SPECIALISTS AND GENERALISTS: BRAVING A NEW COMPACT

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The call has gone out to young doctors to train in generalist disciplines.[1] Residency places for family medicine (FM), advanced internal medicine (IM) and geriatric medicine have increased in recent years while intake for the traditionally less generalist disciplines have shrunk.

This is a good time to ask ourselves some questions. What makes a specialty? Who is a generalist? If I am not a generalist, am I a specialist? What, exactly, is a specialist? Is everything a dichotomy?

Training as a requirement for specialisation

A medical specialty is a branch of medical practice. It is characterised by participation in advanced professional study and by passing an examination administered by senior members of the specialty.[2]

In 1987, the Senate of the National University of Singapore recognised FM as a medical discipline. In the ensuing years, a framework which encompassed a defined training curriculum and structured assessment with practice, training and research components was developed. This framework spans from undergraduate through advanced postgraduate levels.

The various post-MBBS qualifications in FM are pegged[3] to different levels of mastery on the Dreyfus model of skill acquisition.[4] This model describes skill development along a continuum from novice to expert. The Graduate Diploma in Family Medicine, the Master of Medicine, and the Fellowship, following advanced postgraduate training, are set at "competency", "proficiency" and "expert" levels, respectively. Since 2014, fellows of the College of Family Physicians Singapore have been admitted as fellows of the Academy of Medicine, Singapore. One could say that FM meets the definition of a medical specialty.

Until recently, doctors who were specialists and doctors who were non-specialists formed two neat groups demarcated by the Specialist Accreditation Board (SAB). The Singapore Medical Council (SMC)

lists 35 accredited specialties and five accredited subspecialties.[5]

FM is not listed as an accredited specialty. Ironically, FM is an accepted feeder discipline into three of the five subspecialties, viz. aviation medicine, sports medicine and palliative medicine.

Who is a generalist?

The SMC does not define a generalist.

What is generally accepted, however, is that the generalist is the doctor who is not organ-defined; hence the general physician, the geriatrician and the family physician. Clearly, these doctors have undergone structured training and appropriate assessment to get to where they are, and they practise with a clear ethos of their chosen discipline. IM and geriatrics are recognised specialties, and we have seen that FM is de facto a specialty too.

Perhaps it is time to recognise that the old dichotomy is flawed. The generalist is not distinct from the specialist. The generalist, dedicated to the whole person, rightly is distinct from the doctor who focuses his practice on specific organs or body systems.

What makes a specialist?

Does training in a discipline and passing the prescribed examinations make one a specialist? This has been the traditional view. In Singapore, we have the added assumption that the training is focused on specific organs or body systems, or specific skill sets, for example, respiratory medicine or orthopaedic surgery.

In 2011, Singapore embraced the American residency system. New terms entered our lexicon: core competencies, milestones and competency-based training. (Note that competency here refers to the ability to do something, and differs from Dreyfus' competency, which describes a stage in skill acquisition.) Today, a doctor successfully exits residency when he has demonstrated that he has fulfilled the core competencies and passed the relevant examination.

For some residencies, the five or six years of training are divided into basic residency and advanced residency. For example, IM residents complete their basic training in three years, following which they embark on a further period in other training such as renal medicine, cardiology or advanced IM. They may then apply for accreditation by the SAB and registration under their specialty by the SMC.

FM is a three-year programme, following which the doctor may embark on training in palliative medicine, sports medicine or aviation medicine, or the two-year advanced programme in FM. If one trains in any of the first three subspecialties, one may then apply for accreditation by the SAB and registration under the subspecialty.

We propose that the Dreyfus model of skill acquisition may be a useful reference. For FM, the doctor who completes advanced training has been trained to the expert level. It is cogent to consider the family physician with advanced training the equivalent of a specialist in FM.

Quo vadis?[a]

Beyond the specialist-generalist discussion lies other questions.

Jonathan Glass reminds us that medicine, for much of its history, has been about the pursuit of excellence.[6] Today's paradigm is the pursuit of competency in medical education. Perhaps technology, statistics and complexity have so irreversibly altered our landscape that competency alone can deliver the number and skills that we need. Is this the age of the medical technocrat?

What makes the true expert? Intuitively, we recognise genuine mastery as a combination of training and experience. Long practice and faithful application cannot be easily fitted into five or six years. This may be especially true when a specialty is not limited to a body system, but encompasses the whole person. Let us be careful lest we produce many doctors who are qualified generalists or specialists, but who fall short of wisdom. ◆

Note

a. Latin for "where are you going?"

References

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