

Internal medicine in Europe

Political issues in internal medicine in Europe. A position paper

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Abstract

What will be the future of internal medicine in Europe? Because of rapidly growing concerns regarding the position of internal medicine in many European countries, the European Federation of Internal Medicine (EFIM) has established a working group to analyze the situation. Being well aware of the variation in working practices in the different countries, the members of the group used an “all-European” approach to answer the following questions:

- Are there problems for internal medicine? If so, what are these problems and why?
- Why do the health care systems in the European countries need internal medicine?
- Why do patients need internal medicine?
- What needs to be done?

Internal medicine is the modern, clinical, and scientific medical discipline that is responsible for the care of adult patients with one or more complex, acute, or chronic illnesses. Internal medicine is the cornerstone of an integrated health care delivery service that is needed today. Decision-makers in politics and hospitals, insurers, journalists, and the general public need a better understanding of what internal medicine can offer to the health care system and to the individual patient.

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1. Introduction

There are rapidly growing concerns about the position and the future of internal medicine in many European countries (as well as in the United States). These concerns focus on the role of internal medicine in hospitals, in the academic setting (teaching, research, career options), in outpatient care, and in health care systems overall.

The European Federation of Internal Medicine (EFIM) has, therefore, established a working group to analyze the situation and to take action to support the essential role of internal medicine in the health care systems of European countries. The members of our group are well aware of the different working practices in the various European countries. Different countries have different workplaces; with hospital duties only, with outpatient and inpatient care, with private practice (mainly in primary care); with work as a consultant, some with a combination of internal medicine and a subspecialty.

The most evident areas of conflict and problems of identity are in the relationship between internal medicine and its subspecialties and between internal medicine and general or family medicine in the setting of outpatient primary care.

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The aim of this paper is to provide a short analysis of the problems, risks, and opportunities of internal medicine, a description of the position and strengths of internal medicine in today's health care systems, and some proposals for possible action points for the EFIM and for the national societies. We have used an integrated, "all-European" approach, but of course every project or activity has to take into consideration the different working conditions in each country.

2. Are there problems for internal medicine? If so, what are these problems and why?

- 2.1 The changes in health care delivery systems, the steady progress in technology, the problems in financing health care, and the demographic changes in many countries have an impact on all medical fields, especially on internal medicine as a traditional, broad, complex medical discipline.
- 2.2 Internal medicine has lost part of its identity as a scientific discipline. It is much easier to become successful in an academic or professional career in one of the subspecialties than in (general) internal medicine.
- 2.3 Internal medicine is no longer considered the "mother" discipline and is frequently under attack by its "daughters", the subspecialties. This is most evident in the hospitals (de facto elimination of many integrated departments of internal medicine, and the steadily growing number of "chest", "cancer", "diabetes", "heart centers"), but it can also be seen in the areas of teaching, research, financing, industry support, congresses, and health insurance.
- 2.4 Geriatric medicine and palliative medicine—until now core competencies of an internist or of a department of internal medicine—are now considering themselves as independent medical fields.
- 2.5 Some of the young, dynamic, and often technology-supported subspecialties consider that if a patient's condition leads him first to an internist's office or into a department of internal medicine, it acts simply as a detour. They are successful in publicity and in positioning themselves.
- 2.6 General internal medicine has been asleep for too long! It has not yet been able to show its competencies convincingly to the public or to the decision-makers in health care.
- 2.7 A short and clear definition is difficult to find, so internal medicine is often described as "non-surgical", "non-invasive"—it is hard to spread enthusiasm for a "non"-discipline.
- 2.8 Internal medicine has not yet found a new "corporate identity" as a modern discipline of integrated and coordinated health care delivery, of decision-making and disease management, of clinical epidemiology,

and as the medical specialty for complex and polymorbid patients.

- 2.9 The future roles and positions of internal medicine, family medicine, general practitioners, and even nurse practitioners in outpatient and primary care are not clear.

3. Why do the health care systems in the European countries need internal medicine?

- 3.1 With regard to both cost and delivery problems, today's health care has to be an integrated health care and not an accumulation of independently working specialties, even if we need them for their expertise whenever indicated.
- 3.2 As a result of demographic changes in many European countries, we will see steadily increasing numbers of old and polymorbid patients and of complex and chronic diseases; their management is a core competency of internal medicine.
- 3.3 New, expensive, competing methods need to be evaluated scientifically and conflicts of interest avoided; this cannot be done by the promoting specialty itself. The same is true for the establishment of standards and guidelines to be used by generalists, an increasingly important task and research area for internal medicine.
- 3.4 Cost effectiveness means getting the best medicine for the money available. It will never work without good co-ordination between the inpatient and the outpatient sector, and between the specialties involved. This means an evidence-based work-up and treatment; it means the best, but not maximal, use of the diagnostic and therapeutic technologies. Finally, this means integrated disease management (both curative and palliative). Again, these are all core competencies of modern internal medicine.
- 3.5 Hospitals structured as an accumulation of specialty wards or clinics and without a department of general internal medicine are not able to provide high-quality, cost-effective, integrated care for patients with unclear or complex diseases or for polymorbid patients.
- 3.6 Family medicine, general practitioners, and the subspecialties of internal medicine need good teaching in general internal medicine as the cornerstone of their professional formation. The importance of internal medicine in teaching institutions is therefore paramount.
- 3.7 The boundaries between inpatient and outpatient medicine are gradually fading away. Internal medicine is the classical "link discipline", providing primary and expert care in the hospital and, in many European countries, also in the outpatient setting.
- 3.8 The internist is well trained in screening patients, in selecting the appropriate diagnostic and therapeutic

procedures, in avoiding costly over-diagnostics and double-diagnostics, and in leading patients through the health care delivery system.

4. Why do patients need internal medicine?

- 4.1 The internist is a competent, personal doctor who takes into consideration all of a patient's health problems, however complex they may be.
- 4.2 A patient with coxarthrosis or prostate hyperplasia may go directly to the orthopedic surgeon or to the urologist, but if a patient is sick as a result of an undetermined disease or has a combination of health problems, or if there are several diagnostic or therapeutic options, the best doctor to see is the internist and the best place to go is to a department of internal medicine.
- 4.3 For all cases involving several specialties or services, internal medicine is the discipline that oversees, links, and coordinates them all; it does not consider itself better or as the "mother", but simply as the integrating service that is so urgently needed in today's medicine.
- 4.4 In many countries, internal medicine includes outpatient and inpatient medicine, a considerable advantage compared to family or general medicine, which is restricted to ambulatory primary care.

5. What needs to be done?

- 5.1 A definition and a mission statement for the modern discipline of internal medicine need to be established. The EFIM proposes the following text:

"Internal medicine is the core medical discipline that is responsible for the care of adults with one or more complex, acute, or chronic illnesses.

It encompasses multi-system care and integrates other specialties, both in the hospital and in the community. It is patient-centered and committed to ethical, scientific, and holistic principles of care."

Internal medicine is both a clinical and a scientific discipline that analyzes the knowledge, methods, and findings of the subspecialties and that integrates them into specific concepts for diagnostics, treatment, and care for individual patients.

Specific fields of interest include problems caused by polymorbidity, patients with difficult and complex diagnoses, long-term and palliative care, and the challenge of developing standards, decision-making tools, quality improvement tools, and integrated health care delivery systems.

Internists are opposed to any form of discrimination; they need to comply with the principles of the Charter of Medical Professionalism (published by ACP-

ABIM-EFIM) and they need an appropriate setting for their work.

- 5.2 National programs for specialist training (postgraduate education) need to be checked and adapted to make sure the competencies of internists meet the challenges of the profession (knowledge, skills, communication, medical humanities, medical economics, scientific and teaching abilities).
- 5.3 Departments or clinics of internal medicine need to be established or re-established as centers of excellence, of teaching, and of research, not dominating but cooperating with the units of the subspecialty disciplines, bearing in mind the financial components of cooperation problems.
- 5.4 Awards and grants need to be created for specific accomplishments in the field of internal medicine.
- 5.5 Internal medicine needs to be integrated or preserved as a discipline in itself when teaching students, rather than being presented as a mere summary of "a little cardiology", "a little nephrology", "a little infectious disease", etc.
- 5.6 Specific training tracks need to be provided for internists planning to work in primary care in countries where internal medicine is involved in outpatient primary care medicine.
- 5.7 The relationship between internal medicine and the former subspecialties needs to be defined. Perhaps the internist of the future will be a competent general internist with additional training in one subspecialty.
- 5.8 The relationship with GPs and family physicians needs to be defined. In large European cities, internists are clearly the best primary care physicians; in rural areas, it is helpful for a family physician to have additional training in surgery, obstetrics/gynecology and, perhaps, pediatrics.
- 5.9 As with every professional group, internal medicine needs people who are active in marketing; decision-makers in politics, hospital administrators, insurers, journalists, the general population, and our patients need to know what internal medicine can offer the health care system and the individual patient.

6. Action points for the EFIM in cooperation with national societies of internal medicine

- 6.1 Publish a position paper and keep it up to date.
- 6.2 Establish a permanent, working group to promote the position of internal medicine in Europe's health care systems based on a definite strategy and to support specific research.
- 6.3 Give support (written materials, speakers, debaters) to national societies when necessary (political struggle, hospital organization, maintaining or re-establishing the title of specialist in internal medicine, payment systems).

- 6.4 Give continuous support to the European School of Internal medicine (ESIM) and to the European Exchange program.
- 6.5 Create a prestigious award and/or an EFIM grant to encourage research and academic careers in internal medicine. The Foundation for the Development of Internal medicine in Europe and the EFIM fellowship program are starting tools in this area of activities.
- 6.6 Establish recommendations for specialist training in internal medicine, taking into consideration the specific needs of the different countries.
- 6.7 Cooperate with the national societies, with the ACP (initiative “The Revitalization of Internal medicine), and the UEMS (internal medicine section).
- 6.8 Establish permanent contact with politicians and other decision-makers in health care.
- 6.9 Add specific internal medicine sessions (decision-making, outcome research, disease management, integrated health care delivery) to the program of EFIM congresses.
- 6.10 Become involved in the process of establishing guidelines and standards for Europe. Guidelines for use by generalists must never be established solely within the inner circle of the given specialty.