Bringing Generalists to Global Health: a Missed Opportunity and Call to Action

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ABSTRACT

The credo of the generalist physician has always been the promotion of health for all, in every aspect: not just multiple vulnerable organ systems, but multiple social, cultural, and political factors that contribute to poor health and exacerbate health inequity. In recent years, the field of global health has also adopted this same mission: working across both national and clinical specialty borders to improve health for all and end health disparities worldwide. Yet within the Society for General Internal Medicine, and among American generalists, engagement in global health, both within and outside the USA, remains uncommon. We see this gap as an opportunity, because in fact generalists in America already have the skills and experience that global health badly needs. SGIM could promote generalists to global health's vanguard, with three core steps. First, we generalists must continue to integrate health for the vulnerable into our domestic work, generating care models applicable in low-resource settings around the globe. Conversely, we must also engage with and implement international ideas and solutions for universal access to primary care for vulnerable patients in the USA. And lastly, we must build platforms to connect ourselves with colleagues worldwide to exchange these learnings.

J Gen Intern Med
DOI: 10.1007/s11606-023-08573-x

INTRODUCTION

A career in general internal medicine takes many shapes, and attracts physicians from diverse backgrounds. But its core inarguably focuses on the myriad factors that determine adult health.[1–3] That integration studies the impact of social, political, and economic systems on patients' health, and the role that physicians can play in preventing and addressing these acute and chronic clinical challenges.[4] These values align precisely with the goal that global health, a field now reckoning with its colonial origins, also embraces: identifying and correcting the diverse structural causes of health disparity worldwide,[5] not least of which is a vast gap in funding and infrastructure to support health across nations and communities. And among the largest (and most rapidly-growing) causes of health disparities is a global lack of access to the adult chronic disease care that USA-based generalists provide.[6] Yet at our own Society of General Internal Medicine (SGIM) and beyond, gaps between generalists and global health engagement are all too common. We offer a perspective on the reasons for this separation, make the case for closing these gaps, and highlight three steps the generalist community can take to bridge the divide.

THE GENERAL/GLOBAL GAP

Academic generalists have shown steadfast leadership in fighting healthcare access disparities in local populations,[7] and SGIM has pledged to fight the root economic, political, and structural causes of these inequities at regional, state, and national levels.[4] Yet SGIM values statements still position it as an expressly American organization,[4] and SGIM's direct engagement outside the USA is limited. At present, all of SGIM's regions are zones of the USA, and SGIM's annual conference has been held in North America every year. SGIM's 75 active interest groups include only two focused expressly on global issues or perspectives[8]—despite many focused on health policy, social determinants of health, mobile health access, and other fields essential to global health practice. Similarly, of the 70 general medicine fellowships SGIM promotes, only one focuses on global health.[9]

In fairness to SGIM, however, generalists' uncommon participation in traditional "global health" activities, such as clinical practice in low-income countries, has broader, structural causes—especially in the USA. Medical students often lack opportunities for clinical rotations outside of their local training community; when available, these rotations compete with other priorities. There is limited time for global health education within medical school curricula,[10] and schools have limited funding to support domestic or international "away" rotations.[11] For post-graduate trainees, the American Board of Internal Medicine (ABIM) allots only three

Received October 22, 2023
Accepted December 5, 2023
Published online: 22 December 2023

months over thirty-six for nontraditional electives such as rotations outside the USA.[12] After this training ends, the new attending physician's professional and personal commitments—including financial debt, family obligations, and lack of training or travel time[13]—make work overseas harder than ever.[14] An early- or mid-career generalist who has never worked outside their home community might convince themselves they have nothing to offer to global health, and that it's already too late to change that.

GENERAL IS GLOBAL

But to conflate global engagement with international travel is a preventable mistake. In fact "global health" does not necessitate leaving one's own country, or even one's own community. A 2009 consensus definition instead agrees that

> "Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care".[15]

Therefore, any physician can and does do global health as soon as they (1) tackle health disparities; (2) provide integrated, multidisciplinary care; and (3) consider and act on the transnational aspects of their findings. Because fighting inequity and providing interdisciplinary care lie at the core of generalist medicine—and SGIM's vision and values[16]—countless general internists are already engaging in steps 1 and 2. We need only take step 3—and we need not travel to do so.

The global health community needs generalists at their forefront more than ever. General internal medicine is not the only physician specialty fighting inequity and working across disciplines—both values are central to all primary care, and any specialist can choose to embrace them too. But the epidemiology of global health in our lifetime has shifted the field towards not only the values of US generalist medicine, but also its unique subject matter. We focus on the complex care of the adult patient (a field encompassing countless specialties) while rejecting the premise that we must study any given specialty at the exclusion of others—because integration *is* our specialty.

But over the course of the past one hundred years, our unique focus has come to occupy the very center of global health. In 1990, the leading causes of disease burden worldwide were chiefly communicable diseases like diarrhea, measles, and tuberculosis, not unlike the USA one hundred years ago.[17,18] But as of 2019, chronic, non-communicable conditions such as cardiovascular disease, chronic obstructive lung disease, diabetes, and lower back pain have displaced these communicable conditions across the globe.[18]

These chronic conditions disproportionately harm vulnerable populations with unequal access to common, upstream protective factors such as healthy food, clean air, reliable housing, or regular exercise—and often concomitantly impact the same individuals.[19] For many, the concurrent emotional burden of poverty, racism, and unstable housing or employment exacerbates anxiety and depression—with tobacco, alcohol, and substance use associated with those conditions causing a vicious cycle of chronic illness in turn.[20] As a result, millions of low-income adults worldwide bear the strain of complex multi-organ pathology that hospitalists and outpatient generalists are trained to prevent and treat in the USA. Finally, exponential growth in human migration - motivated by economic opportunities in cities, or flight from conflict zones or climate crises -[21] further increases peoples' exposure to chronic disease risk factors.

THREE STEPS TO BRIDGING THE GAP

Because global health involves integrated care for the most vulnerable anywhere and everywhere—and because epidemiologic transitions have expanded the focus to include the care of adults with chronic, multi-system diseases, using interdisciplinary clinical and policy solutions—the general internists of SGIM fighting health disparities in the USA are not only already doing the core work of global health, they are poised to join its vanguard. We must share these lessons with our colleagues worldwide and, importantly, learn from their work in other contexts.[22] Failing to make these connections thus far is a lost opportunity—but also a reversible one. How can we bridge that gap? We propose three ways:

SGIM must integrate all our work with marginalized American communities, people, and places into the global discourse. The work of the general internist in their own domestic community is relevant to health concerns around the globe. But all too often we overlook this perspective in what we do both at SGIM conferences and in our daily lives. We orient ourselves to a public health problem with disease burden statistics and policy options from our own country alone—and as we seek (or overlook) solutions, so shall we find or miss them.

But ideas and interventions developed in one part of the world will not truly correct health disparities until they are available to all. The COVID-19 vaccines—whose access remains severely limited in low- and middle-income countries,[23] despite a US surplus—are a stark example. But so are tried-and-true interventions for chronic conditions. Peer coaching programs such as the Chronic Disease Self-Management Program (CDSMP) have helped those struggling with multiple chronic diseases to help their peers to hold them in check[24]—through guidance on how to set and keep lifestyle goals. As an organization uniquely focused

on evidence-based care innovations in general medicine, SGIM should conference and collaborate with academic and governmental partner organizations in other parts of the world to expand such initiatives. And individual clinicians and researchers at SGIM can support this work both by presenting their domestic learnings at these meetings and through their task forces. Lastly, SGIM's advocacy for vulnerable populations should also include increased American funding for chronic disease control worldwide—to close the financial gaps behind global health outcome disparities. The Noncommunicable Disease Alliance, a global civil society network, could be a strong partner.

Conversely, SGIM must bring lessons from overseas back to American communities to tackle nearby inequities. We generalists are trained to see the health system—like the human body—as an integrated whole. For those of us from the USA, that perspective reveals the waste and injustice in the world's most affluent nation actively refusing to adopt universal access to free healthcare, due to a matter of principle rather than a resource gap, and therefore spending far more on healthcare per capita as a result.[25]

The USA's consequently fragmented primary care system has much to learn from other settings—for instance regarding how nurses, pharmacists, and even volunteer community health workers can fill the provider gap left by a paucity of primary care physicians and clinics. Care models developed in Iran (the Behvarz worker),[26] India (the Asha worker),[27] China (the barefoot doctor),[28] and Costa Rica (the asistente técnico)[29] empower these providers to prevent and treat chronic conditions ranging from hypertension to depression to HIV and AIDS. Generalists who have worked outside the USA need platforms like SGIM to better disseminate the lessons they've learned, a process known as reciprocal innovation.[30] SGIM researchers, leaders, and providers should incorporate these care models and their findings into research papers, clinician training programs, and advocacy work to close health disparities for chronic diseases in the USA. By integrating global learnings in its domestic positions and affairs, SGIM can contradict the narrative that international partnerships are a unidirectional (and hence, arguably, colonial) attempt only to impose its own beliefs worldwide.

Build platforms for all aspects of generalist medicine—research, teaching, and patient care—that bring together local and international solutions to health disparities. The two halves of global health—local and worldwide inequities—will only come together when communities of generalists insist on welcoming them to the same fold. We need individuals and institutions to build that bridge of inclusion for global health perspectives from all regions of the world. This community includes not only general internists per se—a term most common in the USA and Europe[31]—but like-minded generalist physician and non-physician providers worldwide—including nurse practitioners, physician assistants, and community health workers.

SGIM should represent global perspectives in all activities—not only in its designated global health interest groups. To make this diversity tangible, it needs to ensure global partners have seats at the right tables. SGIM's legacy of fighting systemic racism and other root causes of health inequity could make it a powerful advocate before the United Nations—whose 2025 General Assembly will center on chronic disease. But SGIM should also offer travel bursaries to members from low- and middle-income countries to attend the annual meeting, and thereby recruit a global membership. In time, SGIM could relocate regional and plenary conferences themselves to regions outside the USA—to further focus thinking outside national borders.

CONCLUSION

The gap between how much global health expertise internists have, and how little global health they do, is an irony but also an opportunity. Global health is nothing if not integrated care for all persons who lack access to it—exactly the system-based thinking that generalists are trained to embrace. And as the global burden of disease shifts from children to adults, and from acute to chronic conditions, our focus as internists on managing the complexity of these conditions has never been more relevant. We general internists are poised to lead the fight against these health disparities worldwide—and SGIM can and should play a leading role.

Acknowledgements: *We thank Dr. Preston Reynolds, Director of SGIM's Global Health and Human Rights Interest Group, for her review, feedback, and endorsement of this article.*

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Data Availability *A data availability statement does not apply to this manuscript, as it is a perspective piece rather than a research article.*

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