



Developments in Internal Medicine

The changing face of internal medicine: Patient centred care



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ABSTRACT

Patient centred care is now considered the gold standard and there should be 'no decision about me, without me'. Internists who treat patients with complex multi-morbidities should consider patients' preferred outcomes, following a 'goal-oriented' principle. Perhaps the most important barrier to goal-oriented care is that medicine is deeply rooted in a disease-outcome-based paradigm. Rather than asking what patients want, the culture of modern medicine has prioritised optimal disease management according to guidelines and population goals. Doing what is right for the patient should be based on trust. Patients and internists must therefore meet as equals: 'I' and 'you' should be replaced by 'we'.

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1. Introduction

Patient centred care is now considered the gold standard in Europe and the United States, despite differences in patient behaviour from country to country. There should be 'no decision about me, without me' [1,2]. In the 21st century the most common chronic condition experienced by adults is multimorbidity, the coexistence of multiple chronic diseases or conditions [2]. Internists who treat patients with complex multi-morbidities should consider patients' preferred outcomes, following a 'goal-oriented' principle. Although the organisation of internal medicine differs throughout Europe, the core competencies of an internist should be the same [3]. Perhaps the most important barrier to goal-oriented care is that medicine is deeply rooted in a disease-outcome-based paradigm. Rather than asking what patients want, the culture of modern medicine has prioritised optimal disease management according to guidelines and population goals [4]. Doing what is right for the patient should be based on trust. Patients and internists must therefore meet as equals: 'I' and 'you' should be replaced by 'we'. Healthcare relies on a process of collaboration and communication between the patient and the doctor, with many others serving as interested third parties [5]. As the definition implies, the most important attribute of patient-centred care is the active engagement of patients when important health care decisions must be made. Examples include decisions about intensive chemotherapy, medications that must be taken for the rest of one's life, and screening and diagnostic tests that

can trigger cascades of serious and stressful interventions [1]. Internal medicine is a holistic medical speciality par excellence, and for this reason it should be at the forefront of patient-centred care. The fundamental principles are defined in the Medical Professionalism Charter of the European Federation of Internal Medicine (EFIM) and the American College of Physicians Foundation (ABIM), published in 2002 [6].

1.1. Principle of primacy of patient welfare

The principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

1.2. Principle of patient autonomy

Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

1.3. Principle of social justice

The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

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2. Internal medicine in the centre of multidisciplinary health care

2.1. The core business of the internist

Patient-centred medicine requires rational decision making and coordination of diagnostic and therapeutic procedures with emphasis on effectiveness and patient safety. This results in efficient use of public health care resources. These tasks fit the core competencies of the internist [7]. For most medical decisions, more than one reasonable path forward exists (including the option of doing nothing, when appropriate), and different paths entail different combinations of possible therapeutic effects and potential side effects. The basic instrument of the internist is clinical reasoning [8]. The first step in diagnostic reasoning, which is based on knowledge, experience, and other important contextual factors, is always data acquisition. Data acquisition, depending on the setting, may include elements of the history, the findings on physical examination, and the results of laboratory investigations and imaging studies. Ensuring a high quality of patient care and modelling professionalism whilst promoting diagnostic reasoning skills constitute the true art of internal medicine and should attract the most talented students [9]. With all the changes in our health care systems, one thing remains constant: the needs of patients. Patients want a continuing relationship with a doctor whom they trust, and they increasingly need that doctor to act as an advocate to help them get the best care within a fragmented health care system. A strong internal medicine infrastructure is associated with better health outcomes, lower costs, and a more equitable health care system, since internal medicine is the key to providing services to vulnerable populations. There is an urgent need to reverse the current trend of super- and subspecialisation, often triggered by the introduction of new technologies. Few physicians are now completely responsible for the care of their severely ill patients. Moreover “coal face” doctors no longer control the medical system within which they work. It is, therefore, very hard for an individual internist to modify or influence the quality, kindness and honesty of the medical care they participate in providing. Indeed, it may well be that is one of the major reasons so few clinicians now want to work on the front line of general internal medicine. Internists now need to be team players, and they must be involved in the control of medical systems, which needs to go back to those at the coal face. Although the line of students signing up for a career in general internal medicine is getting shorter, the line of patients in need of these doctors is getting longer every day.

2.2. Quality framework of internal medicine

The quality framework advocated by EFIM is one of the focal points of the Federation's activities [10]. This policy is aimed at maintaining a continuously high level of care, to improve care where necessary and being able to provide confidence to society that the best patient care is being delivered. Key concepts in the quality policy are: safety, efficiency, promptness, effectiveness, patient-centred care, and equity [8].

Professional standard: the care provided by internists is state of the art, safe and geared to actual patient needs. This care is most often provided by a multidisciplinary team with the internist taking the lead in coordinating input from other specialities. Internists have a duty to act in accordance with the responsibility imposed on them by virtue of their professional societies or organisations. For example, the internist is expected to follow professional guidelines and is prepared to be evaluated in that respect. The internist creates and manages a medical episode for each patient, providing a true insight into the case history, the differential diagnosis, the treatment and discharge plans and the current state of affairs. The internist is subject to accredited professional training in order to keep his knowledge up to date.

Allocation of responsibility: the internist is primarily responsible for coordinating the care provided to patients. The internist should remain

aware of the limits of his own abilities and expertise and, if so required, refer the patient to another medical specialist or care provider. The internist should hold his colleagues and members of the multidisciplinary team to account in respect of undesired behaviour and is compelled to take action if the undesired situation remains unresolved. An internist who shares care of patients with colleagues and/or other care providers, must enter into proper and joint agreements in respect of the allocation of duties and responsibilities. These agreements must be clear at all times to patients and all who are involved in their care.

Accountability: Internists must be accountable for all their actions. Primarily, they show this responsibility to patients, but also to hospital boards and health insurers who purchase that care. Health care organisations should collect and provide data on clinical activities and outcome, and the internist should engage with their organisation to use these data for quality improvement. Meaningful use of electronic health care records is recommended for high quality patient care. Clinical governance is vital, with transparent processes in place for dealing with serious incidents, complaints from patients and near misses. In the case of an adverse event, the patient is entitled to honest and prompt information. The internist must inform the patient of the nature and the cause of the incident with potential consequences, document this and notify the staff and management boards. The internist should disclose any civil, criminal or disciplinary proceeding brought against him. Health care organisations should provide internists with time and resources to participate in clinical governance.

Continuing professional development: Internists and their health care organisations should render their assistance to: (1) the quality assurance and quality improvement of specialist medical care in the organisation and (2) other activities that can be deemed useful in the interest of the patient and/or the hospital and/or other medical specialists practising there. Internists should participate in activities for accreditation and quality audits. They should have an open mind for mutual investigation and complaints handling. They should put appropriate emphasis on patient counselling, informing patients and patient safety. They should encourage registration of complications, and should institute a system of blame-free reporting of near-incidents. Patients are always entitled to honest and prompt information on the nature and course of incidents.

2.3. Multi-morbidity and ageing

Modern medicine must accommodate the demands of patients with complex medical needs. This challenge has to be pursued in ageing European societies where patients may have several diseases requiring treatment at the same time, leading to polypharmacy. This requires a generalist rather than a specialist approach, which places the internist in a prominent and vital coordinating role. To address this imperative, gerontology (the study of ageing) and geriatrics (the health and social care of the elderly) must become embedded into medical education of internal medicine at all levels, especially the postgraduate training of all residents and fellows in Internal medicine. In geriatric care, general internal medicine has a leading role to play [11]. For example, in setting appropriate goal-oriented outcomes in agreement with patients. These goal-oriented outcomes may not always be based on scientific evidence, whilst in many clinical trials elderly patients with multiple co-morbid conditions are excluded. Adhering to clinical practice guidelines may even have undesirable effects in this patient category [12]. Older patients need to be in the centre of the research agenda of internal medicine in the near future.

2.4. Education

The internist has a unique role as a clinician with a broad knowledge base and a finely tuned skill of clinical reasoning. Because of these skills the internist can make a significant contribution to training

undergraduate and postgraduate doctors and other health care professionals. In a context of growing specialisation of medical units in hospitals, internal medicine has a vital role to teach a generalist and holistic approach to patient-centred care. Clinical reasoning, whatever the students' future career choice, is crucial in the quality of training clinicians.

3. Conclusions

In the not too distant future, populations will be older and burdened with diseases that we cannot cure. To meet this challenge, internal medicine is ideally placed to play a pivotal role in providing patient-centred health care. What will be the major health problems of society? What clinical skills will be needed? The changing context of clinical practice will determine the role of the internist to a far greater extent than will changes in the organisation of health care provision [13]. A truly modern health care system is one in which science and informatics, patient–clinician partnerships, incentives and culture are aligned to promote and enable continuous and real-time improvement in both the effectiveness and efficiency of care [14]. EFIM encourages these aspirations and goals for the time has now come and we must face the challenges that are presented [15]. Internal medicine must focus on better care for individuals, better health care for populations and lower costs.

Conflict of interests

This is an official EFIM position paper, so none of the authors have any conflict of interest to declare.

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