

Health Care System Chaos Should Spur Innovation: Summary of a Report of the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine

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The Society of General Internal Medicine asked a task force to redefine the domain of general internal medicine. The Society believes that the chaos and dysfunction that characterize today's medical care and the challenges facing general internal medicine should spur innovation. The task force proposed the following recommendations. Remaining true to its core values and competencies, general internal medicine should stay both broad and deep, ranging from uncomplicated primary care to continuous care of patients with multiple, complex, chronic diseases. Postgraduate and continuing education should develop mastery. Wherever they practice, general internists should be able to lead teams and be responsible for the care given by their teams, embrace changes in information systems, and aim to provide most of the care required by their patients. Current financing of physician services, especially fee-for-service, must be changed to recognize the value of services performed outside the traditional face-to-face visit and give practitioners incentives to improve quality and efficiency and

provide comprehensive, ongoing care. General internal medicine residency training should provide both broad and deep medical knowledge as well as mastery of informatics, management, and team leadership. General internal medicine residents should have options to tailor their final 1 to 2 years to fit their practice goals, often earning a certificate of added qualification in generalist fields. Research should expand to include practice and operations management, developing more effective shared decision making and transparent medical records and promoting the close personal connection that both doctors and patients want. The task force believes that these changes will benefit patients and the public and reenergize general internal medicine.

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See editorial comments on pp 659-664.

For many patients and doctors, the reality of medicine in the United States falls far short of its promise. Every day, patients, their doctors, and other caregivers team up to achieve unprecedented health improvements, and prospects for medical science, informatics, and service delivery have never seemed brighter. Yet, inefficiency, unsafe systems, medical errors, and a quality chasm between the best possible care and routine everyday care plague the delivery nonsystem of U.S. health care (1, 2).

The cost of care is rising rapidly again, with no evidence that this will lead to better outcomes (3-5). Emergency departments and hospitals are overcrowded (6), often because primary medical care is underdeveloped and inaccessible (7-9). People with sufficient wealth see "boutique" practitioners offering guaranteed access to care that most insured people used to consider routine. Meanwhile, more than 40 million Americans are uninsured, and declining reimbursements discourage physicians from accepting new Medicare patients (7, 8).

This environment is chaotic and dysfunctional for many patients and doctors, especially general internists. While remaining committed to providing high-quality patient care, internists struggle with low reimbursement, rising administrative burdens, and demands for brief visits that satisfy neither doctor nor patient (10-14). Meeting disillusioned practitioners may discourage students who entered medical school interested in generalist disciplines. Yet, well-trained general internists, especially hospitalists, remain in demand (15).

CORE VALUES

A Society of General Internal Medicine (SGIM) task force recently examined the domain of general internal medicine in light of an uncertain future and made recommendations to redefine this domain (Table 1) (the complete task force report is available at www.sgim.org/futureofGIM.pdf). We reflected on Peabody's famous dictum—"The secret of the care of the patient is in caring for the patient" (16)—and the Society's mission "to promote improved patient care." We concluded that instead of fearing change and being paralyzed into living with the chaos we know, general internists should take the opportunity to promote new solutions while remaining true to our field's core values and competencies (Table 2) (17). Some of these values and competencies are common to all professions; others are common to almost all medical specialties. Although shared by internal medicine subspecialties and other primary care fields, some core values would undoubtedly be regarded as distinguishing features of general internal medicine. These values are not new; rather, they have withstood the test of time and have sustained our specialty because patients appreciate them.

ADAPTING TO A CHANGING ENVIRONMENT

In the 1970s, when generalist care in the United States was last reinvented to meet patient needs, lofty goals that have yet to be achieved were set (18): Academia has not trained comprehensive generalists, and the nation's health care system has given generalist physicians no special status. The roles of general internists and other primary care

Table 1. Summary of Society of General Internal Medicine Task Force Recommendations

<ol style="list-style-type: none"> 1. General internal medicine should remain true to its core values and competencies, although market forces may tempt the field to abandon them while adapting to chaos. Our field's strengths are critical to serving our patients' needs, promoting their well-being, and providing compassionate care. 2. The domain of our field should stay both broad and deep, ranging from providing or supervising uncomplicated primary care to delivering continuous care to patients with multiple, complex, chronic diseases. As the principal provider for adults, general internists need skills in gynecology, dermatology, orthopedics, otolaryngology, psychiatry, and internal medicine subspecialties. 3. General internal medicine should embrace changes in information systems, especially those promising to enhance patient partnership and self-efficacy, reduce costs, and improve care efficiency and outcomes. 4. Postgraduate and continuing medical education should develop mastery, which is key to patient and professional satisfaction. Mastery of our field should include delivery of care, practice management, information systems, team leadership, and traditional internal medicine knowledge and skills. 5. General internists should usually work in teams and provide services through contact with patients, telephone communication (directly or through staff), and more asynchronous communication using e-mail and other new communication technologies. Wherever they practice, general internists should lead and be responsible for the care given by their team members and should aim to provide most of the care required by their patients. 6. Current financing of physician services, especially fee-for-service, must be abandoned, reformed, or restructured to include reimbursement for 	<p>services provided outside of traditional face-to-face visits. Physicians should be reimbursed for time spent supervising long-term care, managing teams, and providing services by telephone and e-mail. Alternatively, physicians could be paid a patient-management fee plus reimbursement for specific services or a salary with incentives for productivity, quality, and improved outcomes. We endorse developing reimbursement based on quality and outcomes.</p> <ol style="list-style-type: none"> 7. General internal medicine residency training should be reformed and reconstituted to provide broad, in-depth medical knowledge and mastery of additional skills in informatics, management, and team leadership. General internal medicine residents should have options to tailor their program's final 1 to 2 years to their anticipated practice and career goals, often earning a certificate of added qualification in special generalist fields. Subspecialists would typically diverge from internal medicine residency after 2 or 3 years. For this recommendation to be viable, reimbursement reform is required. 8. General internal medicine educators and researchers should emerge as leaders, promoting the changes in academia that this new vision implies. They will need support from other academic leaders, especially department chairmen. Skill development and research must expand to allow faculty to gain the mastery and tools to teach medical informatics, team leadership, and practice management. Research will expand to include practice and operations management, developing more effective shared decision making and transparent medical records, and promoting the close personal connection that both doctors and patients want. Research should keep improving, not only documenting, the value of generalist, comprehensive, and continuous care.
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providers, including physician extenders, have blurred (19).

To distinguish themselves, general internists should be able to care for patients with multiple, complex, chronic diseases and to perform or supervise uncomplicated primary care (17). Preventing and managing chronic diseases will eventually constitute an estimated 80% of medical care. Fifty percent of all patients with a chronic disease have one or more other chronic diseases. This represents a unique opportunity for general internists to translate their broad and deep training into crucial benefits for patients (20).

Breadth and Depth

Although breadth and depth are general internal medicine's distinguishing features, individual practitioners find them its greatest challenge because they are relative and vary by setting. The current notion of a well-rounded generalist physician who can care independently for all types of patients, referring only a small fraction of cases to specialists, seems obsolete. Instead, we must devise creative ways to manage patients jointly with subspecialists (21–24) to provide the best quality (25). Ultimately, general internists must choose which areas to master and where to maintain breadth, not depth.

Communication

General internal medicine must take a leading role in realizing the potential of new information systems to improve communication and collaboration and to help create

more involved and informed patients. Such systems can help improve outcomes and performance (2).

Mastery

Professional satisfaction will be increasingly tied to mastery (26), ideally designed to meet both professional and patient expectations. Mastery and delivering high-quality services should be the basis of increased remuneration for our knowledge-based cognitive specialty (27).

Training in the delivery of care and practice management is inadequate for a new paradigm. General internists must lead teams and should aspire to cross the Institute of Medicine's quality chasm (2). Patients need doctors committed to distinguishing between advances that are truly beneficial and those offering little benefit despite promotion. General internists should aspire to lead efforts to translate crucial research advances into practice (5, 28, 29). Doing so will require mastering organization and management skills as well as traditional clinical knowledge. Ideally, these skills could also help reduce the gap between lifestyle expectations of students entering medicine today and our field's stressful environment (30).

THE FUTURE IS NOW: CHANGING PARADIGMS

Two-way communication will facilitate increasing information exchange between doctors and patients. Patients will have direct access not only to their medical records but also to better information about medical services, including

costs, risks, and benefits. Many valuable services will be delivered outside of “traditional” visits, including instructing patients as part of ongoing care (31). Information technology will help internists maintain the knowledge needed to care for patients while tracking outcomes.

General internal medicine will comprise health promotion, disease prevention, and care of people with common conditions, both acute and chronic. Increasingly, involved patients will seek advice from a professional who places their well-being first without compromise by mercantile interests or by the focused, even parochial, views of subspecialists. General internists will monitor outcomes of patients in their practice and communities, working with diverse, connected providers including specialists who help manage patients with complex diseases.

Practice

In the future, most general internists will practice in diverse settings in teams, often leading them. Staying connected to patients and information systems will be critical (32). Physicians will need to control their schedules and increase flexibility to meet patient needs. Today’s burgeoning emphasis on self-care and self-efficacy will grow. Some teams will probably broaden to include nontraditional providers offering services of proven effectiveness to meet outcomes that patients value.

Reimbursement should promote, not hinder, patient care (2, 31). Restructured payment alternatives include salary, time-based billing (as with attorneys), or capitation and patient management fees. Electronic records, clinical e-mail, and information systems should be designed to simplify administrative requirements, thereby lowering costs. “Value-added” internists will be reimbursed on the basis of quality and outcomes, not only encounters.

Instead of providing parallel, often uncoordinated services, all persons involved in caring for a patient will coordinate closely for optimal quality and efficiency (21, 22, 33). As experts in managing chronic illness (20), general internists are well-suited to communicate effectively with specialists and to integrate recommendations into individual care plans.

As demands for quality performance measures rise, general internists should become the quality-accountable physicians. This role will be challenging because neither access nor quality rises with costs (3, 4), and there is always pressure to reduce costs (34, 35).

Training

Three years of postgraduate training in internal medicine are expected to build competence to care for diverse populations in disparate settings. These 3 years of training produce hospitalists, broad-based generalists in rural practice, generalists seeing patients only in an office, and internists providing generalist care mostly for people with one disease (for example, HIV infection). Others proceed to internal medicine subspecialty training or specialized fel-

Table 2. General Internal Medicine Core Values and Their Attributes and Competencies*

Core Values	Attributes and Competencies
<i>Expertise in adult patient care</i>	<i>Providing patient-centered, comprehensive, longitudinal care</i> <i>Treating complex and chronic illnesses</i> <i>Coordinating care in health systems</i> <i>Commitment to quality outcomes</i> <i>Commitment to preventive care</i> <i>Expertise in geriatric medicine</i> <i>Evidence-based disease prevention and health promotion</i> <i>Outstanding communication skills</i> <i>Establishing personal, ongoing doctor–patient relationships</i> <i>Cultural sensitivity and competency</i>
<i>Acquiring and sharing knowledge</i>	<i>Breadth and depth of knowledge</i> <i>Practicing evidence-based medicine</i> <i>Intellectual rigor</i> <i>Managing information</i> <i>Education: lifelong learning and educating patients, other professionals, and trainees</i> <i>Adaptability: new knowledge and new diseases, treatments, technology, information technology, communications, and cultural diversity</i>
Leadership	Understanding context Commitment to quality, quality improvement, public good
Professionalism	Altruism, accountability, accessibility Commitment to excellence Duty, service, honor, and integrity Respect for others Equity

* Italics indicate core values and competencies that particularly distinguish general internal medicine.

lowships and become, for example, academic general internists, informatics specialists, and hospitalists.

Despite reforms, current training programs still stress experience with inpatients. However, trainees must develop the depth and breadth of knowledge and skills needed for the future’s various settings and patient populations (36). Most training programs do not adequately cover management skills, managing chronic diseases, mastering information systems, or leading team-based care and quality improvement.

Patients and health care systems will need “value-added” or “master” general internists for optimal health care. This will require restructuring the traditional 3-year residency in internal medicine. While making no specific recommendation about the curriculum, content, or length of residency training, we doubt that the current 3-year programs can teach so much (37, 38).

The first 2 years of internal medicine residency would probably continue to provide core experiences in inpatient and outpatient internal medicine, subspecialties, and other specialties and training in seeking and integrating information. The third year would include more focused experience in specialized areas (for example, geriatrics, chronic

diseases, HIV, or medicine–pediatrics) and settings (hospital practice, rural practice, and office-based practice), with possible electives in informatics and research.

A fourth, “mastery,” year should be more widely available. This year would allow residents to devote extra effort and to acquire the advanced skills and knowledge for a specific career pathway (37). Trainees entering subspecialty fellowships would diverge from general internal medicine residency after 2 or, at most, 3 years. Those completing a fourth year would typically earn a certificate of added qualifications (CAQ), signifying mastery in their chosen special generalist area—geriatrics, hospital practice, medicine–pediatrics, or rural general internal medicine practice.

Radically restructuring a 3-year residency might accomplish this transformation, but if not done well, it risks giving general internists little depth, only breadth (36, 37). They might become even more like nonphysician providers of only the simplest care, serving as gatekeepers rather than comprehensive general internists. Thus, the real risk of not radically changing training programs is to “dumb down” future general internists by adding much-needed new skills at the expense of the core clinical skills that distinguish general internal medicine.

Research

The current ominous trends threaten general internal medicine research less than practice (20). Investigators will continue to focus on better diagnosis and treatment of common problems, long-term management of chronic disease, doctor–patient communication, and needs of special populations, especially those with poor access to care.

New research opportunities spring from advances in medical science, ongoing pressures to reduce costs while improving quality of care, and the need to translate scientific advances into practical ways of improving health. Informatics helps generalist researchers focus on practice improvements, sharing information, and converting sometimes ill-informed consumerism into involved patients with strong self-efficacy skills. More research will pursue patient safety, quality improvement, operations, chronic disease management, self-management, and geriatrics (5, 20–22, 39–41). Research priorities must shift to fund such studies, which currently represent little of the national investment in medical research (5, 28, 29).

CONCLUSION

Medicine’s current chaos gives general internal medicine an opportunity to move from confusion to innovation. Our field must adapt to a new world of consumerism, rising public expectations, widespread information dissemination, and contradictory pressures to hold down costs at a time when the demand for services is increasing because more people survive to old age with chronic disease.

The domain of general internal medicine will continue to be primary and principal care of adults—increasingly as team leaders (17). Broad, deep generalist skill and knowl-

edge, with open information management, can distinguish general internists, improve patient well-being, and use resources effectively and efficiently. Wherever they practice, general internists should aim to meet most (80% to 85%) of their patients’ ongoing care, including common chronic illnesses.

Many changes (especially in reimbursement) are required to accomplish this vision. The fee-for-service system needs to give physicians incentives for providing cognitive services outside typical face-to-face visits. We propose training all general internists more rigorously to provide the breadth and depth of comprehensive ongoing care and to provide the special skills required in various current and future practice settings.

APPENDIX

Members of the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine are Eric B. Larson, MD, MPH (*Chair*); Ronald V. Loge, MD; Eileen Reynolds, MD; Wendy Levinson, MD; Lynne M. Kirk, MD; Mark Williams, MD; Neil Wenger, MD, MPH; Steven Schroeder, MD; Stephan D. Fihn, MD, MPH (*Special Consultant*); Lewis Sandy, MD, MBA (*Special Consultant*); and Martin Shapiro, MD, PhD (*Society of General Internal Medicine President, 2002 to 2003*).

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