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General internal medicine: A core specialty in jeopardy

Specialists in general internal medicine must be involved in community-based training if we are to recruit young physicians to this challenging and essential field.

ABSTRACT: With the proliferation of subspecialties, the need for general internal medicine specialists to supervise care has never been greater, not only for aging patients, many of whom have problems in several systems, but also for younger and middle-aged patients with multisystem disease. Fewer students than ever before are opting for a career in general internal medicine, partly because they lack exposure in medical school to well-run comprehensive general internal medicine practices, where they can learn from able physician mentors. Unless we correct this fault in medical training, we will be condemned not only to poor and fragmented care but to the enormous expense of having one patient attend half a dozen subspecialists when one general internal medicine specialist would be sufficient.

The shortage of general internal medicine (GIM) specialists in Canada is becoming a national emergency.[1] Canadians are not getting the best possible standard of health care because our medical schools and health care planners have failed to recognize the crucial importance of general internal medicine. Subspecialty care has grown disproportionately and we are no longer training enough young physicians in this professionally rewarding specialty.

General internal medicine specialists are highly trained physicians who deal with illnesses in all body systems in adult patients, apart from those who need surgery or OB/GYN care. They provide the vital link between family practitioners (FPs), who give primary care in all fields to all age groups, and subspecialists, who provide care related to a single body system. In many cases, the subspecialist reports back to the GIM specialist, who is responsible for treatment until the patient's illness is stabilized and the patient returns to the care of the FP. Many diseases, including arteriosclerosis, rheumatoid/collagen disease, and systemic infections, affect several body systems. As patients age, an increasing number have separate diseases in more than one system. Only the GIM specialist can coordinate the care for all these problems and provide continuity of care to patients and advice to their families. Having several subspecialists, each treating a different system and attempting to be in charge of the overall care of the patient, is not good medicine and is very costly.

In large cities, where subspecialist access is greater, consultation with a GIM specialist may be bypassed at the request of patients or FPs. In teaching hospitals, this pressure to bypass the GIM specialist may also occur because students and residents believe they will learn more from the subspecialists.

In urban and rural areas without access to teaching hospitals, a well-trained GIM specialist is essential. Often the GIM specialist will have an interest in and knowledge of a particular body system and be able to advise colleagues whether a subspecialist consultation is needed. This is of particular value in those communities that cannot provide enough work for a subspecialist in every system. In this

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setting, the GIM specialist becomes the hub of the medical community.

Community-based GIM specialists provide office and hospital-based consultations, seeing a broad range of common and important medical problems firsthand. In addition to working on call, they often work in ER and ICU settings. This requires a wide knowledge of disease, its investigation and treatment, as well as an understanding of how the patient and family might react to the illness. Thus a wide range of skills is needed to do a challenging job well.

Given the exciting and satisfying nature of the work, why are we not attracting young physicians to this specialty? The main reason is that students during training are not exposed to the type of general internal medicine practice needed in smaller cities and towns not directly involved with teaching hospitals. There has recently been an effort to interest students and residents in the specialty of general internal medicine, but it has not succeeded because in our teaching hospitals the unspoken message is that GIM specialists are inferior to the subspecialists. In addition, the instruction that trainees get from the GIM specialists in teaching hospitals is seldom in the office but mainly on wards, with their plethora of problems related to placement, substance abuse, HIV/AIDS, and other long-term care issues. Patients with other problems rarely stay in hospital after completion of the few investigations requiring admission. Not surprisingly, many trainees find the mix uninspiring. They get little or no exposure to the wide range of patients and human problems that community GIM specialists must handle and that make their work lives so interesting. This is not to say that patients in teaching hospitals are unimportant, just that teaching hospitals do not reflect the type of practice that a GIM specialist in the community will have.

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If we believe that GIM specialists are crucial to our health care system, how can we remedy this situation? We must accept that students and residents are unlikely to be attracted to and can seldom be trained for general internal medicine in the teaching hospital setting as it is now. There are numerous GIM specialists in the province who are able and interested in teaching, and who can act as role models and mentors to students and residents. These physicians often feel alienated from the medical school because of a lack of contact and an apparent disinterest in what they do. They must be brought into the fold, respected for their unique contribution, and made an essential part of the medical school and its programs. They should be involved in decisions regarding community-based training, included in academic CME, and allowed to pass on practical skills learned from a lifetime of clinical experience. They should be made responsible to the dean for exposing, training and, we hope, recruiting young physicians to the indispensable specialty of general internal medicine.

There is a pressing need to act now. Internists grow older and need replacements. Aging patients grow sicker and need specialty care from GIM specialists and subspecialists. Surgeons are operating on a more complicated patient mix, and need preoperative and postoperative support from GIM specialists. Our faculty of medicine has an obligation to train doctors for both teaching hospitals *and* community-based practice. To do this, they need to expose students to general internal medicine early in their careers so that they understand how rewarding it can be. They need to network with internists across the province, involve them in training, and strengthen the specialty from the ground up. Without such action, the health of all Canadians will suffer.

Competing interests

None declared.

References

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