Internal medicine: I cannot live without you as you are my destiny

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Some time ago, Professor Anetta Undas, Editor-in-Chief of the *Polish Archives of Internal Medicine* and Professor Jacek Imiela, national consultant in internal medicine, invited me to write about my life as an internist and the role of internal medicine in today's world of narrow specialization.

My adventure with internal medicine started a long time ago during my medical education. As a 3rd-grade medical student, I went to Montreal in Canada. It was 30 years ago. I had a chance to do my clinical summer practice with wonderful physicians, including Dr. Stefan Horny, in several places in the province of Quebec. When I crossed the doors of the Polish-Canadian Welfare Institute in Montreal, which was a home to elderly Poles requiring medical and nursing assistance, I was asked about my practical achievements and skills acquired during my studies. This was followed by a sort of a practical exam in internal medicine as well as some theoretical exam in English. The staff at the Institute was fluent in English and French. Finally, I was accepted and I was told that I could assisst Dr. Horny in his duties as a physician in the Institute.

Dr. Horny offered me a possibility for clinical practice at an internal medicine ward in the Regional Hospital in Salaberry-de-Valleyfield in Quebec. I was very excited at the opportunity to learn more, to improve my English and learn some French, as well as to discuss different symptoms, diagnoses, and treatment plans. However, it was also a tough time for me as a nonnative speaker of English. In order not to lose such an opportunity, I was trying to do my best and spent much of my summer holidays in the hospital or in the Institute. I was also lucky to spent some time in Royal Victoria Hospital, Montreal, not only in an internal medicine ward but also inthe operating rooms where I assissted during cardiac surgeries and other procedures, such as parathyreidectomy. My stay in Canada was very rewarding in terms of improving my medical knowledge as well as my English- and French-speaking skills.

As many young students, I was dreaming first to become a surgeon, but then I realized that due to obvious reasons, it would not be possible to work in this specialty in the future. The solution to my dilemma came with time. This particular stay in Canada had a profound influence on my future decisions. During my exam in internal medicine at the Department of Nephrology, Professor Michał Myśliwiec, offered me an assistant position at the Department upon graduation. I graduated in 1989 with merit. As the assistant position was available from January 1, 1990, I went again abroad, this time to the United States. I met wonderful people: passionate, intelligent, open, and hard-working. Dr. P.J Wright, a consultant internist, showed me around. I participated in numerous consultations in a large regional hospital serving the states of Minnesota, Iowa, and South Dakota. In addition, Dr. M. Hurley, an invasive cardiologists working in Sioux Falls, South Dakota, made it possible for me to assist during percutaneous transluminal coronary angioplasty. I saw how the procedure spectacularly weakened or ameliorated pain during myocardial infarction, together with reversal of changes in electrocardiogram. It was amazing to watch patients improve after the pain went away with the ballooning of the coronary artery. I spent many hours in a catheter lab and in a cardiology ward watching percutaneous transluminal coronary angioplasty (wearing this very heavy, lead-containing, protective garment), echocardiography, listening to discussions about angiograms, successes and failures (requiring cardiac surgery among others), as well as assisting in the consultations all over the hospital. I saw uremic frost for the first time. In the simulation room, I was taught by residents to create vascular access. I was very grateful that my colleagues devoted their time to share the secrets of medicine with an unknown graduate. It was a great experience for me as there was no invasive cardiology or cardiac surgery at the Medical University of Bialystok at that time.

During my stay in the United States, I learnt that internal medicine was indeed the queen of all specialties. When I started my work in the Department of Nephrology and Internal Medicine, my superior, Professor Myśliwiec, always underlined that we should be the best possible internists as it helped enormously in the nephrology practice. With kidney failure, all the organs are affected. During our duties in internal medicine at an emergency room serving the whole city of Białystok, we were learning how to maintain and improve our skills as well as make decisions. It was not an easy time, as we had to struggle with a plethora of patients with various nonnephrologic diseases in a specialist regional hospital where nephrology was based but which had no surgical, intensive care, or neurological facilities. On the bright side, thanks to Professor Myśliwiec, my generation could learn a lot, in particular, how to make decisions with all the consequences, how to collaborate with other specialties, and how to look holistically at patients. It helped me also during my clinical training abroad, where besides nephrology, I also learnt about renal complications of other diseases, with cardiology and diabetology being the closest neighbors.

I am fully aware about the progress in medicine, with all new guidelines and recommendations; however, we should remember that we do not treat numbers, but patients with numerous comorbidities. We must adopt a much broader view, not only, for instance, at one purulent pimp on the forehead. For me, nephrology consultations are the most convincing example of the importance of internal medicine. In general, renal patients have quite a lot of diseases that should be treated by internal medicine specialists, with additional impairment of kidney function. It makes the whole scenario more sophisticated, demanding, and challenging in diagnosis, therapy, and outcome. It appears that in teaching hospitals, we do need specialized medicine for reference diagnosis and treatment, but to be good in our profession, we have to be excellent internists first as the basis for further narrow specialties. In smaller hospitals, the most required specialty is internal medicine with some geriatric knowledge for our aging population.

I am fully aware of all the limitation in reimbursement, but I am sure that we have to treat patients as human beings, and not just to perform procedures and report them as such. Globally, the comprehensive care lowers the costs and spares hospitalizations. The saddest part of the story is the fact that it is almost virtually impossible to find a place with such holistic approach. Although the resources are limited, we have to do all we can to use them efficiently for the best possible outcomes of our patients. We should bear in mind that one day, we or our closest family or friends will need medical help and we would expect the highest standard of care. As a mature generation of physicians, we should do our best to restore the role of internal medicine, to bring back its beauty, shine, and glory, and to make it interesting for students as a specialty. It should also constitute, as it did before, the basis for other subspecialties, because it is the broad fundamental knowledge and ability to put together the different pieces of the puzzle in the course of the disease that enable us to be better physicians. By excelling our skills as physicians, we can offer more integrated and comprehensive care, even within financial constraints, to our patients, including our most beloved ones.

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