

Internal medicine at the crossroads

To the Editor In reference to a recent interesting discussion in this journal on the dilemmas of internal medicine, I would like to present a few thoughts from the perspective of an old academic physician. I started clinical practice in 1972 as a junior fellow in a nephrology department. I became a board-certified specialist in internal medicine in 1978, and then in nephrology in 1992 and clinical transplantology in 2003. Hence, during my first 20 years, I was a general internal medicine specialist with the greatest expertise in the area of kidney diseases, which was also the focus of my clinical and research activity. Since the second half of the 1980s, I was also practicing as a clinical transplantologist.

Such a background enforced, in a natural way, a comprehensive approach to the patient. We were close to the legacy of Hippocrates, the father of modern medicine, who believed that disease was disharmony of metabolic processes in the human body and that treatment should restore the appropriate balance. It was our everyday experience at that time to investigate how deeply a severe kidney disease disturbed the balance of different bodily functions. Obviously, in an academic center, there have always been departments that focused on particular disciplines in the area of general internal medicine (ie, cardiology, hematology, endocrinology, and others). However, all of us were formally specialists in general internal medicine.

The development of narrower specializations on the foundation of internal medicine has its beginnings in the late 1980s. However, it should be strongly emphasized that the aim was to build “upper floors” on the fundamentals of internal medicine rather than to replace them by separate entities. The development of new diagnostic and therapeutic technologies inevitably led to creation of narrow fields of the highest competence. At that moment, we found ourselves at the crossroads—how to combine a holistic approach to the patient with a deep insight into his or her particular medical problem? Today, a patient at an internal medicine ward is typically an elderly person with multiple comorbidities and multiorgan complications. It is reiterated that this patient requires a comprehensive holistic approach. However, in my view, in postgraduate education we went too far in the fragmentation of the broad area of internal medicine into increasingly narrower

subspecializations. Rather than creating a separate new specialty of hypertension treatment and geriatrics, we should have focused on developing research, clinical, and educational centers that would deal specifically with the problems of hypertension and geriatrics within medical universities. Just to give an example from my specialty of nephrology: hypertension is one of the main symptoms of renal diseases—it is present in more than 90% of patients starting renal replacement therapy. In a cross-sectional study, a mean age of the patient hospitalized in the nephrology ward was 67.6 years, patients older than 65 years constituted 59.5% of admitted persons, and those older than 80 years—15%.¹ Unfortunately, patients increasingly believe in the idea that curing a single organ will result in their overall health and well-being.

What are the possible ways to prevent the “fragmentation” of the human body in medicine? Firstly, in the postgraduate education of doctors, internal medicine should constitute the basic specialization that has to be completed before pursuing further more detailed specialties. Secondly, in the module specialization system, the 3 years of training in internal medicine should be followed by a unified test for all trainees to verify their knowledge in the field. If we insist on “fragmentation” and subspecialization, the question arises of who should take responsibility for the diagnosis and treatment of a typical patient in the area of internal medicine, that is, an elderly person with multiple comorbidities. In my view, it should be a specialist whose competence encompasses the most serious medical problem that determines the patient’s prognosis. However, for such an approach to be safe for the patient, competence in a detailed subspecialty should be built on the extensive knowledge in general internal medicine.

The concept of creating a hospital network as the basis of the health care system organization creates a good opportunity to rebuild the position of a general internal medicine ward in a district hospital. Cardiologists, nephrologists, rheumatologists, or hematologists trained in internal medicine would be able to serve as consultants deciding which medical problems could be dealt with within the hospital or when the patient should be transferred to a reference department in a university center. Finally, the position of a specialist

in general internal medicine should be rebuilt in outpatient care. In my view, the best model would be an outpatient family clinic with a pediatrician and a general internist, and in larger units also with a gynecologist and a surgeon. We cannot expect that a single family doctor will be competent enough to care for pediatric, adult, and elderly patients at the same time.

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- 1 Ministry of Health. <http://www.mapypotrzebzdrowotnych.mz.gov.pl/>. April 2016. Polish.