Bridging the Gap between Physician Specialists: A Role for the College of Physicians, Singapore

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The rapid growth of new medical knowledge, and the drive toward increasing specialisation and sub-specialisation, are closely related aspects of modern medicine. Specialisation and sub-specialisation allow the individual doctor to have depth of understanding in a specific condition or organ system, and to concentrate the patient volume that favours technical skill, service efficiency and clinical research, all of which in turn drive medical discovery and further sub-specialisation.

Increasing medical knowledge and specialisation/sub-specialisation clearly benefit patients. Clinical outcomes are better when patients with a serious illness, such as myocardial infarction, are cared for by specialists.[1,2] However, specialisation and the exponential growth of medical knowledge have also raised several new issues.

From the training standpoint, the expansion of the medical knowledge base has made it harder for every trainee to become fully trained in every aspect of internal medicine. In Singapore, there are 14 specialties in internal medicine and the advanced training period for each specialty is hitherto 3 years. If one were to attempt (foolishly) to fully train in an overlapping manner in just 6 specialties, 2 at a time, the shortest duration would surely exceed 10 years. Unsurprisingly, then, there appears to be a trend toward shorter training programmes and earlier specialisation in some countries.[3]

For Singapore, the Advanced Specialist Training programme for the more "general" internal medicine has recently been shortened from 3 years to 2 years. In fact, the emphasis of the training in Internal medicine is not to make a General Physician a "super" specialist, but to ensure that the physician gains the necessary skills to manage undifferentiated medical conditions, handle medical emergencies, and decide when to refer patients to specialists in other specialties within internal medicine.

Even after obtaining certification in a particular specialty, specialists can remain "general", but can continue to further "sub-specialise". For example, a qualified neurologist may further sub-specialise in cerebrovascular disease, epilepsy, movement disorders, or neuromuscular disorders; similarly, a cardiologist in electrophysiology, interventional cardiology, echocardiography, and so on. Practising specialists thus have to decide whether they should stay as "general" specialists or become sub-specialists in their respective fields.

One concern from the above mentioned specialisation and sub-specialisation relates to the fragmentation of, and declining interest in, general internal medicine.[4] In the hospital setting, patients often present with complex multisystem disease, and a strong Internal medicine department is invaluable for both service and training needs. Ideally, a certain amount of expertise and a broad knowledge base should ideally be maintained for all specialists.

From the patient's perspective, increasing specialisation and sub-specialisation may mean multiple clinic visits to different specialists if they have more than 1 medical condition. Ideally, the patient's family physician should be involved in managing all but the more complex problems, but it has been observed that "primary care" is sometimes provided solely by a specialist.[5] As an example, patients with an acute illness such as stroke or myocardial infarction often have concomitant conditions such as diabetes, renal impairment and anaemia. Should all such patients be referred to different specialists? Having a low threshold for referral increases costs and inconvenience for the patient, and contributes to the fragmentation of care, but if the patient is not referred, how confident is the primary specialist that the management of conditions outside his area of expertise is optimal and reflects the latest best practice?

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To address this question, we need to look at how specialists keep up with their continuing medical education (CME). Although the pace of medical progress means that there is more to learn, the resources for medical education have never been better. There are many websites competing to offer instantaneous on-line CME. Regularly updated evidence-based summaries of medical literature are now widely available, although costly. All these options augment the conventional CME sources such as medical conferences, journal club meetings, and commercially sponsored lectures.

Whereas there is no shortage of learning opportunities, however, much of it is increasingly focused along sub-specialty themes. This focus is expected, since medical meetings are often organised by specialist societies, and clinicians are naturally more attracted to conferences tailored to their specialty. The more specialised the physician, the more likely this is to be true; reflecting the desire of the expert to improve in his own specialty or subspecialty, and the confidence that the time investment will yield returns. Meetings for general internal medicine are increasingly poorly attended.

Another concern is that if we allow Internal medicine to further fragment into separate component disciplines, we might lose our identity in organised-holistic medicine. However, further sub-specialisation is an inevitable part of medical progress. Thus, many challenges face us. One challenge is not how to limit specialisation, but how to maintain the connection that ties us together as a specialty called Internal medicine. From the individual specialty's viewpoint, the converse challenge is how to advance the practice of sub-specialties within each specialty, while maintaining the fundamental integrity of the specialty. Another challenge is to determine what specialists need to know outside their areas of expertise.

This is where the College of Physicians of Singapore, and its respective Specialty Chapters, could play a pivotal role. The College will continue to encourage specialisation while promoting the practice of, and sustaining interest in, general internal medicine. The Specialty Chapters will continue to encourage sub-specialisation, while promoting the integrity of their respective specialties. In addition to supporting CME meetings organised by specialty Chapters and/or societies, the College could develop CME activities that are tailored to address the issue of what constitutes core general internal medicine knowledge for the more specialised physicians.

Likewise, Specialty Chapters could aim to regularly identify the latest developments in all subspecialties that are relevant to all those specialists of their Chapter who are *not* sub-specialists in that area. In particular, new developments that significantly alter best practice for common medical conditions should be highlighted. It is important to simplify the delivery of such knowledge in a concise format that will attract all physician specialists to voluntarily keep updated outside their usual area of interest. Web-based CME activities are an example of this approach.

All physician specialists should recognise that updating themselves in general internal medicine is a crucially important component in maintaining our competency to deliver the best holistic medical care for our patients. Working together, we in the College can help to bridge the gap between all physician specialists in Singapore.

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