The Overlapping Roles of Primary Care Physicians, General Specialists and Sub-specialists

Research Questions:

From the perspective of determining the most efficient utilization of physician resources in the healthcare delivery system,

1. Is there adequate definition of the most appropriate boundaries of activity between three broad groups of physicians:
    a) primary care physicians,
    b) consultant specialists who are "generalists",
    c) consultant sub-specialists?

2. Are educational institutions fulfilling a social responsibility to:
    a) train an appropriate number and mix of primary care physicians, general specialists and sub-specialists,
    b) ensure that the content, training environments and working relationships are relevant to current and anticipated future needs?

Background:

Before determining the most appropriate interactions between physicians and other professionals in the health care delivery system, it is important to better define the relationships of the various segments of the medical profession with one another. Failure to do so compromises physician resource planning within a well-integrated system..

As current medical students choose careers, they appear to be drawn away from primary care towards specialization, and increasingly to sub-specialization. The factors that contribute to this trend range from one extreme of concern solely with lifestyle and remuneration to a more altruistic fear of being unable to maintain competence in a broader field of medicine. It may also be influenced by an increasingly knowledgeable public that seeks access to the most "expert" opinion for their particular health problem. This trend toward sub-specialization, while meeting some legitimate needs, is nevertheless aggravating shortages of both primary care physicians and "general" specialists.

Such an imbalance between the numbers of primary care physicians, "general" specialists and sub-specialists creates difficulties in smaller regional communities that require general specialist services, but are not large enough to support or satisfy a sub-specialist. Problems also exist in larger urban centres where sub-specialists tend to gravitate. Here the care of individual patients may become increasingly fragmented among these same sub-specialists. As a result, many patients become uncertain of the identity or role of a primary care physician. In addition, referring primary care physicians are frustrated by the need to communicate with an increasing number of "specialists" in the care of a single patient.

An interesting component of this topic is the unique situation in the USA where physicians who have trained in Internal Medicine and Pediatric specialty programs provide a substantial segment

of primary care. Are these individuals in a complementary or competitive relationship with primary care physicians trained in Family Medicine programs? Though general internists still function primarily as consultants in other countries, the issue is surfacing in a different format where an increasing number of sub-specialists are being perceived as primary care physicians by patients who require their skills for a very specific problem. Examples include Infectious Disease physicians caring for patients with HIV/AIDS, nephrologists looking after patients on dialysis, or others who attend an increasing number of subspecialty clinics. When such patients confront their sub-specialist with problems (sometimes minor) outside the latter's specific area of expertise, there seems to be an increasing tendency for referral directly to another sub-specialist without involving the family physician who is often left "out of the loop". This tendency towards increasing fragmentation of care may not only reduce the stature of family physicians, thereby contributing to the declining interest in the discipline, but also contribute to increasing costs.

While the major areas of concern are in the broad fields of General Internal Medicine and General Surgery, the problem is also beginning to emerge in other surgical specialties, psychiatry and radiology where a similar trend away from generalism is emerging. Many training programs have developed a culture where the better residents are strongly encouraged to sub-specialize. As this becomes the "trendy thing to do", the net result is an aggravation of the shortage of primary care physicians and general specialists.

The above issues relate to the social responsibility of postgraduate programs to produce the appropriate numbers and types of physicians required to function in a well co-ordinated health care delivery system that is inclusive of all legitimate health professionals and designed to most effectively meet the needs of all the public.

Directives to Authors:

Authors are asked to address the general issue of practice patterns and inter-relationships among primary care physicians, "general" specialists and sub-specialists from the perspectives of:

a) public access to both primary care and specialist/consultant services,

b) trends toward sub-specialization among residents in various "general" specialty postgraduate training programs,

c) the extent to which access to consultant services influences the scope of practice of primary care physicians,

d) trends toward Family Medicine training among graduating medical students,

e) duration and content of Family Medicine training,

f) the extent to which the content, culture and location of postgraduate training environments reflect the various working environments for which their residents are being prepared,

g) the extent to which remuneration and lifestyle influence career choice and work pattern, and

h) amount of primary care done by specialists and sub-specialists.