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# Academic General Internal Medicine: Past, Present, Future

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### The Past

Before the subspecialization of medical research in the 1920s, academic internal medicine was academic general internal medicine. Over the next 50 years, the subspecialization of academic medical research increased. However, internal medicine hospital wards remained undifferentiated, remaining open to patients with a variety of medical ailments. This pattern held true for physicians as well; academic internists became increasingly specialized in research interests, yet remained generalists in their ward work.

This arrangement began to break down in the 1970s when academic general internists and subspecialists began to move in opposite directions on the wards. Specialists began to retreat from attending on general medicine services moving to wards organized by subspecialty or to consult services. This shift allowed subspecialists to do inpatient work limited to their area of expertise. General medicine services responded to this trend in one of two ways: either by placing general internists in the growing number of available attending positions, or by decreasing in size as patients were admitted less frequently to general medicine services and more frequently to the expanding subspecialty services.

In some institutions, wards remained as general medicine services with only one or two subspecialty wards, such as cardiology and oncology. In this case, the remaining subspecialists limited their inpatient work to consult services. In these institutions general internists filled the attending positions vacated by the

subspecialists and were able to maintain their traditional identities as Oslerian internists, caring for patients with complex problems.<sup>1</sup>

In other institutions, medicine subspecialties established their own wards. As a result, general internal medicine became one of many services, generally of lesser medical interest and tending to attract patients that were less desirable to the subspecialties. General internists in these institutions conducted less inpatient attending and found themselves focused more exclusively on primary care.

A continually expanding knowledge base in internal medicine was certainly conducive to an increasing specialization among internists. With this increasing breadth and depth of knowledge, a retreat to delimited areas was desirable for many specialists. It was likely thought by many specialists that the same breadth and depth of medical knowledge that moved them to subspecialty care would rightly move general internists away from the complexity of "all-comers" inpatient internal medicine; moving general internists toward a more limited scope of practice. General internists however, did not agree and continued to seek roles for themselves in which they could maintain an identity as Oslerians, caring for a wide range of patients with complex problems.

### Rediscovery of General Internal Medicine

Academic internal medicine rediscovered academic general internal medicine in the 1970s and 1980s. Several factors led to the reemergence of "generalism." Moving away from a consultative role, internal medicine practice also shifted toward primary care while "general practice" became less viable as a "specialty."

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In 1969, the federal government presided over the creation of the specialty of family medicine. In the mid-1970s, the government began to encourage internal medicine's increasing role in primary care by supporting the creation of primary care tracks within internal medicine training programs. These legislative changes were based on the widely held opinion that the American health care system was skewed toward specialty care, which increased costs and decreased access. The primary care grants that resulted from the Health Professions Educational Assistance Act of 1976 (PL 94-484) were intended to shift the career choices of American medical graduates away from the specialties and toward primary care.<sup>2</sup>

Internal medicine was an important beneficiary of this legislation. However, many internists were deeply ambivalent about primary care, believing that it did not measure up in intellectual rigor to traditional Oslerian internal medicine. In the early 1950s, Ward Darley, MD, former director of the Association of American Medical Colleges, urged internists to take on the role of primary care, yet he was rebuffed.<sup>3</sup>

By the 1970s, however, chairs of departments of internal medicine could not afford to turn away from the federal money in the form of primary care grants. Academic general internists of this era were leery of embracing primary care as a defining role for general internal medicine. The discussions leading up to the formation of the Society of General Internal Medicine (SGIM), the first general internal medicine academic society, reflected this ambivalence.<sup>4</sup>

As a result of the legislation, primary care tracks appeared and were the occasion for general internists to markedly raise their visibility within academic departments of medicine. Around this time, the Accreditation Council for Graduate Medical Education's Residency Review Committee for Internal Medicine (RRC-IM) mandated a continuity clinic experience for all internal medicine residents. Since few subspecialists had either the desire or time to supervise continuity clinics, many departments of internal medicine looked to the new divisions of general internal medicine to supervise the outpatient experience.

During this time, new opportunities in health services research developed<sup>5</sup> in areas such as clinical epidemiology, medical decision-making, and health policy studies. Spurred by the possibilities of grants from federal agencies and foundations, a growing number of general internists developed these research interests. The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation were particularly important in providing fellowship level research training for general internists.

In the mid to late 1980s, many academic health systems favored rapid expansion of their primary care base.<sup>6</sup> They reasoned that an increased primary care

base would bring patients to their health systems and would prevent the loss of patients to other systems. This rapid practice expansion required large numbers of general internists to provide primary outpatient care.

An increased supply of academic general internists likely accelerated the retreat of subspecialists from general medicine wards. During the past 15 to 20 years, generalists, including hospitalists, have increasingly come to dominate staffing of inpatient general medicine wards at many institutions.<sup>7</sup>

These varied forces have stimulated the growth of divisions of general internal medicine to sizes ranging from the teens to greater than 100 members at most academic medical centers in the United States in 2005.

In 2001, division chiefs of general internal medicine joined to form the Association of Chiefs of General Internal Medicine (ACGIM). The defining goals<sup>8</sup> at the inception of ACGIM were to:

- Provide professional development through leadership and management training.
- Provide forums in which to exchange information.
- Provide personal development and networking for chiefs.
- Influence and educate institutional leaders about issues relevant to academic general internal medicine.

Currently, ACGIM has a growing membership with more than 100 members. The association sponsors many initiatives and activities, including a yearly institute for division chiefs. The institute focuses on general leadership and management issues as well as specific issues such as measuring clinical productivity and building a general internal medicine research program.

### The Present

In 2005, research in many divisions of general internal medicine continues to flourish. The Agency for Healthcare Research and Quality has funded significant research for many divisions of general internal medicine. The National Institutes of Health (NIH) have increased funding for quality and outcome studies over the past 5 years, enabling many divisions of general internal medicine to receive federal funding. The Department of Veterans Affairs Health Services Research and Development Centers of Excellence have also become a major funding source for important outcome studies. In addition, foundations continue to be generous in supporting various academic general internal medicine activities.

From an educational perspective, the need for general internists seems to increase annually. General internists continue to oversee outpatient continuity clinics at many institutions and fill the majority of inpatient medicine ward attending positions. Currently, the majority of academic hospitalists are members of academic general internal medicine divisions. These divisions also include the clinician-educator cadre.

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A major challenge facing general internists and their educational role is a lack of adequate financial support for outpatient continuity clinic supervision. Whereas some institutions recognize the costs of this RRC-IM-mandated activity, other institutions expect division of general internal medicine to provide the supervision without adequate financial support. An unpublished survey of ACGIM members found that as much as one third of divisions receive no significant financial support for supervising the resident clinic (R. M. Centor, unpublished data).

Outpatient clinical activities of academic general internal medicine are financially challenged, just as are those of our counterparts in private practice. Compared with the private sector however, academic medicine has more problems with overhead and payer mix. ACGIM along with SGIM is currently focusing on physician payment concerns. As medical care increases in complexity, inadequate payments for cognitive services continue to plague general internists and many subspecialists.

ACGIM is also focusing on the quality movement. This movement has influenced national thinking. More quality measures are being reported, while pay for performance will become more widespread during the next few years. ACGIM and SGIM are working to better define quality measures and to inform decision-makers of the problems associated with the pay for performance movement.

## The Future

Although it is always difficult to predict the future of research funding, it is likely that health care practices for quality and errors will continue to be examined. These studies, which are currently funded by NIH, will include multi-disciplinary teams of general internists and subspecialists in departments of internal medicine.

Pressures on financing for the education of physicians-in-training will likely continue. ACGIM and SGIM will work with other members of the internal medicine community to advocate for improved financing of outpatient and inpatient medical education. In particular, the documentation demands for inpatient supervision will require continued scrutiny.

General internists provide care to patients with multiple medical problems. How payers will value the care of these patients will influence the clinical future of academic general internal medicine. Current reimbursement systems do not recognize or adjust for the amount of time necessary to provide high-quality care to these patients. The current system focuses on a checklist of variables such as history, physical, and complexity. This system undervalues the cognitive function and almost totally ignores the time demands of complex patients.

For example, payers reimburse for visits regardless of the required preparation time and the time spent

evaluating lab work and imaging studies. The current system does not reward the diligence and painstaking attention to detail that patients with complex problems require. The reimbursement system, which discourages physicians from spending adequate time with these patients, may sometimes result in substandard care.

There is an opportunity for general internists to demonstrate the value of managing patients with complex problems. Internists, particularly general internists and nonprocedural subspecialists should seek change in reimbursement for both inpatient and outpatient care. Until there is an adjustment made for the amount of time necessary to care for patients with complex problems, some will receive inadequate care due to time constraints.

## The Role of Academic General Internists in the Future

There are many opportunities and challenges for academic general internists in the future. It will be important to determine how general internal medicine is defined in the future and understanding how general internists can fill important roles in the future of health care.

The hospitalist movement will provide opportunities and challenges for academic general internal medicine. As the hospitalist movement<sup>9</sup> grows, it may conflict with academic general internal medicine. For instance, some institutions have created separate divisions of hospital medicine as a result of this growth. Academic divisions of general internal medicine however, should continue to include general internists who have both inpatient and outpatient expertise.

Academic general internal medicine will need to balance the advantages that hospitalists provide through teaching and inpatient care with the disadvantages that accrue to other general internists who no longer participate in hospital medicine. Also, academic general internal medicine will need to determine how much inpatient work is needed for an internist to remain effective.

Another challenge facing the role of general internists is the continued expansion of subspecialty medicine.<sup>10</sup> Many subspecialties need to expand to provide important care to patients. For instance, the demand for nephrologists, gastroenterologists, and cardiologists is growing more rapidly than the current system can produce. However, a threat to general internal medicine occurs if subspecialty fellowships increase their output without a corresponding increase in residency size. Without increasing residency size, fewer general internists will be produced.

## The Future of ACGIM

ACGIM will continue to work to achieve the goals articulated at its formation. The association will work to help divisions of general internal medicine provide

high-quality clinical care in both the inpatient and outpatient setting; pursue an expanded research agenda (focusing on issues related to practice, in areas such as measuring health care quality); and, seek continued improvements in graduate medical education. In working to reach these general goals, ACGIM will address many emerging issues, such as the proper role of part-time faculty and how to best measure quality of care.

Academic general internists face many interesting challenges, as do all of their internal medicine colleagues. Academic general internal medicine will continue to work with the subspecialty community to best define complementary roles (both in academic settings and private practice settings). General internists have a responsibility to creatively advocate for the issues that are especially germane to general internal medicine and to join with our colleagues in the internal medicine community to work on mutually beneficial solutions to shared problems.

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