, real-world problems, however, seldom have a single best solution and choices may need to be revisited. Generalism is often implemented in ways that are contextual and adapted to individual situations, framed within a distributed web of knowledge production. There is creative potential arising within and from clinical encounters for combining disease-based and procedural knowledge with more complex knowledge forms about the person and their situation. The clinician no longer positions themself as all-knowing, although they are of course introducing, connecting and filtering expert knowledge; rather, they are co-producing relevant knowledge during an encounter, including inviting the expertise of others. Generalists become positioned as part of a collective community of professional and personal ways of knowing. The patient also shifts from being a passive recipient of care at a single point in time to someone

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

participating in multiple exchanges of information, knowledge and personal experience over time.

So, through interaction and negotiation, clinicians and patients explore an expansive range of possibilities, collaboratively problem-set and prioritise, then use their collective knowledge and expertise to formulate a plan most fitting for that person at that moment in time, which may be revisited or adapted according to need.

Wider implications

Generalism has profound implications for clinical education, explored in Part II (Chapters 6 and 7). It has an exceptionally broad and dynamic knowledge base and requires learners to integrate multiple knowledge paradigms: biomedical sciences, clinical guidelines, psychological, behavioural and social sciences, communicative and procedural knowledge, and situated knowledge. The pedagogies associated with the acquisition of clearly defined 'codified' knowledge, such as anatomy and physiology, therefore need to be supplemented with approaches that stimulate criticality, curiosity, reflexivity and practical wisdom – learning from and with patients and peers. The development of situated knowledge and practical wisdom requires longitudinal connections between learners, patients, practitioners and places. Generalist knowledge requires curricula to be dynamically connected with evolving practice and research, and responsive to local patient and population health needs, rather than fixed. Assessments need to examine how learners explore expansively, work collaboratively, integrate knowledge and manage uncertainties.

Similarly, there are important implications for how services are designed and organised, explored in Part III (Chapters 8–14). Generalism as a way of working does not happen in a vacuum. A healthcare system includes many interconnected elements, such as hospital-based services, specialist services that operate in community settings, social care services, pharmacists, dentists and general practitioners. Each element relies on and contributes to the efficiency and effectiveness of the others. Generalism as a way of working requires enabling systems, processes and resources if it is to flourish within this wider health and social care ecosystem. Generalists often find themselves addressing gaps in other services – 'holding work' for people who cannot get a hip replacement, 'listening work' for people who cannot get a mental health referral, emergency antibiotics for people who cannot get a dental appointment. Generalists require a responsive functioning specialist healthcare system, just as much as specialists need generalists. Generalism needs the various

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

sectors within a healthcare system to be coordinated so that one cost centre is not incentivised to push people as problems into a neighbouring cost centre, but instead to work collaboratively across sectors.

Generalists sometimes act as a pivot between specialist and intersectoral services, signposting and helping people navigate between them. As discussed above, generalists, particularly within primary care and emergency services, are sometimes thought of as gatekeepers to the wider healthcare system, triaging which diseases can be managed now and which require referral (9,10). We also described how gatekeeping is not merely limiting access to resources: there is also a simultaneous responsibility to act as 'gate-opener'. This is particularly important in areas of social deprivation where the generalist attends to how healthcare is accessed and distributed. Generalists balance the needs and wants of different individuals, assessing how these can be met equitably in relation to the resources and possibilities of a particular health or social care system. Generalism therefore benefits from systems that prioritise people who are vulnerable and/or frail or who have complex or enduring needs. Examples include scheduling a weekly clinic in a hostel for homeless people or a visiting system for people living with frailty, or inviting people with multimorbidity or complex conditions for regular review.

Focusing holistically on patient and population health outcomes has structural implications for how health and healthcare are organised and resourced. Ill health is driven by social and environmental factors, such as poverty, education, nutrition and housing. Sociopolitical inattention to these factors adds compound pressures to generalist services as they provide comprehensive, universal healthcare to people with undifferentiated problems. Generalism therefore requires healthcare resources to flow towards rather than away from areas of population need (to build capacity) and for population health to be prioritised, including the social, economic and environmental determinants of health (to reduce demand). Investment in ever more technical solutions to disease without addressing the determinants of health is neither efficient nor sustainable. We argue that the values that a generalist brings to their practice should be mirrored when making resource allocation decisions and designing services. Patients and communities should be involved as partners with academics and clinicians to co-produce service innovation and improvement ideas. Doing generalism well therefore requires investment in spaces (time and headspace as well as physical and online spaces) so that patients, carers, communities, learners, specialists, generalists, academics and practitioners can connect and learn from each other in ways that are responsive and dynamic.

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

Healthcare data and monitoring systems also need to be optimised for generalism. If monitoring is too loose, there is a risk of rogue or unprofessional practices; however, if systems are too tight they risk stifling the creative and adaptive approaches that generalists bring. Most health service data are collected for single-hypothesis observational research (is pathway A better than pathway B?). This mode of data use is often hard to translate into generalist practice as decisions are negotiated and contextualised rather than prescribed. We argue that generalism is supported by more complex data-driven tools (such as AI, inductive approaches and semantic technologies). Shared data can then be used to identify emerging areas of excellence; to encourage the diffusion of successful service innovations and improvement ideas; to make visible areas of care that are not working well; and to identify unmet population needs.

Example 1.5: Organising end-of-life care around people's needs

End-of-life care was not working well locally. Care homes were understaffed at weekends and there was a tendency to call an ambulance for people who were approaching end of life, rather than employ extra staff to support them. The most vulnerable people, those without families or friends to advocate for them, were most likely to be admitted. Once in hospital, people were often overtreated, hospitalised for weeks, or even admitted to intensive care. Step-down care was also difficult as the care homes sometimes refused to take people back if they were unstable. After reading a particularly painful account of end-of-life care that had been flagged on Care Opinion (an open data feedback platform), the local clinical commissioning group decided to set up an integrated system that was centred around the needs of people rather than service needs. Patients and families were consulted about their preferences and needs, the care homes had training and support to provide high-quality end-of-life care, and community advocates were employed for the most vulnerable. The service was resourced through the cost savings associated with fewer hospitalisations. The service was positively evaluated by patients and families and was less resource-intensive overall. After sharing the evaluation at a regional meeting, it was adopted or adapted by neighbouring areas.

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

Conclusion

Knowledge changes all the time and people and contexts are constantly evolving and developing. Personalised approaches to care require a shift in the organisations and systems which govern, prioritise and support particular approaches to knowledge creation and use. We have made significant steps over the last century towards a more balanced and inclusive acceptance of approaches to science and practice; however, many of our established clinical and education systems and institutions remain focused exclusively on biomedical and disease-based knowledge.

Generalist practice is an exciting space, constantly operating at the interface between different sets of knowledge, and boundaries between what is and is not known. This might be the intersection between a biomedical and experiential lens to make sense of an interaction, or acknowledging the interfaces between stress, illness and disease in formulating a problem-set and plan, or acknowledging the limits of one form of knowledge or indeed 'not knowing'. Through critical reflexivity clinicians can safely create an inclusive and expansive approach to clinical practice: one that embraces a range of knowledge forms and ways of knowing; recognises the value of relational expertise in supporting knowledge deduction and induction; is able to interconnect forms of knowledge; and is able to apply and implement this in a meaningful way in the individual context and situation of a particular patient at one moment in time. As you continue through this book, we hope this philosophy will help you to recognise and articulate generalist approaches, to engage in new ways of reasoning and thinking, and even when a suitable option appears unavailable, to feel confident to negotiate an adaptive and responsive way forward.

References

1. Finlay I, Cayton H, Dixon A, Freeman G, Haslam D, Hollins S, et al. Guiding Patients Through Complexity: Modern medical generalism. Report of an independent commission for the Royal College of General Practitioners and the Health Foundation. 2011. Available from: www.health.org.uk/publications/guiding-patients-through-complexity-modern-medical-generalism (accessed 2 May 2023).
2. Stott N, Davis R. The exceptional potential in each primary care consultation. *J R Coll Gen Pract*. 1979;29(201):201–5.
3. Heath I. Divided we fail. *Clin Med*. 2011;11(6):576.
4. Murtagh J. Common problems: a safe diagnostic strategy. *Aust Fam Physician*. 1990;19(5):733–4.
5. Donner-Banzhoff N. Solving the diagnostic challenge: a patient-centered approach. *Ann Fam Med*. 2018;16(4):353–8.
6. Rapley T. Distributed decision making: the anatomy of decisions-in-action. *Sociol Health Illn*. 2008;30(3):429–44.

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

7. Solnit R. *The Faraway Nearby*. Granta Publications; 2013. Available from: https://books.google.co.uk/books?id=UnRgkYpxFiMC (accessed 18 February 2024).
8. Michiels-Corsten M, Bösner S, Donner-Banzhoff N. Individual utilisation thresholds and exploring how GPs' knowledge of their patients affects diagnosis: A qualitative study in primary care. *Br J Gen Pract*. 2017;67(658):e361–9.
9. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457–502.
10. Park S, Abrams R. Alma-Ata 40th birthday celebrations and the Astana Declaration on Primary Health Care 2018. *Br J Gen Pract*. 2019;69(682):220.

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms

This content downloaded from 81.132.242.239 on Tue, 13 Jan 2026 10:42:30 UTC
All use subject to https://about.jstor.org/terms