

The current situation and future of internal medicine in Poland from the point of view of an endocrinologist

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I am pleased to share my opinion in the debate on the importance of internal medicine in our health care system, the discussion aimed at searching for the causes of the clinical training crisis in this field. Before I introduce you to my considerations, it falls to me to note that quite a long time ago, that is, in 1978, I completed a postgraduate internship in the field of internal medicine at the Second Department of Internal Medicine, Medical Academy of Lodz (currently the Medical University of Lodz) in Łódź, Poland. I have been an internal medicine specialist for 32 years, and my activities in the field of internal medicine have been focused on endocrinology: the area in which I have worked as a national consultant for 15 years (until now), and in the meantime, I was a provincial consultant for 7 years.

The narrow specialty that I represent penetrates deeply into the pathomechanisms of various diseases treated not only by internists, but also by many other specialists, and the application of hormones in the treatment of various clinical conditions is very common.

In many countries all over the world, the specialty in endocrinology is combined with diabetology, and a group of diseases covered by the specialty in endocrinology includes also metabolic diseases (metabolic bone disease, disorders of water and electrolyte balance and of lipid metabolism, obesity, eating disorders, as well as some of the so called rare diseases, resulting from various genetically conditioned errors in metabolic processes). Moreover, endocrinology comprises also andrology and reproductive medicine.

In contrast to the above tendency to combine very detailed narrow specialties into more extensive ones, in our country no agreement has ever been achieved on such consolidations. For a long time, diabetology has been a separate specialty (until now and still, with exclusion of pediatric diabetology, which has recently been combined

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with pediatric endocrinology). Similarly, “rare diseases” have recently been separated as a new specialty called “metabolic pediatrics” (unfortunately, people over 18 years of age, affected by such diseases from childhood, have been somewhat forgotten in those arrangements).

The present time is not conducive to specialty of a general nature, I would call the classic ones like internal medicine, which is based on the fundamental methods of medical practice, physical examination, medical history, and laboratory findings, and includes equally various aspects and areas of medical knowledge. Progress is so fast that not only widely understood internal medicine, but also all other medical and nonmedical issues undergo acceleration, fragmentation, and specification.

One can say that analytical thinking (which perhaps is easier) dominates over what is meant by synthetic thinking (ie, an ability that allows the physician to associate all components of detailed reasoning in complete harmonious conclusion, with simultaneous perception of all significant aspects). The ability of synthetic thinking is useful for all outstanding internists. In turn, the ability to analyze seems sometimes easier, and in this aspect, one can even say that the modernity kills the intelligence.

Increasingly rare are the cases of doctors, embedded on their “bridgeheads” of work—whether in rural outpatient clinics, in urban hospital wards, or in highly specialized academic departments—whose medical knowledge, diagnostic intuition, the ability to synthesize and associate signs and symptoms, coexisting with professional vocation, make them worth the title of the outstanding internists. According to current educational programs, the range of knowledge required from an internal medicine specialist is almost unlimited. Only the best candidates—after assimilating such a huge amount of information—are able to think synthetically, link the data logically, simultaneously understand all aspects of the issue, eliminate “background noise” and “blind paths,” and eventually use only the most relevant information in the diagnostic process.

Therefore, it is not surprising that the evolution of a variety of medical specialties goes towards the module specialty in which the part of the basic material, more or less equally required in various medical specialties (which should be assimilated during the first 3 years of training: basic module), is substantially limited. However, the basic module should be completed by verification of acquired knowledge in the form of the exam. Otherwise—in my opinion—it does not work properly. The only exception may refer to situations when both modules (the basic and the specialist ones) are supervised by the same doctors and are conducted in the same clinical unit.

Until the year 2013, endocrinology in Poland was a so called integrated specialty, that is, tailored to train doctors with different basic specialties by means of the same “integrated program”.

The regulation of the Ministry of Health, dated January 2, 2013, brought a particularly painful division of that integrated specialty in endocrinology into 4 separate medical specialties: “endocrinology” (0741), “gynecological endocrinology and reproduction” (0799), “pediatric endocrinology and diabetology” (0796), and “metabolic pediatrics” (0795). While the separation of “pediatric endocrinology and diabetology” from the general specialty in endocrinology seems inevitable because of the current existence of other medical specialties distinguished according to the age criterion for “pediatric” and “adult” ones, the creation of another endocrinology-related specialties is at least debatable. In my opinion, nothing bothered specialists of gynecology and obstetrics to take and complete a full 3-year specialty in endocrinology. “Metabolic pediatrics”, in turn, could well be a part of, for example, “pediatric endocrinology and diabetology”.

However, this fact does not seem to me to be the most dangerous, in terms of newly created specialties in the modular system. A number of specialist modules, which are to be completed after the basic module of internal medicine, has been shortened to 2-year training only. Unfortunately, endocrinology also belongs to this group (together with, for example, allergology, diabetology, geriatrics, immunology, nephrology, or rheumatology). As a spokesman for specialty in endocrinology, I would like to state clearly that the administrative actions, aimed at accelerating the process of obtaining new specialists in endocrinology—by shortening the time of training—is a misguided initiative, and the enormous queues for visits to consultant endocrinologists have a number of different underlying causes, but actually neither a lack of endocrinologists in the labor market nor the lack of interest in this specialty among the candidates are the true causes.

Without going into details, I would like to point out that if the health care system ensures equitable remuneration for endocrinologists working in the National Health Fund’s outpatient clinics, they would not “run away” to various nonpublic or private institutions, to get a much better salary. On the other hand, the number of trained endocrinologists is constantly increasing (60–70 people per year), which is not necessarily associated with the improvement in education quality.

The currently approved duration time of the specialist modules in the above mentioned specialties in Poland does not provide the possibility to recognize these specialties in the European Union. Issues related to the recognition of specialist training acquired in European countries are regulated by Directive 2005/36/EC of the European Parliament and of the Council of September 7, 2005, on the recognition of professional qualifications.

The document indicates which specialties obtained in a given European country are automatically recognized in other countries of

the Community. Article 25 of the aforementioned document regulates the general issues related to specialist training. The period of training is an important criterion indicated in the document (in the case of endocrinology, not less than 3 years and it is a requirement to recognize the specialty automatically—Annex V).

This is consistent with previous arrangements of the European Union of Medical Specialists (Union Européenne des Médecins Spécialistes [UEMS])—an organization which for a long time (1994 and even 1991, “The Leuven/Louvain Document”) has been recommending 4-year specialty in endocrinology, preceded by 2-year experience and training in internal medicine (“general internal medicine”) (Chapter 6, CHARTER on TRAINING of MEDICAL SPECIALISTS in the EU REQUIREMENTS for the SPECIALTY Endocrinology, Diabetes and Metabolism. Board with Specialist Section Endocrinology, Diabetes and Metabolism, November 1994).

These recommendations of the UEMS were updated literally in the last days, that is, September 30, 2016, and the new document continues to state that the specialization in endocrinology should start with at least 2-year training in general internal medicine conducted in full-time employment, followed by at least 4-year training in endocrinology together with diabetology, metabolism, and nutrition (DEFINITION OF ENDOCRINOLOGY AND OUTLINE OF THE TRAINING NEEDS OF ENDOCRINOLOGISTS, IN ACCORDANCE WITH CHAPTER 6 [ENDOCRINOLOGY] OF THE UEMS CHARTER; Monospecialist Section of Endocrinology of UEMS and European Board of Endocrinology [September 30, 2016]).

The current state of facts raises concern that a number of detailed specialties carried out in the modular system is currently conducted in Poland according to the regulations that probably will not be recognized in the European Union. In my opinion, this is an important mistake, which should be corrected as soon as possible. Additionally, in Poland the interest in internal medicine, as well as in the training of specialists in internal medicine, has been reduced, for the reasons that I have discussed above.

In 2014, together with my colleagues from the team of the provincial consultants in endocrinology, we prepared a new 4-year program of specialty in endocrinology. We had completed it before we were informed about the forthcoming categorical and immediate reduction in the duration of this specialty by half, with the formation of the 2-year specialist module in endocrinology. Initially, we had planned the introduction of that 4-year program after a 3-year basic module in internal medicine (3 + 4). Our project was not introducing any revolutionary extension of the speciality period, because—according to the previous system—the 3-year speciality in endocrinology was carried out after the 5-year speciality in internal medicine, pediatrics, or even

6-year specialty in general surgery or obstetrics and gynecology. In no way, the reduction of duration of the specialty in endocrinology from 3 to 2 years and the replacement of full specialty in internal medicine with a 3-year module seems to be beneficial. The new 4-year program of specialty in endocrinology, which we prepared, included a significantly increased duration of specialty internships, which were divided into internships conducted in hospital wards, as well as in outpatient clinics, specified the scope of professional knowledge and practical skills, and provided a clear distinction of skills, tests, and examinations which the candidate should perform by himself or herself and interpreted personally, or the performance of which was not strictly required, but the interpretation should be provided by the candidate.

Our program took into account the progress in the diagnostics of endocrine diseases (eg, it required the ability to assess the results of positron emission tomography). The new program also included an obligation to provide hospital discharge summaries prepared independently by a candidate under supervision of a specialist in endocrinology and internal medicine (50 discharge summaries), in diabetology (16), in endocrinology and pediatrics (12), and in endocrinology and gynecology (12). As a result of the hasty shortening of the specialization to a 2-year period, all of the components of the specialty have been reduced by about a half.

Summing up this part of my considerations, I would like to emphasize that the introduction of a “fast track” to obtain detailed speciality (3 + 2) not only adversely affected the “classic internal medicine” and reduced the number of people interested in a full specialty in internal medicine, but probably in the near future, it will lead to a reduction in the quality of education in the detailed specialties. Furthermore, the short specialist module will result in difficulties in the recognition of specialties obtained in our country.

It is a pity that this part of the reform of the specialty system was based on the fallacious premise that the reduction of training period is the antidote to arising queues to specialists.

Finally, I would like to raise one more issue, which refers to speciality in internal medicine, as well as almost all other medical specialties. The examination system in the currently accepted form raises many doubts, and perhaps in the future it should be slightly modified to improve the quality of the training process.

Although many arguments reasoned against practical exams involving patients, it does not mean, however, that it was impossible to organize a practical exam without their participation. And yet, the practical exam has been abolished since 2011 (spring session).

The claim that nothing prevents questioning candidates about certain practical issues during the oral examination is partially correct, though of limited feasibility, because of the limit of

questions asked at the oral exam (4 to a maximum of 6 questions).

Therefore, an attempt to deeply assess the practical knowledge of a candidate by means of questions asked during the oral exam, may lead to insufficient verification of theoretical knowledge, owing to the limited number of possible questions. I am of the opinion that the matter of the practical exam in specific areas had to be considered individually rather than eliminating administratively that exam for all specialties.

A statutorily guaranteed threshold for passing the test exam (60% of correct answers) also raises my doubts, because it allows a candidate to give wrong answers in 2 questions out of 5 and still to pass the exam. In comparison with the real medical decisions the specialists have to make every day, it may raise justified concerns about the level of the specialist competence. I absolutely agree that the quality of the prepared questions plays an important role in the difficulty of the test exam. Also questions too difficult or too complicated in construction may affect the result of the whole test exam. Anyway, comparing the Polish threshold to pass the specialty test exam with the thresholds of different exams in many other countries, we cannot boast of too excessive requirements.

On the other hand, it may happen during the oral examination, carried out in accordance with the current rules, that a candidate does not pass the exam because of a negative assessment of only 1 out of the 4 (to maximum 6) exam questions by the committee, as a result of an unsatisfactory grade given by only half (50%) of the present members of the examination committee, namely, usually by 2 people. This occurs even when other members of the committee assess the answer positively, and even if all of the answers to the other remaining exam questions were assessed positively. To me, this regulation actually seems very rigorous and too restrictive.

Therefore, the current state of internal medicine in Poland is affected by many factors and circumstances. The increasing development of medicine, which provides more accurate and more detailed diagnostics, as well as dozens of new medicines and treatment possibilities, guide medicine along the paths of a narrow specialty.

The current conditions of the basic level of general medicine, that is, primary health care, are unable to withstand competition with the treatment by various medical specialists. For this reason, patients “run away” from general practitioners, or from internal medicine consultants to specialists, thereby weakening the interest in doctors with more general qualifications.

Additionally, in many specialties (but not in all), the attempt to repair the system by increasing the number of specialists is a procedure leading in a wrong direction. A considerable improvement will come when expenditures on health care from the national budget increase significantly enough to make the doctor's work financially

profitable at every level of health care and at every level of reference. Importantly, the doctor's decision on working on various positions in health care should depend not only on the professional vocation and the satisfaction with helping people by providing effective treatment, but also on the financial conditions allowing for decent existence of a doctor and his or her family.

It seems apparent from the above considerations that the restoration of the true internal medicine will require numerous vital changes that have to include modification of the training system by introducing modern programs of specialty, carried out in a tailored time that will not be forcibly shortened in any way, as well as by providing a fair examination system that will not allow candidates with an average or even poor degree of preparation to take the final national specialty exam.

It seems obvious that if the tendency to expand the detailed specialties and to lower the criteria for obtaining qualifications remain a constant approach, the “real internal medicine” will never be recovered and much time will pass before a new group of outstanding specialists in internal medicine is experienced enough.

Note The opinions expressed by the author are not necessarily those of the journal editors, Polish Society of Internal Medicine, or publisher.