Training and the future of Internal Medicine

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Abstract

The future role of Internal Medicine must be clearly defined in order to enable us to provide an appropriate post-graduate education. The General Internist inherited a role as master diagnostician--consultant that has been largely usurped by technical advances. In the last years, some policies have been implemented aimed at training General Internists as Primary Care Specialists, and thus artificially restricting their clinical activities. These were the two major reasons for the decreasing number of General Internists and an increasing number of sub-speciality Internists. Another important point is that Internal Medicine does not give sufficient outpatient experience during the undergraduate medical training period, which is a wonderful opportunity to experience the value of Internal Medicine as a career of choice. In the United States, health care evolved into a largely Specialist/Sub-specialist system and now proves to be more expensive while the outcomes are not clearly better. The author presents some ideas that he believes would increase the attractiveness of General Internal Medicine.

Key words: education in Internal Medicine, future of Internal Medicine.

It is usual to say that the future is with the youth. Such irrefutable truth also applies to Internal Medicine, which will evolve according to the training given nowadays to Internists, being essential a clear definition of the Internist role in order to ascertain the learning model.

There are specific problems in Internal Medicine training both in central as district hospitals. However, any solutions must be previously related to solving the background question i.e., which is the most appropriate profile for the Internist in the years to come.

In 1897, William Osler has defined internists as physicians, giving them such name to make a distinction from general practitioners, surgeons, obstetricians and gynaecologists. In such time, it was evident the need for a speciality with an integrating view of the human body, without missing as well the diseases pathophysiological basis. The patient general knowledge was a motivating challenge in the 60s, leading the best to choose Internal Medicine. It was created a myth around the great diagnostician, the Medical Science Sherlock, the living anticipation of the computer producing differential diagnosis based in introduced data. Clinic was the bases of all medical exercise and whoever control that, integrating signs and symptoms denouncing the diseases, was able to ground the diagnosis, even if unable to show it. Such power of seeing what was not obvious, would take the medical experts to an almost celestial level… The Internist, paradigm of such mystery, would deride a higher level of satisfaction from his activity.

As new technologies emerge, capable of making visible the disease before only analysed, has made the clinical act a common thing before the lay and non-lay public, making it apparently dispensable… In almost no time, the patient lost patience for the anamnesis, he is anxious when referred to CT scan and no longer trusts in his physician´s words, wishing to see them also written on the report of whatever test.

A growing lack of acknowledgement of the internist's work, both by the public as by other colleagues of other specialties has been seen. To the general perception it became difficult to understand a speciality that does not dominate a given organ or system. Colleagues with more defined limits of medical knowledge quickly lost the graciousness of humbleness, thinking to be absolute masters of the sharing of the human organism, without concern for the multiple interlinks making the general whole.

The internists' insatisfaction lead to a progressive reduction of their number in the USA, leading to the emergence of a health system widely supported in specialists and subspecialists. Such system has already shown to be dysfunctional and expensive, but it has not been possible to prove that in most diseases, such

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is translated in better results. In the USA most Internal Medicine residents opt subsequently for a subspeciality. Such evolution is considered inadequate by the American Board of Medicine and by the National Institute of Health.

It is evident that creating independent departments for subspecialties is deleterious for medical education and it is not capable of producing real clinical researchers, which was supposed to generate. But a big argument to increase "general" internist training it is because they are much more cost-effective, knowing that the resources for health care are always scarce. The system based in subspecialists, incapable of treating a situation out of their scope, fragments the healthcare service, multiplies the cost and not rarely delays the diagnosis. For such reasons, internal medicine became highly desirable for the political power but it is unable to seduce more youngsters to choose such career path. As a matter of fact, the multi-aspects of the general internist training lead politicians not to succumb to the temptation of converting them in healthcare goalkeepers. The abuse of such manoeuvre to the limit of the absurd made some internists to see in the subspecialisation the only way to make a clinical advance and research. Will this be the unavoidable evolution of Internal Medicine?

In countries where subspecialisation was an almost general rule, several studies came to condone such trend. In fact, many subspecialists lose clinical practice, as the ability as general internists suffers a natural atrophy. The possibility of the subspecialist being also able to provide general care is, over the years, just a mirage. Obviously that what was said does not invalidate that the internist has particular areas of interest, such as non-invasive cardiology, nephrology or gastroenterology, and endocrinology or rheumatology. This is very different from becoming a subspecialist, in its usual understood sense, i.e. to acquire training in state-of-the-art techniques which belong to the respective speciality.

The acknowledgements by the hospital institution of the internist work must be reflected in its organisation. Petersdorff and Goiten advocate that the general Internal Medicine should be at the core of the medical department, having subspecialties as interlocutors. Only that way they can find ways of working together, making more cost-effective the means available, whether for learning purposes or clinical research. Other aspect no less important, it is the need of increasing the common stem, and it is considered reasonable a period of three years of residence, before opting for a given medical speciality. Only this way it is possible to acquire a working critical mass, capable of reserving general internists for their real role that should not be the primary care of all patients, without any collection, arrives into the hospital. This implies a change of mind in our specialty colleges, in a way that they find demandable to all specialists skills to the treatment of problems with average severity that often, coexist with the underlying disease.

Without delay there must be a definition on the Internet profile desirable for our days and for the future, bearing in mind the tasks you will have to face. In my view they were well listed by the American College of Physicians:

1 – It should be the first contact with the patient and provider of general and continued care.

2 - A physician that evaluates and treats all the aspects of the disease and of the patient.

3 - A Specialist in preventing disease and needs early detection.

4 - An "advocate" before the patient before the complex health system and its various sub specialities.

5 - Specialists handling advanced diseases involving different organs and systems, whether for outpatients as inpatients.

6 - Consultant when the patient as symptoms and signs of difficult explanation or undifferentiated problems.

7 - A Specialist familiar with the epidemiology and clinical, able to take decisions, promoting practical evaluation and the patient's treatment.

With the characteristics of the Internal Medicine specialist defined, increasing the concept of the general internist, we can detect the missing gaps felt at present. Training in Internal Medicine must privilege evermore the outpatient care favouring the contact with our reality. The outpatient care or in teams and home care, must assume much more importance. I'm persuaded that if that is done, apart of improving the care delivered, a great professional satisfaction will be reached because it's outside the hospital that the relationship physician – patients is more intensified. Knowing the reality of the health care system is complete making it ever closer between family doctors, district hospitals and a reference at Central Hospital. Integrated stages provided in Internal Medicine internship in health care centres is

still difficult to put in practice, many stages must be overcome in the relationship between the hospital doctor and the family doctors until such is possible. However the contact of the internal medicine resident with hospitals of different levels seems to me beneficial and easy to implement. Internal Medicine internships would then be made in hospital groups led by a central hospital, where the residents would attend one year of the time dedicated to Medicine in a district hospital of their choice, being appointed there a respected training adviser.

Internal Medicine internships in district hospitals and central hospitals have problems that must be overcome. In district hospitals there is quite often missing a routine of clinical discussion and the scientific activity and research are underestimated in favour of the caring work. In the central hospital, the frequency of difficult cases gives the wrong idea to the intern regarding the concept of diseases epidemiology which is compulsory to have in mind.

Organising internships in health functional units, integrating a central hospital, district hospitals and later health centres, would enable an internship with all the available means adjusted to our reality. We should no longer have interns of several categories with choices of training place dictated by objectives other than quality, mixing the contact of technical and difficult cases with common pathologies avoiding difficult to correct vices. The Internal Medicine internship should continue to promote a global learning, valuing the role of the "general" internist emphasising areas where the scope of knowledge results in better performance (intensive care and medical oncology). The "derivations" during training, promoting specific profiles before regulation, should be considered undesirable. ■

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