Specialisation has sidelined the internist

Specialisation in medicine has been a virtually inexorable trend for many years. Originally, the specialisation possibly started in the United States, as progressive separation of obstetrics and gynaecology, paediatrics, internal medicine, surgery and its superspecialties, from general practice. The first US speciality board (ophthalmology) was established in 1917, followed shortly by a dozen other specialities, including the American Board of Internal Medicine in 1936 and the American Board of Surgery a year later. The American Board of Medical Specialities added its 24th sub-head, the American Board of Medical Genetics, in 1991. This Western trend has been gradually seeping into other countries including India. Such super-specialisation has been necessitated by the explosion of new knowledge coming from the amazing discoveries and developments in biomedical research. Another stimulus for super-specialisation has been the view that the future of clinical practice lay in super-speciality expertise, and that an internist would lose capacity to manage serious or complex diseases as the knowledge base of clinical medicine continued to expand.

What is wrong with specialisation?

With growing sophistication of technology, the super-specialists have become increasingly dependent on technology/instruments to make a diagnosis. This has, unfortunately, led to clinical medicine taking a back seat. This has also made therapy more expensive, more tedious and more inhuman. So, when a middle-aged male comes with chest pain, he undergoes a haemogram, full biochemical profile of renal and liver functions, ECG, TMT, X-ray, echocardiogram, angiography, CT scan and so on, and still the diagnosis of dry pleurisy is missed. Or, when a 65 years old male reports to an orthopaedic surgeon for low backache, he undergoes CT and MRI scans, a referral to the rheumatologist, and even a disc surgery, while the actual diagnosis (multiple myeloma) is left for an internist to pick up later. Old clinicians’ tools such as history taking, physical examination, and thoughtful analysis are gradually being consigned to history as these are considered inefficient, inaccurate, and time consuming.

Super-specialist practice contributes to fragmentation of patient care and diffusion of responsibility. Super-specialist care is also more costly than generalist care, tends to involve greater use of technologies and results in referrals to additional super-specialists for difficulties outside the expertise of the referring specialist, leading to cost escalation. The cost issues have come under increased pressure in recent years with the emergence of managed care in the USA, and institution of the gatekeeper mechanism for limiting access to specialists. Even for us in India, time has now come to analyse the role of an internist in this era of super-specialisation.

Clinical medicine and the internist

No amount of technological sophistication can replace information derived from history and physical examination. For example, occupational history may provide essential clues to the correct diagnosis. Insights into the cause of a patient’s persistent fever might lie in knowing the patient’s lifestyle or occupation: the source could be endocarditis in an intravenous drug user or tularaemia in a rabbit hunter. In a painter, one thinks of lead intoxication or chronic alcoholism, but an additional disorder that may be more relevant for fever is histoplasmosis, because of extensive exposure to bird (probably pigeon) droppings.

Need of internists in the era of super-specialisation?

The crisis in medical care due to the growing super-
specialisation has been a subject of intense debate in the US. The Federal Council for Internal Medicine has considered it a national need to lay stress on the role of internists. The question relevant to our country is not whether specialisation should be resisted, but whether there remains any room for the generalist.

Who is an internist? The website of American College of Physicians proclaims that an “internist” is not an “intern.” An internist is a fully trained specialist who practices “internal medicine.” An intern just finished medical school and is learning how to be a doctor. A better definition has been given elsewhere: “the master clinician is the internist, the diagnostician, the doctor trained in the basics of super-specialties of medicine, someone totally familiar with the heart, the lung, the bowel and the kidney, someone trained to decide if a skin problem is the result of joint disease, if the murmur might represent cancer, someone who understands the aged, knows when to welcome death and when to fight, knows both to hold a hand and pound the chest, someone able to step beyond the boundaries of an organ system, or a technique, into the realms of diagnosis... his or her gift for diagnosis flows from a sound knowledge of science of super-specialties and from the art of the medicine.”

Even the UK has been debating the need for internists. While some authorities suggest that specialisation is an irresistible force and it has brought considerable advantages in the way we care for patients, the merits of such thoughts have been strongly refuted by some papers. The main arguments for persisting with general physicians have been that:

- Some physicians need to be able to handle the wider spectrum of emergency medical admissions. It has been shown that many acutely ill patients are managed well by general physicians.
- Patients presenting with vague symptoms benefit from the skills and knowledge of physicians who have retained a general approach.
- There is no proof that super-specialisation always results in better outcomes for patients. Data from the literature do not support the idea that centralisation of treatment of patients with solid cancers per se leads to improved results.
- Problems such as boredom, poor undergraduate teaching, high surgeon to patient ratio, high cost, and insufficient cover for emergencies may arise with super-specialisation. Attempts to follow the Western, metropolitan organisation of surgery have impaired surgical service in developing countries.

Who manages emergencies better: a super-specialist or an internist?

India has followed the British pattern of doctor's duty rotation. Physicians, who practice a super-speciality, have to maintain their general skills and knowledge and share general physician call rotation. Few consultant physicians practice purely general medicine. Proponents of super-specialisation harp on the point that acutely ill patients are best treated by a doctor who specialises in their condition, but the evidence for this statement is not clear-cut. It is true that patients with asthma or with gastrointestinal haemorrhage may do best under the relevant specialist. Such benefit, however, has not been shown for disorders where the diagnosis is less clear at presentation. In a recent study, employment of general practitioners in accident and emergency departments resulted in reduced rates of investigations, prescriptions, and referrals. This suggests important benefits in terms of resource utilisation, but the impact on patient outcome and satisfaction needs to be considered further.

Super-specialist care is not only more costly than generalist care, but also less satisfying for the patient, due to compartmentalisation. Moreover, when the patient comes to the casualty, it is not always possible to identify the relevant speciality straightaway. It needs clinicians who understand a wide range of specialities. An alternative strategy would be to have every super-specialist available round-the-clock, to be able to deal with acute problems arising from any system. The latter is not only impractical at present but also full of additional problems. A patient being looked after by the “wrong” super-specialist is likely to be poorly managed. With a greater the degree of specialisation within the system, the staff will see fewer patients from “alien” specialities and thus run the risk of atrophied generalist expertise.

Problems in India

Rural India, like many of the developing countries, suffers the
plight of having few doctors, fewer generalists (general surgeons and general physicians), and still fewer super-specialists, (a good proportion of the latter having migrated to the developed urban world). A poor referral system, private practice by professionals, and lack of a supporting network of General Practitioners encourage self-referral towards generalists and specialists. The result is a chaotic system with much inefficiency. Given the situation, we need to reevaluate our norms based on the above contextual factors, instead of borrowing figures and ratios of human resource needs from the developed world. We need more generalists than specialists, and generalists with special interest rather than super-specialists and more super-specialists. Researchers and policy makers who focus their attention mainly on the developed West, often forget this aspect.

What should an internist do?

An internist needs to keep himself updated. Habit, local practice patterns, and product marketing are strong determinants of the way we practice. Controlled trials have shown that traditional continuing education has little effect on combating these forces and changing doctors’ behaviour. Approaches that do change targeted clinical behaviours include one-to-one conversations with an expert, computerised alerts and reminders, preceptorships, advice from opinion leaders, and targeted audit and feedback. Other effective strategies include restricted drug formularies, financial incentives, and institutional guidelines.

Over the centuries, physicians have believed that medicine should be at once dispassionate and compassionate—scientific (that is, evidence-based) to the extent permitted by knowledge and, characterised by a sense that the knowledge is incomplete. Thus, an internist must cultivate four attributes:

- Sensitivity in response to human suffering and vulnerability.
- Scientific approach (evidence based).
- Realisation that the priorities of the state and of society must flow from priorities of concern for the individual rather than the reverse.
- Ideas of equity and fairness should be tempered by the knowledge of variations in health status and access to medical care in different populations.

A word for health planners

Today, the doctors are rushing to become super-specialists because the latter is perceived to have better “market value.” After M.B., B.S., a doctor undergoes rotating internship for one year, followed immediately by M.D. (Medicine) – a 3 year course. Then he rushes to become a super-specialist by enrolling for another 3 year course for D.M. Between M.D. (Medicine) and D.M., he has no clinical experience of managing patients belonging to other specialities. Most senior physicians feel that a thorough grooming in internal medicine is very essential to become a super-specialist. It is here that the health and medical education planners have to step in. Lack of experience is the reason why a neurologist sends his patients to an endocrinologist for diabetes, to a cardiologist for hypertension and early CCF, and to a gastroenterologist for drug-induced dyspepsia. There is also a tendency among the affluent and the powerful ones to directly approach a super-specialist instead of an internist or the family physician. Such people may possibly demand multiple referrals to get the best possible care but all they get is fragmented care, where medicines given by one super-specialist will often have adverse interaction with those given by another super-specialist because none of the super-specialists have the time or inclination to see what the other super-specialist is prescribing. A code of conduct for referral also needs to be developed.

The internist is here to stay. Instead of wishing him away, he should be made the indispensable pivot around which the patient care should revolve. His status should be enhanced. He should be the primary care physician of a given patient, and he should choose when and whom to refer a patient, should the need for a super-speciality consultation crop-up. The other side of the coin may also merit some consideration. The super-specialist’s knowledge of internal medicine should not be allowed to atrophy. He should be able to deliver the treatment for uncomplicated disorders like hypertension, diabetes, IHD, and commonly encountered infections. He can continue to do internal medicine called duties by rotation, as is being practiced today in many institutions.

Conclusion

A more general approach of an internist is optimal in the
identification of newly presenting disorders and poorly defined symptomatic syndromes. As the Indian population ages, an increasing proportion of individuals will have diseases in multiple organ systems that will require simultaneous medical management. There will be greater need for coherence in clinical care and for someone to make nuanced judgements concerning clinical priorities, including when to exercise technologic restraint in clinical management. Even in the future, it appears unlikely that “teams of specialists can be on duty all the time and will learn to collaborate effectively in sharing individual patients’ care.” All will agree that patients do not wear a diagnosis on their foreheads; diagnosis can best be made by a good general internist with skills in physical diagnosis.

Often a question is asked, “Is general medicine too broad a discipline, too hard to master?”

This is best answered by saying, “Is life?”

References
