On Specialization
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We general internists tend to have a love-hate opinion about focus or sub-specialization within our specialty. When I meet with younger faculty regarding career development, they frequently tell me that one of the reasons they went into general internal medicine (GIM) is the breadth of the field and its emphasis on caring for the whole person. And yet, as I typically advise them, it is difficult to have a successful academic career without some degree of focus. I will argue below that a certain amount of focus can improve clinical care as well.

GIM investigators learn quickly that they must focus on a specific area in order to successfully compete for grant funding and to have a sufficient knowledge base to conduct novel research. The focus area might be a disease area (heart failure quality of care) or a methodological area (improved communication methods), but it should be there. Focus is important in other areas as well. Most general internists who focus on medical education eventually concentrate most of their educational innovation in a specific area, such as the undergraduate curriculum, the graduate curriculum, or team-based learning. This doesn’t mean that they do not teach in other areas or that they cannot change areas over time, but they tend to be most successful if they focus initially in one area.

What about clinical care? The extent to which GIM clinical care benefits from or is harmed by focus is a subject of longstanding debate in our field. This debate has taken various forms over the years. As one example, some have argued that women would benefit from having GIM providers specially trained in women’s health, while others feel that every general internist should be equally well versed in women’s health. Do we risk fragmenting our field by having areas of focus or specialization within our field? Or do areas of focus improve clinical outcomes?

In my mind, the question depends on whether patients are better served by their providers having some degree of focus. After years of running a number of different clinical units, I have come to the conclusion that clinical systems run better if they have anchor personnel—that is, individuals who spend a substantial fraction of their effort within that system, who sit on committees relevant to that system, and who have the primary interactions with the non-physician providers in that system.

Let me use the example of our GIM perioperative inpatient service. At one point in the past, each of our inpatient ward teams took perioperative consultations in rotation with admissions. This meant that each month each ward service would typically have one to three patients admitted with hip fracture. It was a nice opportunity for teaching about perioperative medicine. But important items sometimes were overlooked, depending on the team’s level of expertise with perioperative issues. In addition, our relationships with our surgical colleagues were strained. Each surgeon and each internist tended to have a unique way of approaching a given clinical situation, and we would argue repetitively about deep vein thrombosis prophylaxis regimens, treatment (or not) of asymptomatic pyuria, etc.

Over a period of years, we dealt with this unsatisfactory and unsafe situation by recruiting and supporting a group of perioperative general internists to staff a dedicated service. We now have three inpatient perioperative teams, each with physician and advanced provider personnel focusing on certain surgical areas. This has led to much improved patient outcomes as well as enhanced collegial relationships. Quality and efficiency metrics have improved for the surgical patients, we have hammered out clinical pathways covering key clinical controversies, and some of our perioperative faculty have secondary appointments in key surgical departments, which provides a great deal of credibility for them with the housestaff in those departments. The perioperative faculty value having some time on GIM ward teams, and some of our hospitalists rotate on the perioperative services. But in each case, the faculty member with less effort in an area benefits from the systems and clinical pathways set up by the faculty members with more effort in the area. Trainees do not very often care for hip fracture patients on an inpatient GIM ward service, but we have dealt with their perioperative curriculum in other ways, including rotations for some on the perioperative service. Our scholarship in perioperative medicine has increased.

Although less far along, I see some focus areas developing within our ambulatory patient-centered medical home practices as well. For example, one internist has special expertise in osteoporosis and...
vides formal or informal consultation for thorny osteoporosis questions on patients of other physicians. Similarly, another internist provides advice for difficult lipid issues. A few of our practitioners are especially facile with procedures and handle office procedures for others in the practice. I see the development of these primary care focus areas as a positive thing not only because they enhance our quality of care but because they also enhance our teaching and scholarship.

Some general internists wonder whether SGIM as a Society is more closely aligned with those general internists with primary care interests than those with other interests. This is understandable, given the fact that our Society was initially named SREPCIM—the Society for Research and Education in Primary Care Internal Medicine. However, the renaming of the Society in 1988 as the Society for General Internal Medicine affirmed that we embrace the broad spectrum of GIM practice, education, and research. I believe the future will bring even greater focus, with its attendant benefits and risks. Clinically, what brings us together is an overlap in the clinical knowledge base to be mastered by those in different settings, as well as the need for better interaction between our systems of care. General internists are often the “quarterback” of their practice environment (or perhaps the “symphony conductor”). There is an important skill set of being in the quarterback/conductor role, whether as a primary care physician, as the inpatient attending, or as the co-manager of surgical patients. Ideally this skill set should bring our field together as well.

In the end, I do not see it as paradoxical that we embrace some amount of focus in our field while still remaining true to the underlying concept of caring for the whole patient. GIM has become so complex that it is difficult for any individual to remain a master of every single aspect of care. I hope that we can ensure that SGIM remains a Society that draws together individuals engaged in the different focus areas relevant to our field to foster understanding and collaboration and to enhance education and research.