The case for and against subspecialization in family medicine

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Family doctors take pride in delivering a broad range of services to varied populations; however there are challenges to this strongly held view. Robert Heinlen argued in favour of generalism, saying that that a competent person should be able to (among other skills) "change a diaper, balance accounts, set a bone, comfort the dying, take orders, give orders, cooperate, act alone, solve equations, and analyze a new problem". His punch line is that: "Specialization is for insects."[1] Heinlen's list could well apply to some of the skills we need daily in family practice.

The opposing view is expressed in the growing trend in many places for subspecialization among family doctors. It is worth examining the arguments for and against this position so that we can make wise individual decisions in our careers. This can also help us to chart a prudent educational and political course for our profession.

The rise of specialization in medicine dates from the early 20th century in the United States with ophthalmology and pediatrics achieving recognition as the first medical specialties with their own examination boards and qualifications.[2] The split between medicine and surgery as distinct professions goes back earlier, to the Middle Ages. Medicine was a learned profession that belonged in the University, while acts like surgery and bone setting were practiced by tradesmen and barbers.

The rise of academic family medicine in North America, the United Kingdom, and continental Europe in the 1970s put the generalist philosophy of comprehensive care on the table as a core value. Other core values include continuity, communication, community context and coordinated care, together with comprehensiveness, known as the Five C's of Family Practice. We have challenged the value of some of these axioms in previous editorials (continuity of care and the family orientation, for example) and will continue to do so, to prevent testable hypotheses from becoming religious beliefs.

The American Academy of Family Practice now lists 28 subspecialties in which additional fellowship training is possible for family doctors at the end of specialty training.[3] These include the care of patients fragmented by age, (adolescent or geriatric patients), by gender (women's health), by organ system (dermatology), by practice location (intensive care, emergency room, or rural medicine) or by the patient's occupation or hobby (sports medicine). There is a similar trend in Canada with emergency care and geriatric medicine as the two most prevalent programs offered in all 17 residency training programs across the country, in an additional year of training.[4]

There are many forces that may lead a recent graduate to seek solace on the path of subspecialization. One is that there is just too much to learn to be a good family doctor. By focusing on a limited area of interest (such as sports medicine or the care of adolescents) a doctor can hope to gain some sense of control of the body of knowledge and skills required to practice.

Other forces are economic. In fee-for-service payment schemes, a subspecialty focus may be tied to lucrative procedures. This is less of an issue for our readers working for a salary in the National Health Service, but it certainly drives family doctors in other countries to learn endoscopy, outpatient surgical techniques, and even laparoscopic cholecystectomy.[5]

Some do it for love of learning or the craft. An intellectual interest in a given area may lead a family doctor to pursue a hobby towards a higher degree and subspecialization in that field. We all know colleagues in general practice with a special interest in respiratory

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medicine, dermatology, or mental health. With a team member like this in our family health unit, our patients can benefit from consultation with these 'specialoids' and we can certainly learn a lot from them.

Some family doctors may limit their practice out of fear. High malpractice insurance premiums and frightening damage settlements have led many family doctors in the US to abandon intra-partum obstetrics in their careers, even though this is part of their training.

Limitation of practice is also a kind of specialization. A dislike of a particular aspect of care may lead practitioners to say: "I don't do that." The Portuguese health care system actively encourages certain activities with pay for performance incentives. That is an offer that is hard to refuse. However it can lead practitioners to delegate activities that they prefer not to do.

Rural isolation may lead GPs to broaden their interests include to a wide range of services required by their population. It can also cause them to focus of specific techniques, which may be hard for their patients to access. In over-served urban areas, GPs may hone a skill, which makes their services attractive.

My own career has taken a turn towards electronic counselling in recent years.[6] This is partly based on a need to maintain clinical contact with a distant population but it also reflects a growing academic interest in counselling as a core skill of the family doctor. It has also become a fruitful research interest. Subspecialization by family doctors can be the product of all three factors.

Critics of subspecialization have produced compelling evidence why we should not follow this path.[7] Specialty focus leads to fragmentation of care. The patient may be seen as a diseased system, organ, or tissue rather than as a whole person. This can lead to over-investigation, over-diagnosis, or overtreatment because of loyalty to the specialty by the practitioner. Coupled with this are rising costs and increasing risks of adverse effects of tests and treatments without measurable increases in health.

A compromise may be found in the approach that supports the continuing professional development of family doctors with a special interest or special focus rather than promoting certified subspecialists with a limited practice profile. By maintaining our generalist orientation, we can continue to give the high quality service needed and valued by the public. We can also provide our patients and our colleagues with special, limited services when needed.

Our professional associations, colleges, training schemes, medical schools, health care administrators, and the general public need to hear our message. Comprehensive general practice is good for the country. There is also room for specialized knowledge and skills implemented by well-trained family doctors in special cases. We encourage you to do the research and produce the data needed to prove or disprove this point. We will be happy to publish the results of your research in our journal.

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CONFLICT OF INTEREST

None

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