Abandonment of internal medicine as a specialty: the point of no return?

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I was asked by Professor Anetta Undas, Editor-in-Chief of *Polish Archives of Internal Medicine* and Professor Jacek Imiela, General Consultant in Internal Medicine, two eminent physicians, scientists, and opinion leaders in Polish and international medical community to share my personal opinions on the current status and condition of internal medicine as a clinical discipline. First, I should probably introduce myself to the readers in more detail to put my comments into context.

I graduated in 1992 and chose internal medicine as the first specialty; this was my choice on my way to nephrology—I decided very early to become a nephrologists, but the first step was to become an internist. I completed the 1st degree specialization in internal medicine in 1996 and the 2nd degree—in 1999. My specialization in nephrology (2003) was followed by that in hypertension (2006; right after its introduction as a new specialization) and clinical transplantation (2010). This means I am a "triple subspecialist", on top of my internal medicine training and specialty. The clinical ward I presently run is the only university-affiliated department of nephrology with great interest in clinical transplantation in the region of Warmia and Mazury in Poland. However, every second or third day, we also serve as an emergency internal medicine ward for half of the city of Olsztyn (population of up to 180 000).

I should ask myself: do I know internal medicine now? I should probably not admit this in public (at least my students should never read this), but the answer is "no". I have no idea how to treat hematological malignancies according to recent guidelines (maybe except myeloma), what to do exactly with a patient with atrioventricular nodal reentrant tachycardia, or the one who suffers from idiopathic pulmonary fibrosis (although all these diseases belong to internal medicine). On the other hand, I am quite convinced that most of my colleagues – internists have never heard about C1q nephropathy, have never seen a patient with Goodpasture disease, and have no opinion on the contribution of convection to blood purification during hemodiafiltration.

The question arises: do we still need internal medicine? And the answer is "no" because internal

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medicine is too large and too detailed a subject to be followed on a professional level by any doctor. I heard once (although I cannot recall the source of this information) that physicians were able to follow the progress in medicine as a subject until the first or second decade of the 20th century; later on, the "explosion" of medical knowledge made it virtually impossible. Since currently we live in the era of evidence-based medicine, all diagnostic and therapeutic procedures must be applied based on the knowledge coming not even from the latest handbooks, but from the guidelines published by boards of experts and updated periodically or after publication of new, important clinical studies. For this reason, the most recognized Polish handbook of internal medicine, *Interna Szczeklika* (*Szczeklik Internal Medicine*) must be updated annually. This is not a privilege, but an obligation of a physician to be up-to-date with current knowledge, and thus, narrowed specialization is mandatory.

The answer is also "no" because the health care market and medical marketing neither support internal medicine nor attract junior doctors to this specialty. I presume that most of patients do not consider internists as specialists. Patients, employers, and payers look for "specialists", not for internists. If not sure what to do, general practitioners (family physicians) are expected to refer patients to a subspecialist and not to another "general practitioner".

Another reason for "no" is income, as most of people, doctors included, also want to make money. I am convinced that many doctors choose specialty based on income expected in the future (ie, when they are already established specialists). I am not aware of any Polish data concerning physician's income by specialty. Let me, however, quote the latest survey on the US doctor income by specialty, performed annually by the popular web resource for physicians, Medscape (http://www.medscape.com/features/slideshow/compensation/2016/public/overview). Out of 26 specialties ranked in this survey, the top three money makers are orthopedists, cardiologists, and dermatologists, while internists are on position 21. Interestingly, endocrinologists, internists, and nephrologists are at the bottom of the rank by overall satisfaction with their specialty. Only 25% of internists (position 26, ie, the last one) and 35% of nephrologists (position 24) will choose again the same specialty, in comparison with 74% of dermatologists (hopefully, nephrologists are very good internists not only because of a similar level of frustration).

Yet another reason for "no" is research. Given the fact that medicine is highly specialized, medical research is specialized even more. Medical fellows or even students who are interested in research must choose the area of their scientific activities very early and must become highly specialized to achieve success in this area. No one will publish studies on internal medicine, and I am not sure if such a research area does exist nowadays. Although the best medical journals, such as the *New England Journal of Medicine*, *Lancet*, or *Polish Archives of Internal Medicine* do not identify any subspecialty in their vignettes, in fact they contain papers documenting highly specialized medical research.

Finally, "no" because of the financing and organization of the health care system. The system (payer, health managers) no longer perceive sick people as patients (although they frequently declare to do so to be politically correct), but as procedures. The overwhelming need for categorization, calculation of costs, reporting effects, and so on forces people to choose specialties that are more "measurable" ("quantifiable"), and this is not the case of internal medicine. This may be the source of frustration (mentioned above) for internists and those subspecialists who underwent regular training in internal medicine (many specialists do not harm themselves by thinking about the diseases beyond their specialties). When admitting the patient, my colleagues and I cannot pretend that we do not see his or her diseases other than kidney problems. Unfortunately, the system of disease/procedure coding and quantification does not allow our institution to be fairly reimbursed for all what we do for our patients. Many activities that must be done despite the fact that they do not "fit" our specialty profile are not reimbursed and we are perceived by our managers and other "income-bringing" specialists as "debt makers". We, the internists, investigate the patient's problems in detail and usually find more problems than expected on admission. We desperately need to be recognized for our efforts, though they create deficit in our institution.

Yet, I think that there are still arguments to support internal medicine. True integration of medical knowledge is possible only in internal medicine wards with access to modern diagnostic procedures and specialist consultations (internists with subspecializations as employees). One of the greatest paradoxes of the modern health care system is the fact that in "specialized" medicine, diagnosis has been split from treatment: subspecialists are no longer supposed to diagnose diseases, but **exlusively** to treat them (at best, to confirm diagnosis right before treatment). Patients are admitted to oncology to receive chemo- or radiotherapy; to cardiology, to undergo coronary angiography; and to vascular surgery, for aortic bypass or stent-graft implantation. Patients must be clearly labelled with proper diagnosis before admission and bring the label with them to these and many other wards. The health care system clearly indicates what to do with "labelled" patients but does not explain how the process of "labelling" (diagnosis) should look like and where it should take place (some diagnoses cannot be established on an outpatient basis). In my opinion, there is a huge gap between general practitioners and subspecialties (which results with purposeless overreferral), and this gap is filled up

and should remain filled up with internal medicine wards. There is no place in the health care system other than internal medicine ward to admit sick people, in whom the diseases are not yet named, not yet precisely defined, and where one of the greatest arts of medicine—**differential diagnosis**—can take place.

Internal medicine also supports, and sometimes replaces or at least initiates, long-term, palliative, and end-of-life care. From my perspective, at least 10% to 15% of hospital admissions to our ward are "social" or "palliative" in nature. We, the internists, help severely ill, elderly people who have experienced stroke, suffer from dementia, are permanently bed-ridden, and live on their own without or with minimum support from their families, to find nursing home or attract more attention from institutions. This is not a role of internal medicine and hospitals in general, but in my opinion—at least at present—no one will replace us in this role. I think that internal medicine wards serve as an "ultimate resort" for many people. Paradoxically, illness that finally results in hospital admission in case of many patients (also including the homeless or drug and alcohol addicts) may result in improvement of their social situation. I am convinced that we really care! System (payer) does not account for this social role of internal medicine. But system also does not replace us in these activities.

An internal medicine ward is the best place to establish the right diagnosis. Many patients will also be successfully treated here, while many others will be further referred to subspecialties. But—and this role of the internal medicine ward cannot be replaced by any other—this is also the place where end-of-life issues are faced. Again, hospitals and internal medicine wards are not designed as places for dying people; in theory, a hospice should take care of them. But since nowadays almost no one dies at home and end-of-life or hospice care is largely insufficient, with lack of space and resource, an internal medicine ward can also be a place to die with dignity. Dying people are frequently rejected by highly specialized wards that treated them before. My staff and I would prefer to refer dying patients to a specialized care center, but we will not avoid end-of-life care at our ward, even if more "procedures" cannot be applied.

Postgraduate training in internal medicine has been switched to the "modular" one: to become a subspecialist in one of the internal medicine specialties, junior doctors no longer need to achieve the degree of a "general" internist. I am not sure if this would be successful. We should do our best to support the "internal medicine" module during the residency program in any subspecialty. We should also support development or, at least, preservation of "general" internal medicine wards, which are the special places of broad-spectrum care offered to sick people.

To me internal medicine as a subject and specialty is of great value. My staff and I would not be able to run a specialized renal/transplant/hypertension ward and practice my subspecialties without the experience and knowledge in internal medicine.