Internal Medicine and the future

Faustino Ferreira*

Abstract

In this article author asks two questions suggesting answers he would like to discuss: 1) What is the future role of Internal Medicine and physicians in the coming years; 2) How to attract trainees in the field of Internal Medicine under the new conditions that are expected in the future. These questions are relevant in view of the signs of the change that is likely to affect traditional medical practice in the near future.

Key words: Internal Medicine, physician, future, mission, physician's role, recruiting, training, career.

At the end of this millennium, we live under the sign of change. Old paradigms have been questioned and new ones are still under construction. Trying to imagine them, when all we have are vague sketches, is risky, but urgent. Immersed in a highly demanding and absorbing daily life, we can be tempted to ignore the signs of change. Internal Medicine is inevitably affected by this turbulence.

The media, the commentators and the politicians focus all their attention on issues of financing and management when they address "the Health problem". However, an interested observer will notice the predictive signs of the profound changes that are underway. What stands to change the most are the working models and methods that we were trained in.

In the global village we now live in, the exchange of information has become immediate, instantaneous; interactivity has become a reality, teamwork a requirement, and information technology an essential working tool.

The conceptual and technological advances of Medicine, in areas such as Neurosciences, Immunology and Genetics, will have short- and medium-term implications in our daily clinical practice, and will transform the ways in which a large number of pathologies are addressed, whether at the level of prevention and diagnosis, or in terms of therapy.

The loss of sainthood status of the physician, of his knowledge and power, is an acquired and irreversible fact, even in the most traditional of societies – although we are witnessing the emergence and/or re-emergence of various types of alternative practices in which the magic component prevails. Today we are faced with a need to affirm the respectability of the medical profession in a social context where we have gone from being "gods to demons". Apparently condemned to the practice of a defensive Medicine, we feel tempted to hide behind protocols, informed consents, insurance, legislations...

In today's information society, how many times do we come across patients who arrive for the consultation already "armed" with the latest information obtained from the internet, with their group of diseases — AIDS, rheumatoid arthritis, lupus, multiple sclerosis etc. — and how many times do we come across, on opening the newspapers, abstracts of scientific articles that will be published in the next issue of New England or Lancet.

These facts are determining the emergence of new models of relationship between doctors and patients, and new ways of organizing the services. New working methods are being tested; the registration of the clinical history will no longer be paper-based, but fed into a computer, and it will certainly have a different structure; the patient's history will be recorded on a microchip, in the user's card, which will permanently accompany the patient; the family history will lose the significance it has nowadays, as the genetic code will be part of the patient's identification card. The patient, by the time he arrives at the clinic, will have already had an initial biophysical-chemical evaluation performed by a nurse, using non-invasive methods. The methodology for requesting additional

*Head of the Medicine Service of the Hospital dos SAMS, Lisbon

exams will inevitably be carried out differently, with new types of communication and interaction between prescribers and executors (clinical pathology, imaging, for example), saving time, and increasing profitability and comfort for the patient. The means of interdisciplinary communication within the hospital and with the external environment tend to change too, in particular, the level of attributions and relations with other health professionals — nurses, technicians, pharmacists, managers, etc.

The very concept of hospital, as we know it, is at stake, as it is clear today that the concentration of diagnostic and therapeutic means will be more important than the number of beds, which are being reduced through a widespread process of "de-hospitalization of disease". Hospitals will be increasingly become acute hospitals, with a high percentage of beds in intensive care.

The relations between hospitals and the community will inevitably change. It might make sense for the hospital to go to the community, contrary to what happens today. The internists will travel to the health centers, where, together with family doctors, they will observe previously selected patients, helping in their diagnostic and therapeutic guidance; when required, they will make available and promote the provision of hospital resources for these patients, and may collaborate in the home care and follow-up after discharge.

This complex scenario of change will offer multiple opportunities for intervention by internists, who will play an increasingly fundamental role, which they will assume in a proactive way, and not in a reactive, resigned way, as has sometimes happened in the past. They will therefore need to strive to search for better solutions for patients, for the prestige of Medicine and the dignity of Internal Medicine.

The Portuguese internists have a daily routine that revolves around hospital emergency. Hospital emergency, in our country, is the one last stronghold where support and safety is sought by all those who, feeling sick, are directly or indirectly referred, due to the disorganization and inability of the health services and the failure of social welfare services. The daily experience of permanent catastrophe provides internists with a unique knowledge of our reality, our deficiencies and difficulties, but also of the potentials to be exploited.

The objective and subjective conditions that are forcing internists to anticipate the new challenges facing Medicine, and particularly Internal Medicine, are coming together.

Within this scenario, it seems to me that two questions deserve special attention:
1 – What is the mission of Internal Medicine, what are the roles of the internists in the near future?
2 – How can we ensure the recruitment of new internists to fulfill this mission?

The rudimentary answers that I venture to give in the following lines are intended to promote reflection and discussion, which in my view, are urgent. They are mere "hares" in a long "race" in which it is imperative to speed up right from start in order to achieve a good result.

The mission of Internal Medicine and the roles of the Internist

In the scenario of transformation and change that is foreseen, Internal Medicine will have ideal conditions to resume its role of leadership, and act as a pivotal intermediary in Medicine.

It is the mission of the internist to work in prevention, diagnosis and curative, non-surgical therapeutic guidance on diseases involving the organs, systems or multi-systemic conditions of adolescents and adults — healthcare function — their main function. In the future, fulfilling this mission will involve the existence of a hospital organization where the function of the internist will be to organize and distribute (pivot) hospital work, mobilizing and coordinating, for each patient and for his groups of patients, the intervention of colleagues from other specialties (medical or surgical), and then bringing all these interventions together.

The internists tend to be doctors in the hospital and of the hospital. This is because: 1) without the internists and the Internal Medicine Services, there can be no hospital – they are the essential doctors in a hospital; any other specialty can be absent, or present only part-time; 2) in order to operate, hospitals need the permanent physical presence of internists, 24 hours a day – other specialties can be on call!; 3) internists tend to be the only ones who take responsibility for the role of doctor, when faced with the ultra-specialization of other specialists, who often act as mere executors of techniques. The doctor-patient relationship tends to revolve around the internist, who receives the patient, outlines the circuit of his

diagnosis, analyses the results and possible therapies, which he prescribes (medical) or refers (surgical), and discharges the patient. Nowadays this trend is being seen in all areas, particularly surgery, where the anesthetist and surgeon might limit their intervention to the actual surgery itself – and the intervention of the radiologist tends to be limited to carrying out the exam requested and writing up the due report. The more serious and complex the patient's condition, the more frequent this phenomenon is, with the internists being responsible for pre- and post-surgery evaluation (examples: oncological surgery, transplant surgery, cardiac surgery, etc.)

Internal Medicine will continue to impose itself in all spheres of hospital life, through global knowledge of the hospital and its operations, and naturally, the internists will be called upon to assume management positions. The presence of internists is, and will be, indispensable on all the committees and work groups formed in the hospital (ethics committee, committee of infection control, antibiotics, artificial nutrition, food, training, quality, etc.) — role of internal consultant.

The internist's role is to act as the principal interlocutor between the hospital and the community, liaising with health centers and acting as a facilitator of communication between the hospital and the various hospital departments. He might also travel to the health centers — role of interlocutor/ external consultant.

In his daily activity, one of his primary roles will be that of "information manager". The high levels of scientific, analytical and widespread over-production are creating a need for highly specialized doctors, capable of making syntheses, after careful selection of what is relevant from all that is experimented on and published. This is the product of this permanently updated synthesis, which enables the best options to be found for each case, and regularly creates and updates protocols for diagnosis and therapy for the various groups of principal pathologies.

Clinical research — function of scientific researcher — this should be an essential part of the daily activity of the internists, perfectly interconnected with his care-related tasks, and with the role of teacher, whether at graduate or post-graduate level, general internship, common core of medical specialties, and specific differentiation of Internal Medicine.

Guardians of the hospital temple, internists are the most faithful inter-peer trustees of the Hippocratic ideals. Among the new challenges that future will bring for Medicine and physicians, internists will remain faithful to their ethical mission, struggling to ensure that the complexity of situations does not prevent them from finding the most appropriate ethical behavior for each concrete situation.

Recruitment and training of new internists

Internal Medicine is a specialty that can only be fulfilled and fully affirm itself in excellence. This desire can only be fulfilled it has at its service a body with a sufficient number of excellent, dedicated professionals.

In recent years, it has been seen that with some exceptions, smaller numbers, and a lower quality of interns are opting for Internal Medicine.

Today, choosing Internal Medicine as a first option, and not as a last resort or a transitory solution, is difficult and uncommon. The specialty is very demanding and not very rewarding. It is demanding because internists, whether interns or qualified specialists, are required to fulfill heavy burdens of care-related work on the ward, in consultation and emergency, frequently carried out in physical environments that lack the necessary conditions, demanding enormous physical and mental effort. They are also normally required to carry out extraordinary work in emergency. It is also demanding because of the vast amount of knowledge they need to master, and the discipline that the need for permanent updating imposes.

It is not very rewarding because internists are still seen by the services, as "another pair of hands for work", and it is rare for the training plan to go beyond general good intentions, and the learning to continue to be based on the method of imitating older colleagues — "do as I do".

It is also not very rewarding because after concluding the internship, the prospect of unemployment, or insecure employment, still persists. Licensed to work in a hospital, their place of practice par excellence, the perspective of becoming unemployed after a few months, without possible alternatives in the job market, is discouraging, even for the more motivated ones. The internists who are excluded from the hospital are prevented from practicing their specialty and are forced to accept undifferentiated, low-paid tasks. Most specialties, particularly the medical specialties, enable interns to carry out one or various techniques that can be "profitable" outside the hospital (cardiac echography, endoscopy, haemodialysis, etc.) and

hence those areas become more attractive.

The issue of the real difficulty in recruiting new internists must be faced with pragmatism and rigor, since the medium-term future of Internal Medicine depends on it. It seems to me that one possible way out would be for Internal Medicine to claim a career for itself, one with a special remuneration statute.

When reflecting and discussing on the future, this possibility needs to be raised. The current discussion on a hospital statute and medical careers could be a good opportunity for introducing the issue. This case is not unique, since our colleagues in public health already have their own career and special remuneration statute, and those in General Practice are trying out new methods of remuneration. This issue is also important for other hospital specialties, such as General Surgery and Pediatrics.

The future of Internal Medicine inevitably includes achieving conditions for recruiting interns who, when making choosing their careers, are aware of the increased level of demand they will face – starting with the selection – and that they are assuming the risk that this demand will continue throughout they professional lives, but at the same time, being assured that once the previously defined and regularly evaluated objectives have been fulfilled, they will have a career and a remuneration statute that are worthy and attractive.

The premises for a specific career in Internal Medicine should be as follows:

a) Assessing the need for internists in the medium and long terms

An assessment of the needs of the country (and Europe!) for internists has to be done ten to fifteen years ahead, to ensure there are enough internists. A lack of internists would jeopardize the overall performance of Internal Medicine; too many would be a waste. The average training time for an internist is more than ten years — from the time they enter Medical School to the end of the internship (it is actually thirteen years!). We cannot continue to have "maps of openings" as a result of election calendars or pressure from services that need "fresh labor", but are not able to expand their staff and make it appropriate to their needs.

b) Recruitment

Recruitment for Internal Medicine will become more demanding and complex, going through various phases:

National Admission Exams for Complementary Internships — the first filter; only doctors who achieve results in the top third for each year can apply for the supplementary internship in Internal Medicine.

Specific assessment of candidates for Internal Medicine concerning their profile for the specialty (written and interview), namely analysis and synthesis skills, team work ability, ability to listen and make decisions, leadership.

Selected candidates will be able to choose from the centers that are willing to receive them, and there will always be more centers than candidates.

c) Training

The complementary internship training program in Internal Medicine, recently published in the Diário da República (I series-B, no. 114 of 17-5-1997), seems to be adequate to cover the near future and the transition period.

The whole training process will be dignified, professional, and eventually supervised by an autonomous training institute (made up and managed by a partnership between the Ministries of Health, Education, Science and Technology, and the Ordem dos Médicos). The greater responsibility required of the services should be compensated through additional funds for training purposes, allocated based on the number of interns they receive, and possibly even an "award" for each intern successfully trained. The current situation, where "training costs nothing" is not realistic and leads to a low level of training demand required of teachers.

In Medicine, particularly in Internal Medicine, shoulder-to-shoulder training will continue to have an important role (and has been the training method used for many generations of internists). However, modern times oblige us to look to the pedagogical relationship in a different way, to make use of teachings from pedagogical sciences in order to improve our training. Doctors, in general, do not receive any pedagogical training as part of their academic or postgraduate curriculum, and they are normally self-taught. Training in this area would therefore be very useful in clinical practice, and in the relationship with patients, since one of our missions is to re-educate patients in terms of attitudes and behaviors.

The initiative of the Ordem do Médicos in promo-

ting the "Pedagogical Training Courses for Medical Internship Supervisors" seems to me to be a good one, and one that would be worth continuing and developing further.

Supervisors/teachers of complementary medical internships should be held accountable, and rewarded for this activity - reduction of care-related tasks/responsibilities or compensatory remuneration, due to the additional time and availability involved.

The suitability of training services will need to be regularly accredited based on previously defined objective criteria, including the results obtained in the training of interns (level of satisfaction, success rate, etc.).

d) Assessment

Assessment is the chapter where new methodologies will need to be developed, to enable the monitoring and improvement of interns' performance throughout their training, while at the same time, correcting any deficiencies in the training. A final assessment by a common national jury for all interns who completed the internship for a particular year, is desirable, and should be carried out according to a previously known curriculum.

e) Entry to a Hospital Career in Internal Medicine

Each year, the forecast number of interns will complete the internship, a figure that should meet the predicted needs. Access to existing openings will then be naturally ensured. The methodology for filling these places could be by crossing-referencing lists. Candidates would be able to apply for any places they wanted, creating lists of preferences, and the hospital institutions with openings could apply to receive the candidates in whom they were interested, creating, in turn, their list of preferences (and meanwhile, interviewing the candidates). Through interactive and successive matching of these lists, positions would be obtained for all candidates.

f) Remuneration Statute

One option for Internal Medicine is a special remuneration statute.

The future internist will spend the most part of his or her professional life in the hospital, without being able to carry out extra-hospital activity to offset off the low salaries earned. Nowadays, many internists are able to increase their pay by working extra hours, either in internal or external emergency services, whether in Intensive Care Units or in emergency services in other hospitals and clinics from the main one in which they work.

Notwithstanding other working regimens/workloads, today there are few internists who work less than 54 hours per week (full-time with the addition of 12 "mandatory" hours of overtime) — a new remuneration statute for the internists has to be considered; one that rewards the dedication to hospital life with the level of demand required of internists, regardless whether they remain in the current regimen of exclusivity.

The responsibility assumed by internists when evaluating a patient, formulating diagnostic hypotheses, prescribing exams and therapeutic guidelines, has been systematically undermined. The fundamental acts on which all depend — the patient's life and the costs of his recovery — are not usually accounted for or valued, therefore they "do not cost anything", they are cost-free acts. They are not listed and do not have cost comparable to technical or surgical acts. The technical act is frequently an individual act (payable by the "piece"), the practice of Internal Medicine is more of a collective activity, carried out by a team.

The remuneration component in the process of reaffirming Internal Medicine cannot be ignored.

The spirit of mission and service will continue to set the tone for internists, but the continuation of a situation of real economic subordination in relation to other colleagues discredits the specialty and puts it at risk.

If we must demand of internists for increasing levels of responsibility, and since there is no health system that can function without them, we must seek to recognize their work, a recognition that should be translated into fair remuneration.

Conclusion

The future is here. We need to play an active role in building it. The future of internists depends on them, their investments, and their ambitions. The quicker we prepare for the future, the better it will be for Internal Medicine and internists, and as a result, the patients and the community where we are inserted will benefit too. ■