Executive Summary:
The mandate of the CuRe task group on Generalism is to explore and develop evidence-based curricular strategies that value and address the generalist approach within the unique context of the University of Manitoba.

The task group met on a biweekly basis since July 28, and completed:
1. A working definition of “generalism.”
2. A defined, desired outcome for graduating students with respect to generalism.
3. Defined objectives of the task group.
4. A review of CuRe existing activities and outcomes related to generalism.
5. A review of generalism within the existing UGME curriculum, specifically how generalism is valued and how the generalist approach to disease is taught.
6. A review of the literature regarding existing standards and curricular innovations related to generalism, particularly those approaches which are evidence based.
7. A review of curricular/pedagogical approaches related to generalism at selected UGME programs in North America.
8. Recommendations that facilitate the likelihood of graduating medical students who (a) understand and respect the role of generalist physicians within the health care system, and (b) can apply the principles of generalism in clinical settings.

Based on the above process, the task group presents the following ten recommendations:
1. Establish an administrative lead and steering committee for overseeing generalism initiatives in UGME.
2. Explicitly integrate generalist approaches to disease within the UGME learning objectives.
3. Develop a syllabus for all UGME educational activities related to generalism.
4. Develop a generalist ‘Master Teacher’ program.
5. Develop mandatory longitudinal early clinical experiences and reflective exercises within generalist settings.
6. Increase the number of outpatient experiences during the core clerkship.
7. Implement core clerkship intersessions which integrate teaching sessions on the generalist approach.
8. Develop and implement a four week “Introduction to Residency” at the end of Med 4, incorporating generalist clinical exposures and a summative review of the generalist approach to disease.
9. Develop and implement a program evaluation process for the generalism component of the curriculum.

10. Provide ongoing funding and infrastructure to enable the above recommendations.
Overview:
As recommended in the *Future of Medical Education in Canada* document, undergraduate medical education (UGME) must more effectively integrate broadly based generalist content, including comprehensive family medicine, into its curricular structure. Moreover, generalists from many specialties (i.e. both family medicine and other disciplines such as medicine, surgery and pediatrics) must be integral participants in all stages of medical education. The mandate of the CuRe task group on Generalism is to explore and develop evidence-based curricular strategies that value and address generalist approaches within the unique context of the University of Manitoba.

Membership:
Clayton Dyck (Co-chair, Family Medicine), Glen Drobot (Co-chair, Internal Medicine), Lawrence Gillman (Surgery), Jeff Hyman (Pediatrics), Brent Kvern (Family Medicine), Michael Semus (Internal Medicine), Larry Tan (Surgery), Kristel van Ineveld (Geriatrics), Ed Tan (Family Medicine Resident), Mark Epp (Med 2), Carol Friesen (Librarian), Karen Howell (Resource/Support), Anna Urbanik (Support)

Process:
The task group met on a biweekly basis from July 14 to September 29, completing the following tasks:

1. Development of a working definition of “generalism” and determination of the objectives of the task group
2. Definition of a desired outcome for graduating students re: generalism
3. A review of CuRe’s existing activities and outcomes related to generalism
4. A review of generalism within the existing UGME curriculum, specifically how generalism is valued and how the generalist approach to disease is taught
5. A review of the literature regarding existing standards and curricular innovations related to generalism, particularly those approaches which are evidence based
6. A review of curricular/pedagogical approaches related to generalism at selected UGME programs in North America
7. Development of recommendations regarding generalism within the new curriculum

Detailed minutes were taken at each session. A dedicated Wiki site was developed and used for posting of reference materials, members’ comments and summary documents and meeting minutes. During the first few meetings, arrangements were made to allow members to phone in if they had difficulty attending in person.
Definitions
The working definition of generalism developed by the task group is:

“One who possesses, and uses daily, a breadth of knowledge with unselected patients; who has the ability to make sound decisions in relative uncertainty and undifferentiated presentations; to problem solve critically, provide ongoing care and accept care partnerships”

Modified from 2005 Canadian Association for Medical Education Conference
Quoted in U of T Generalism Task Force Report, 2005

The task group agreed that this definition was to include generalism within all fields of medicine and in all practice settings (i.e. including but not restricted to family medicine/primary care).

Desired Outcome:
At the end of training, a graduating medical student who understands and respects the role of generalist physicians within the health care system, and can apply the principles of generalism in clinical settings.

Pre-identified Themes:
The CuRe Steering committee had already identified a number of themes and ideas for change, both during its own meetings and through the Faculty wide retreat held in April 2011. These were used to form an early framework for the group’s discussions. Detailed descriptions of these are found on the CuRe website, with broad themes including:

- Increasing the role of generalists within preclerkship.
- Modifying preclerkship content to better reflect the generalist experience and approach to disease.
- Developing early clerkship exposures in generalist settings.
- Increasing leadership and input by family physicians and other generalist physicians regarding the UGME curriculum.
- Developing a longitudinal integrated clerkship.
- Increasing use of alternate settings for clinical teaching opportunities, including ambulatory care/primary care and distributed education sites (both rural and urban).
- Acknowledging and addressing challenges presented by limited numbers of available generalist teachers.
Existing UGME Curriculum:
Task group members reviewed the UGME website, UGME program objectives and selected documents from the April 2011 UGME accreditation survey to determine how generalism is presently taught and identify “hidden curriculum” issues:

- There is presently no explicit reference to generalism within the existing UGME objectives, either conceptually or as a specific objective.
- The overall curricular structure follows the common “2 + 2”, six block + clerkship approach, and thus far there have been limited opportunities for longitudinal learning.
- Preclerkship:
  - The proportion of generalist teachers involved in formal preclerkship teaching is small, with scientists and subspecialists providing most didactic teaching and facilitating most small group learning. Generalist teachers are primarily limited to clinical skills, the Comprehensive Patient Assessments, lectures in ethics and humanities, and several family physicians/general internists/general pediatricians acting as facilitators for Problem Solving sessions. Recruitment of physicians with generalist skills is mostly haphazard and by convenience as opposed to conscious and planned.
  - The content of cases used in Problem Solving and lectures is often esoteric and not reflective of cases commonly seen by generalists. As well, there is limited reflection of the generalist approach to disease (i.e., undifferentiated illness, multiple comorbidities, continuity of care and evolution of disease over time), and “patients” frequently need referral to a specialist or subspecialist before the “correct” diagnosis or management occurs.
  - Comprehensive Patient Assessments are generally hospital-based and performed on patients who have been already been thoroughly assessed by their patient care team.
  - There are limited numbers of early clinical exposures, mostly confined to exposures in family physicians’ offices and the popular rural week at the end of first year.
  - While this has improved in some subjects (e.g., MSK), students are frequently critical of the “subspecialist” perspective presented during lectures. For example, in their accreditation report, medical students comment on the lack of a generalist approach within “orphan courses” such as dermatology, ENT and ophthalmology.
- Clerkship
  - Aside from the family medicine and pediatrics rotations, there is a lack of outpatient exposures during the core clerkship.
Aside from family medicine, internal medicine and pediatrics, preceptor physicians primarily tend to be subspecialists.
- There is no specific rotation related to care of the elderly.
- While students have extensive elective time, most students dedicate this time to exploring their residency choices and increasing their visibility within programs of interest to them. In general, students do not choose electives within generalist settings unless they are interested in family medicine.

Literature Review:

A literature search was performed by a reference librarian using the terms “generalism,” “generalist” and “medical education.” “Generalism” did not capture enough articles, while the term “generalist” tended to bring a family medicine focus. Hence, the initial list was abbreviated by reviewing titles and abstracts, and eliminating articles that were of indirect relevance to the main topic. Articles were added based on a review of article references and the table of contents from their respective journal issue. Focus was placed on articles which defined a generalist physician; described medical schools with courses and experiences that promote generalism; or evaluated relevant outcomes for generalist physician training. Three or four articles were assigned to each task group member to review and summarize. These summaries were presented to the entire task group in written and verbal formats.

Defining “Generalism” and the Historical Underpinnings of the Specialist Model

Burke et al. (1994) define a generalist approach as the reasoning processes and management techniques required for the provision of comprehensive and longitudinal care, and which is often, though not exclusively, taught in an ambulatory setting. Recognizing the continued importance of specialty- and hospital-based clinical exposures in medical school, the authors propose better curricular integration to ensure a full range of clinical exposures, and the promotion of greater patient access to care and consistent follow-up.

Prislin et al. (2010) present the thesis that the physician community at the time of the Flexner report in 1910 was almost entirely comprised of generalists. With the proliferation of clinical specialties that accompanied the widespread adoption of the scientific approach to medicine and modern technological advances, they argue that physicians have “become masters of caring for diseases but have lost much of the art of caring for patients.” They propose “rebalancing” medical education from its excessive focus on disease management to a greater emphasis on health improvement.
Increasing trainees’ Interest in Generalist Careers

Schwartz et al. (2005) reviewed four evidence-based strategies to rekindle student interest in generalist careers which are summarized in this table:

<table>
<thead>
<tr>
<th>Table. Strategies To Increase Choice of Generalist Careers</th>
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<tbody>
<tr>
<td><strong>Improve satisfaction and enthusiasm among generalist physician role models</strong></td>
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<tr>
<td>Dramatically enhance reimbursement for cognitive services</td>
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<tr>
<td>Decrease clinical time pressure with more flexible and controllable schedules</td>
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<tr>
<td>Enhance the status and promotion of clinician-educators in academic medical centers</td>
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<tr>
<td><strong>Schools of medicine should redouble their efforts to produce primary care physicians</strong></td>
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<tr>
<td>Modify admission selection criteria to recruit students who are likely to enter primary care</td>
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<tr>
<td>Implement effective medical school curricula in primary care</td>
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<tr>
<td>Establish primary care “honors” or “scholars” tracks</td>
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<tr>
<td><strong>Facilitate the pathway from medical school to generalist residency</strong></td>
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<td>Direct training funds to schools with track records of producing graduates in primary care</td>
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<td>Develop or expand primary care fast-track programs</td>
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<td>Link choice of a career in primary care to loan forgiveness</td>
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<tr>
<td><strong>The U.S. government should increase funding for primary care research and research training</strong></td>
</tr>
<tr>
<td>Substantively increase investment in primary care research</td>
</tr>
<tr>
<td>Increase and assure funding for fellowship training in primary care</td>
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Linzer et al. (1994) review admissions’ strategies to recruit generalist-oriented students. They note that exposure to ambulatory care during training can increase the proportion of generalist graduates, by establishing satisfying patient and mentor experiences. Other interventions during medical school can include: 1) formation of generalist support groups, 2) reduction of inpatient clerkship rotations, 3) focusing on gathering and analyzing complex information to make medical decisions instead of rote mastery of knowledge, and 4) changing the perception of the generalist life style (with the perception being more work for less money and prestige).
Urbina et al. (1994) undertook a non-systematic review of innovative generalist programs. This included ensuring the “pipeline” is filled with high school and college students interested in generalist health careers, and modifying admission targets to include students from rural areas who commit to practicing family medicine in rural and underserved areas. In medical school, they recommend establishing early and sustained exposure to generalist role models and emphasizing ambulatory sites for training.

Obbard et al. (1995) reviewed medical student initiatives to promote the education of generalist physicians. These included generalism career days, lunchtime information session debunking the myths about generalist practice, and student-run community health clinics. They also suggested primary care apprenticeship programs for students wanting to pursue careers in medicine and summer work experiences in primary care/generalist settings in underserved areas. Lastly, they recommended student representation on committees that affect policies pertaining to medical education and a primary care curriculum.

Shadbolt et al. (2009) studied some of the determinants which influence medical students in choosing general practice as a career.
Intrinsic factors included:
1) Self-awareness: graduates primarily look for a career that is stimulating and interesting,
2) Gender: while females used to be more likely to enter family practice, lifestyle factors are equally important to both genders, and
3) Personality and personal goals/values: patient-centeredness and social orientation lead to a primary care preference.
Extrinsic factors included:
1) Family circumstances, which strongly influenced choice of a rural career,
2) Work-life balance: general practice was reviewed favourably, but some students didn't think it was “intellectual enough,” and
3) Flexibility: the opportunity to add a year of special interest training.

Structure and Evaluation of Medical School Curricula

Headrick et al. (1994) recommend teaching and learning methods to develop competencies needed by generalist physicians. These include supervised longitudinal patient care experiences, problem-based learning, and the use of standardized patients. These methods would foster teamwork, communication skills, medical interviewing and physical examination skills, and medical decision-making.
Most of the articles reviewed recommend a reduction of the inpatient component of clerkships because they tend to skew the perspective away from generalism. The corollary is an increased emphasis on clinical exposures in the ambulatory setting.

Rubenstein et al. (1994) present a non-systematic review on the evaluation of educational interventions designed to enhance a program towards generalism. While focused on postgraduate training, the recommendations are quite broad and could be applied to evaluate a generalist undergraduate curriculum. They recommend using a 6-point checklist to evaluate whether particular education strategies are effective in producing the desired result, i.e., more graduates pursuing generalist careers. They recommend that: 1) program goals and objectives should be explicit, and closely related to measureable changes in structure, process, and/or outcomes, 2) measures of structure, process, and outcomes used in the evaluation should be relevant to program goals, and evaluated for their performance characteristics (i.e., reliability and validity), 3) program interventions should be theoretically based, and that program materials and methods are documented, 4) data collection and sampling methods should be documented and justified in relationship to study questions, 5) analysis methods should be documented, continuously updated, and available for review, and 6) study results must be disseminated.

The Interdisciplinary Generalist Curriculum Project

The Interdisciplinary Generalist Curriculum (IGC) project was undertaken at 10 U.S. medical schools in the 1990s (see Scotti (2001) for an overview). It was designed to determine if a school-wide change in the curriculum in the first two years of training result in larger numbers of students entering generalist fields. The project did not answer the original question because: (a) the end of funding did not permit extension of the project until students entered practice, and (b) the confounding influences of managed care and rapid increases in enrollment, which caused teaching to be actively moved into outpatient settings for essentially all U.S. medical schools. The project, however, acknowledged that introducing generalist clinical experiences early in the curriculum is beneficial, and that professionalism and dedication to patients need to be explicitly taught. Other advantages included: 1) students being better able to identify bridges between clinical and basic science, and 2) earlier identification of students with communication difficulties.

The ICG project, published as a supplement in Academic Medicine (2001), included overviews of the IGC projects at 10 American medical schools. As an example, the Eastern Virginia medical school (Matson et al.) introduced a 2-year “Introduction to the Patient” course which incorporated material taught previously, and integrated the continuum of generalist learning through all 4 years. This collaborative process defined
the content and a comprehensive faculty development plan was created to ensure competencies were taught well. At the University of Wisconsin medical school (Skochlak, Thaler and Gjerde), faculty members from family medicine, general internal medicine, and general pediatrics worked together to develop the learning goals and provide the curriculum for the program for 1\textsuperscript{st} and 2\textsuperscript{nd} year medical students. Each student was matched with a community-based physician and they participated in early clinical experiences, spending 14 half-days with their preceptors. They also developed a traditional communication and clinical skills curriculum, and a core lecture series on professionalism, evidence-based medicine, and health care system organization.

In summarizing the IGC projects at the 10 demonstration schools, Skochelak, Barley and Fogarty recommended the following: 1) establishing broad buy-in across sectors of the school, 2) creating a team administrative structure that fosters participation by all groups, with central, rather than departmental, administration, and 3) requiring strong support at the highest levels of the organization, especially the medical schools’ deans. The article also states that working towards a common educational goal fostered collaboration between generalist departments. Osborn and Kotrady (1994) note that most academic medical institutions are geared towards supporting specialist and subspecialist physicians, even though generalists require a breadth of medical knowledge that is often greater, and becomes more important once training is complete. They focus on the organizational changes that would be required in moving to more generalist education.

Other UGME Programs:
Task group members were assigned external UGME programs to review for their approaches to the inclusion of generalism within their curricula. Information was gathered through interviews with program leadership, review of the program’s websites and/or additional documentation provided by the program. Eight programs in total were reviewed and presented to the group (See Appendix A for highlights).

A follow-up review was conducted on the Interdisciplinary Generalist Curriculum Project, described previously in the literature review. Additionally, leadership within the following organizations were interviewed:

- Canadian Undergraduate Family Medicine Educators (CUFMED)
- Canadian Association of Interns and Residents/PARIM
- Canadian Federation of Medical Students/MMSA

While there is some variance in activity, most of the reviewed programs have processes in place or in development, to increase the role of generalism. Arranged thematically, these initiatives include:

1. \textit{Major curriculum initiatives}
a. Major task force reviews on generalism or family medicine within the UGME curriculum
b. CUFMED development of an online National Shared Curriculum in Family Medicine (SharC-FM)
c. Development of the synergized CANMEDS-FM undergraduate learning objectives by the College of Family Physicians of Canada

2. Leadership and infrastructure for generalism initiatives.
   a. Formally appointed leads for generalism within the UGME leadership structure
   b. Centrally located, interdisciplinary UGME steering committees on generalism
   c. Department of Family Medicine representation on all course committees

3. Generalism building blocks within the curriculum (all four years)
   a. Use of spiral curriculum to revisit/develop generalist topics and themes
   b. Use of horizontal courses or clinical exposures throughout the curriculum
   c. Increased use of generalists as teachers at all levels

4. Resources
   a. Funding for a dedicated cohort of UGME family medicine teachers
   b. Increased funding for community based teachers

5. Preclinical generalism activities
   a. Processes for development and review of “generalist friendly” small group cases, including undifferentiated presentations and chronic care
   b. Mandating that all cases and lectures must be taught with a generalist perspective
   c. Expansion of early clinical exposures in the generalist, primary care and/or community setting
   d. Implementation of full courses in Family Medicine, including lectures, small group learning and clinical skills relevant to family medicine topics
   e. Continuity of care experiences (e.g., follow a particular chronic care patient regularly over the year)
   f. Use of logbooks and reflective exercises regarding generalist care
   g. Conjoint teaching by generalists/subspecialists and basic scientists

6. Clinical generalism activities
   a. Increased use of the outpatient setting
   b. Increased use of community/non-tertiary care settings
   c. Longitudinal integrated clerkships
   d. Fourth year courses on generalism
   e. Intersession courses on “core” topics embedded within the core clerkship
   f. Longer family medicine rotations
   g. Mandatory proportion of elective time in generalist settings
Unfortunately, evaluative outcomes for many of these initiatives are uncertain, either because they are early in development or no formal evaluative process was identified.

**Recommendations:**

Bearing in mind their defined outcomes, task group members drew on their gathered data to brainstorm potential recommendations specific to the U of M UGME curriculum. These ideas were collated and, through two iterations, members voted on their final recommendations in order to achieve consensus and a rank ordering of the most important concepts for consideration by the larger curriculum planning committee.

1. **Establish an administrative lead and steering committee for overseeing generalism initiatives in UGME.**

   As supported from the literature review and advised by task groups in other UGME programs, dedicated leadership and formal input from generalist educators will be necessary to successfully enhance the value of generalism within the UGME curriculum and facilitate teaching of the generalist approach.

   The steering committee must have broad faculty wide representation, and would include the lead, generalist educators from a variety of departments, representation from the department of medical education, residents and medical students. In consultation with and reporting to UGME leadership, it would be mandated to develop, implement and evaluate new learning activities related to generalism. As well, it would regularly review the curriculum to ensure generalism is appropriately represented and work with course directors to facilitate changes where required. Members also would play a key role in engagement of fellow generalists and other stakeholders. Appropriate infrastructure will be required from the Faculty of Medicine.

2. **Explicitly integrate generalist approaches to disease within the UGME learning objectives.**

   To ensure the specific objectives are met, the generalism steering committee should develop a horizontal generalist syllabus incorporating all relevant course activities, specific learning objectives and lesson plans through the four year program, “blueprinted” to relevant UGME objectives. The syllabus would also facilitate progressive development of the student through their training, through organization of increasingly complex concepts and cases.

   The UGME program learning objectives should clearly define what is expected of the learner by the end of their training. However, presently there are no objectives which reference generalism either directly or indirectly. Learning objectives should be developed to address both attitudinal domains (i.e. understanding and valuing the role of generalists) and cognitive domains (i.e. conditions commonly seen by generalists and
the generalist approach to disease). Explicit inclusion of these objectives will also demonstrate the value of generalism within UGME program and ensure that specific student outcomes related to generalism are identified.

3. **Develop a syllabus for all UGME educational activities related to generalism.**

In many programs (including the U of M), educational activities and opportunities related to generalism tend to be distributed across course and departments. With an increased emphasis on a “spiral” curriculum and longitudinal activities, a more formalized process will be required to ensure that all identified student outcomes are addressed.

A horizontal generalist syllabus should be developed incorporating all relevant course activities, specific learning objectives and lesson plans through the four year program, “blueprinted” to relevant UGME objectives. The syllabus would facilitate progressive student learning through organization of increasingly complex concepts and cases through the program. It would be developed and maintained by the Generalism Steering Committee in consultation with UGME leadership and other course directors.

4. **Develop a generalist ‘Master Teacher’ program.**

Part of the “hidden curriculum” is the prominence of specialist teachers during the pre-clerkship years, and the relative lack of generalist teachers during this time, except for clinical skills and problem solving sessions. To advance the visibility of generalist teachers, a Master Teacher program should be developed. Generalists completing this program would obtain the necessary skills and innovative teaching methods to ensure that they are prepared for the increased teaching responsibilities that would occur in pre-clerkship courses.

5. **Develop longitudinal early clinical experiences and reflective exercises in generalist settings.**

Currently, early clinical exposures are optional for pre-clerkship students, varying from half- or full-day shadowing experiences, up to 2 week clinical exposures with any physician, generalist or specialist. A program of mandatory, longitudinal early clinical experiences with generalist physicians should be developed. This would ensure exposure to the “generalist” approach to complement and balance the current system-based teaching which is predominantly taught by specialists. Ideally, this would pair generalist preceptors with one or two students on an ongoing basis. This course would result in better integration of clinical skills at an earlier stage, increase the visibility of generalists to students, and foster an approach to patient care that is both continuous and holistic. A curriculum of generalist concepts would be developed, to ensure a more structured learning experience. A mentored clinical casebook project (modeled on Harvard medical school) and reflective exercises after patient encounters would comprise some of assessment methods for this course.
6. **Increase the number of outpatient experiences during the core clerkship.**
Much of the current clerkship involves inpatient practice, with a variable amount of outpatient exposure, sometimes dependent on site and preceptor. Similarly, the latest accreditation report cited the electives component of the clerkship as a concern, which allows the student to choose more than elective in a specialty area, which may not include a significant outpatient component.

7. **Implement core clerkship intersessions which integrate teaching sessions on the generalist approach.**
There is a lack of integration during the clerkship, especially with respect to which core concepts are being taught and by whom. Clerkship rotations tend to operate independently, often without coordination of content delivery, teaching of clinical skills, or synthesis of cross-specialty information. An intersession between clerkship rotations should be introduced and could include such generalist topics as ethics, approaches to common patient problems and the undifferentiated patient, interprofessional education, critical appraisal, reflective work, and coping skills for the students.

8. **Develop and implement a four week “Introduction to Residency” at the end of Med 4, incorporating generalist clinical exposures and a summative review of the generalist approach to disease.**
It is recognized that there needs to be an improved process for transition from undergraduate to postgraduate practice. Akin to the “Introduction to Clerkship” (ITC), an “Introduction to Residency” (ITR) program could be introduced, integrating learning from the pre-clerkship through the clerkship years. Within the ITR, a summative review of the generalist approach to patient problems would be integrated within Medical Council of Canada Qualifying Part I exam preparation. This would include the approach to the undifferentiated patient, comprehensive care of patients, and managing patients with multiple medical problems. The program would also share features with the “sub-internship” that is prevalent in U.S. medical schools, incorporating a “selective” rotation in generalist settings such as general internal medicine, family medicine, geriatrics, general surgery, or general pediatrics.

9. **Develop and implement a program evaluation process for the generalism component of the curriculum.**
A process must be in place to determine if the UGME curriculum is successfully met outcomes related to generalism and to identify areas for improvement. Such an evaluation strategy should be developed by the steering committee in synergy with the broader UGME curriculum evaluation process. Specific assessment tools will be better defined once UGME learning objectives are defined as recommended previously. Potential evaluative instruments could include the use of student portfolios and
tracking systems, inclusion of generalist content within existing exams (e.g. the Comprehensive Clerkship exam or PBL exam), and review of cohort outcomes from MCC exams and CaRMS match results.

10. **Provide ongoing funding and infrastructure to enable the above recommendations.**

Sufficient funding will be required on an ongoing basis for teaching faculty and committee members. In case where faculty are drawn from the existing GFT pool, funding may be required to backfill the physician’s clinical commitments. Alternately, these faculty may need to be allowed to decant those academic responsibilities unrelated to the UGME program. Community based faculty will expect sufficient remuneration for their teaching time to make up for income lost. As well, secured administrative support, office space and funding for supplies and incidental costs will be required.
### Appendix A – Highlights of Generalism Initiatives in External UGME Programs

| University of Calgary | - Task Force on Family Medicine as a Career Choice in 2009  
| | o Multiple recommendations regarding curricular change  
| | o Increased numbers of dedicated UG FM teachers (and resources for same)  
| | o FM representation on all course committees  
| | o Review of seminar cases to ensure FM “friendly”  
| | o Longitudinal ½ FM curriculum  
| | o Longitudinal community clerkships |
| University of Ottawa | - Task Force on Generalism in UGME 2004  
| | o Increased use of distributed sites (urban and rural), “nodes” of teaching sites  
| | o Removal of “antigeneralism” themes from PBL  
| | o All PBL, cases, lectures from a generalist perspective  
| | o Increase use of generalist teachers  
| | o Spiral curriculum including chronic care/longitudinal cases/undifferentiated problems  
| | o Primary care sessions in each teaching block  
| | o Increased funding for FM/generalism  
| | o Increased use of FM for clinical skills, community based  
| | o Longitudinal exposures in 3 and 4 year  
| | o 4th year program in generalism  
| | o generalist selectives |
| Queen’s University | - “Foundations in Family Medicine” course in Block 1  
| | - Longitudinal exposures in 1 and 2 year  
| | - Intersessions on core topics embedded in core clerkship  
| | - Longitudinal community clerkship |
| UBC | - Family medicine course in first year  
| | - Longitudinal community clerkships |
| University of Toronto | - Generalism Task Force 2005  
| | o Generalism theme coordinator and implementation committee  
<p>| | o FM Longitudinal exposures in year 1 |</p>
<table>
<thead>
<tr>
<th>University</th>
<th>Longitudinal Exposures</th>
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<tbody>
<tr>
<td>Harvard University</td>
<td>- Clinical based longitudinal exposures in year 4</td>
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<tr>
<td></td>
<td>- Mentored clinical casebook project</td>
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<tr>
<td>Northern Ontario School of Medicine</td>
<td>- Strong emphasis on generalist teaching and topics</td>
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<td></td>
<td>- Longitudinal community clerkships</td>
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<tr>
<td>Memorial University</td>
<td>- Present curriculum similar to U of M</td>
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- Community longitudinal exposures in year 2
- Increased use of generalist tutors
- Conjoint teaching of generalists/subspecialists
- Increased length of FM clerkship rotation
- Increased emphasis on community based, generalist oriented clerkship rotations
- Mandatory 2-4 week community elective
Selected Bibliography


