Toward the Resolution of Generalist-Specialist Boundary Issues

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Two articles in this issue of the *Journal* illustrate the problem of jurisdictional disputes at the interface between specialties. The paper by Halvorsen and his colleagues[1] deals with the interpretation of office radiographs by family physicians, while the Controversies in Family Practice feature addresses the role of family physicians in performing exercise tolerance testing.[2] As horizontal specialists cutting across vertical specialties in medicine, generalists in primary care must face the inevitable boundary issues with the nonprimary care specialties. In family practice, some of the common issues currently in dispute include selected hospital privileges (eg, intensive care, obstetrics), and some office procedures, such as obstetric ultrasound, colposcopy, flexible sigmoidoscopy, or limited colonoscopy.

Although generalist-specialist boundary disputes are common, jurisdictional disputes among the other specialties are also frequent and may be even more intensive. Current examples include the longstanding turf battles over disc surgery (neurosurgery/orthopedic surgery) and hand surgery (orthopedic surgery/plastic surgery/hand surgery). It is unrealistic to expect that any particular area of medical knowledge or practice is inherently the domain of only one specialty. Draper and Smits[3] make this point as follows:

> In fact there is nothing intrinsically rational or permanent about the way in which medical specialties are currently defined; all are more or less arbitrary. A specialty is essentially a social definition rather than a scientific or logical one; it is simply a social recognition of a grouping of practitioners who are carrying out similar work. Furthermore, the definitions of specialties are constantly changing, and the boundaries of few specialties are hard and fast: the nephrologist will need to be able to read kidney biopsies as well as or better than his colleague in pathology; specialists in respiratory diseases would not consider it appropriate to ask a radiologist to interpret chext x-ray films for them. Any clinical specialty is in fact a mixture of fields such as pathology, anatomy, physiology, biochemistry, pharmacology, and psychology; what defines the specialty is its focus rather than a unique kind of knowledge or skill.

How might interspecialty territorial disputes then be resolved?

The American Medical Association, the Joint Commission for Accreditation of Health Care Organizations and the American Academy of Family Physicians agree that all privileges should be based upon documented evidence of (1) training, (2) experience and (3) demonstrated current competence. These criteria are clearly essential yet allow for variation in education and training according to the need of the knowledge or procedural skill in question together with variation in rates of learning of individual physicians. Another important criterion to apply to territorial questions is the need for practitioners to demonstrate outcomes that are generally equivalent to those of other specialists. In fact, the Academy has now established a Task Force on Clinical Policies for Patient Care to analyze the available evidence in the literature, including outcome studies where available, for process of care for specific areas of practice; this will provide a consensus development mechanism within family practice. The first such areas to be addressed are criteria for use of oxytocin for induction and augmentation of obstetric labor; detection, treatment and prevention of hyperlipidemia; and detection and treatment of breast cancer (personal communication, Dr. Dan Ostergaard, February 10, 1989).

Generalists undertaking areas of practice on the boundaries of other specialties can and should meet outcome standards equivalent to those of other specialists in that area. These outcome standards may not correlate with the educational requirements established unilaterally by a given specialty group, as their educational requirements often are arbitrary and unrelated to either patient care outcomes, variations in training settings, or rates of learning and competence of individual physicians.

With the broadest scope of training and practice, family physicians are prepared to practice across a wide spectrum of practice settings from urban to rural. In some situations, such as smaller communities and more remote rural set-

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tings, family physicians may be called upon to treat a patient or perform a procedure under urgent or emergency conditions for which their level of clinical competency or procedural proficiency may be less than that of another specialist but in which the optimal patient care outcome may require their intervention. Peer review and medicolegal standards not only need to account for these variables, but also need to recognize the particular advantages to the patients of their personal physician providing care within the full limits of each physician's capacity. These advantages include easy access and convenience for the patient as well as cost savings. In addition, the primary care physician brings to bear knowledge of the patient's previous care and a level of trust developed over the years in a continuing relationship, as well as knowledge of the family and family dynamics, all of which may contribute to increased patient satisfaction and improved outcomes of care.

The study of interpretation of office radiographs reported in this issue by Halvorsen et al[1] provides a useful prototype for studies needed in other boundary areas. The authors have demonstrated a high level of congruence of interpretations by family physicians and radiologists and minimal differences in outcome for those few occasions of interpretive error. As family practice takes an increasingly active role in establishing its own practice boundaries, it has the challenge and responsibility to define appropriate standards of education, training, competency, and outcomes. This challenge can be addressed and met at many levels through education, quality assurance, and research activities of individual and group practices, clinical departments of family practice in hospitals, collaborative research networks, family practice residency programs, and academic departments of family medicine in medical schools. The benefits of these activities should lead beyond the resolution of boundary issues with other specialties to more effective mechanisms assuring optimal patient care outcomes.

References

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