

## Starting a Conversation about the Future of Internal Medicine

Health care in the United States is like a rudderless vessel drifting close to the shoals of uncontrollable cost, inconsistent quality, and patient demand. Internal medicine is a passenger on this vessel, but it must also cope with dissatisfaction within its ranks, mostly from general internists, and reduced attractiveness to medical students who are choosing a career path. The problems that have brought general internists to this point are immensely complicated and important. They are our problems, and their solutions require our best effort.

Asserting a role in solving these vast problems, *Annals* has published articles intended to help internists understand the world that their actions help to shape. Articles in the “Improving Patient Care” section of the journal (1) help internists to systematize and improve their practice. A recent supplement, “The Future of Primary Care,” commented on the challenges facing primary care (2). To motivate creative thinking about potential solutions to the problems that vex our specialty, we publish in this issue a summary of the report by Larson and the Society of General Internal Medicine (SGIM) Task Force on the Domain of General Internal Medicine (3).

We hope that the report will spur conversations among internists and their colleagues, patients, and others with a vested interest in seeing the health care ship safely through dangerous waters. To start those conversations, we have asked 5 individuals to respond to different aspects of the report. Dr. Richard Baron practices internal medicine full-time in a small, independent group practice in Philadelphia, Pennsylvania. We asked him to comment because we wanted to know how well the report speaks to the full-time practicing internist. Dr. Howard Rabinowitz, Professor of Family Medicine at Thomas Jefferson Medical College, Philadelphia, Pennsylvania, points out the commonalities of the 2 disciplines that provide most of adult primary care. Dr. Robert Copeland, a past Chair of the

Board of Regents of the American College of Physicians, has practiced cardiology in a small town in Georgia, an experience that makes him well situated to comment on the role of subspecialists in providing primary care. Dr. Gail Wilensky is an economist and Senior Fellow at Project HOPE (Health Opportunities for People Everywhere). As a former director of the Medicare program and former chair of the Physician Payment Review Commission and the Medicare Payment Advisory Commission, she offers her views about the report’s proposals for payment reform. Dr. Holly Humphrey, Professor of Medicine at University of Chicago and a former President of the Association of Program Directors in Internal Medicine, offers her thoughts about the report’s proposals for reforming residency education.

We are publishing this report partly because we think that responding to the specific proposals can help internists find common ground from which to begin solving the problems that challenge our specialty.

—The Editors

**Requests for Single Reprints:** Customer Service, American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.

*Ann Intern Med.* 2004;140:659.

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## Generalism as Intention

Rosemary Stevens said it well: “As a would-be ‘general specialty,’ internal medicine has been in constant search of its own definition” (1). In this issue, Larson and the Society of General Internal Medicine (SGIM) Task Force on the Domain of General Internal Medicine (2) attempt to define *generalism*, with a list of skills to be acquired and potential reforms of payment and education that might help to realize their definition. As a mid-career practitioner engaged in community-based, independent medical practice, I agree with what they say, but there is a

dimension I’d like to add. Something essential about generalist *practice* is missing from a description focused on core *skills* of the generalist.

In my opinion, the defining feature of generalism is our commitment to work at “a meeting of at least two personal intentions, one seeking help and the other offering it” (3). Our practice embodies the telos (an ultimate end or object) of medicine because we position ourselves to respond to patients’ needs, taking our brief from the patient rather than from any particular body of expertise. If

the patient thinks his or her problem is medical, then it's in our domain. The report appropriately understands the chaos of our "nonsystem" as an opportunity to change what generalists do and how we are trained, but the centering idea for practitioners actually implementing change is not a skill set but a durable intention to meet our patients where they are. Working at the interface between patient needs and awesome medical capacity, we connect, interpret, personalize, and customize medical care.

Generalist practitioners are the accessible face of a failing health care system. Relationships with individual patients over time sustain us, but our daily failures must inspire us. Even more than "mastery," we need humility and a tolerance of uncertainty because we confront our inability to meet patient expectations for access, quality, and affordability every day in practice. Those of us who put a sign on the street that says "come here for health care" must create tools and opportunities for delivering that promise. We must think systematically about the institutions and organizations in which we practice and ask ourselves how well they meet patients' needs. What hours are we open? How do patients get laboratory results? How are phone calls handled? Why does the retail company Land's End do a better job conveying information among its large sales team than we do in our 4-doctor office?

Competently delivering the goods in generalist practice is a team sport where lots of folks beside the physician have starring roles. While we strive for a system that delivers the encompassing "best" for our patients, we need to measure how we are doing at the population level in actualizing our intention to give excellent care. Choosing to

leave these problems to the administrators, medical training and the care given in academic health centers defines "medical expertise" narrowly, focusing on knowledge of the latest journal articles. But those of us in practice must take on the messy job of consistent implementation. While we think creatively about how the world could be, the generalist intention, not any particular body of knowledge, is our own internal compass for knowing whether we got it right.

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*Ann Intern Med.* 2004;140:659-660.

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## Working Together—That's Innovation!

For the past 40 years, a major force driving primary care was the overall shortage of generalist physicians. Today, while primary care continues to face important challenges, we no longer have a consensus about the need for more generalists, except in rural and urban underserved areas. As a result, for the first time in recent history, the major focus of primary care leaders needs to shift from simply training more generalists to more clearly defining how primary care contributes to the health care system. Therefore, the 2 specialties that are the principal providers of care for adults in the United States (1), general internal medicine and family medicine, must focus on defining their added value to health care, both as individual and collective disciplines. In approaching this task, the 2 disciplines should ask whether their differences are important enough to justify taking separate paths.

In this issue, the report by Larson and the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine (2)—like the similarly titled

"The Domain of Family Practice: Scope, Role, and Function" by Phillips and Haynes (3)—attempts to distinguish the discipline, as all specialty groups do. In reality, the domains of the 2 specialties have many more similarities than differences. Both specialties provide acute, chronic, preventive, and coordinating care, and the values and competencies listed in this report apply equally to family medicine. Also, studies of outcomes, mortality, quality, satisfaction, and cost have not shown consistent differences between the disciplines (4–6). Apparently, what we do for patients and what we accomplish for them are similar. What then divides us? Perhaps the greatest differences between the 2 specialties relate to our cultures and professional identities. Although most general internists and family physicians feel strongly about the differences between their disciplines, most patients do not care.

Given the serious problems in primary care today, the difficulties in our daily work providing generalist services, and the decreasing number of students entering the field,

what will it take for us to overlook our differences and work cooperatively toward more creative solutions? These are the real challenges and opportunities for the 2 specialties. But working together may not occur until the challenges facing primary care mount to a point where the benefits of collaboration are more clearly recognized and exceed their perceived losses.

If general internal medicine and family medicine need any more motivation to work cooperatively, consider the following. Many of the important recommendations in this report will be resolved, for better or worse, in a political arena—within organized medicine, among payers, and legislatively. Having several generalist specialties—each with its own agenda and self-interested voice—contributes to its own form of system chaos. In the resulting disarray, we are all likely to be ignored—in the marketplace, in legislatures, and within the medical profession. However, the combined force of all generalists—representing 30% to 40% of all physicians and bolstered by generalist nonphysician clinicians—could collectively speak with a much more powerful voice to address the critical issues regarding the important role of primary care in the health care system. Achieving our shared goal—successfully providing effective and efficient primary care to all patients—will require this collaboration. Working together—that's innovation!

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*Ann Intern Med.* 2004;140:660-661.

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## Making It Possible for General Internal Medicine To Survive

I have practiced for almost 4 decades as a small-town cardiologist who has also provided principal or primary care. In this issue, Larson and the Society of General Internal Medicine (SGIM) Task Force on the Domain of General Internal Medicine got it right (1). They outline a future mission that reaffirms the fundamental strength of internal medicine: breadth and depth. They recognize the potential for teams of clinicians to improve patient care. They highlight the importance of a reimbursement system that rewards high-quality care and good outcomes.

Our already overworked and under-reimbursed training programs and physician practices cannot meet the cost of these necessary changes without payment reform. From my perspective, payment reform includes paying for patient care transacted over the telephone and e-mail. It also means paying more for high-quality care. Without this fundamental change, internal medicine cannot survive, partly because internists cannot otherwise afford to redesign their practices to meet the challenges of contempo-

rary practice. We must find effective ways to reward practices that invest in the large changes necessary to produce consistent high-quality care.

A fair system that pays more for high quality will be difficult to design. I am concerned about the validity of quality indicators. Methods for risk-adjusting payments are rudimentary. I worry about physicians gaming the system and the potential perverse effects of financial incentives on physician-patient trust and on professionalism. These concerns are real, but we really have no choice but to go forward.

Small-town, fee-for-service practice in a small group requires a different skill set than does practice as a salaried internist at Kaiser-Permanente. Larson and the SGIM Task Force recognize this fact and propose a bold solution: tailor the training of the future general internist to fit the site or type of practice the medical student plans to enter. This proposal will challenge residency training programs to evolve and become more attractive to medical students.

I have watched medical records evolve from hand-written notes on index cards to complete computer-based information systems. Larson and the SGIM Task Force correctly note that the future internist must master the information infrastructure of the practice of medicine. Patient care cannot reach its full potential for excellence without electronic medical records to document quality of care and facilitate the role patients have in decisions about their health. Patients want to know that their medical information is complete, correct, and available immediately when needed!

From my perspective, subspecialists are providing less principal care than was provided 30 years ago when the reports by Mendenhall and colleagues (2, 3) documented a high proportion of subspecialists' time spent in principal care. The recommendations of Larson and the SGIM Task Force will further the trend toward general internists being the main source of principal care. When everyone has better information systems, communications, and coordination, subspecialists can be better consultants and partners with the generalist physician in jointly managing complex problems. The new general internists can re-emerge as the leaders in most patient care.

Education reform will require academic and subspecialty leaders to see the value of the new general internist and support the necessary changes in training. The rest of

internal medicine will look to these leaders for breadth of vision and greatness of spirit.

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*Ann Intern Med.* 2004;140:661-662.

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## Reforming Payment for Primary Care: Making It Happen

**M**y comments focus on the report in this issue by Larson and the Society of General Internal Medicine (SGIM) Task Force on the Domain of General Internal Medicine (1) for changing reimbursement for general internists' services. The authors propose paying for services that are provided outside a personal visit and also paying a case-management fee to physicians. For employed physicians, the authors recommend supplementing a salary with incentives based on productivity and quality.

Some of these proposals would pay for services that physicians have historically provided without payment. Larson and the SGIM Task Force argue that physicians need incentives to provide these services. This rationale will convince few payers. The authors should adopt the payer's perspective long enough to see what might motivate the payer to change. In our predominantly fee-for-service system, paying for more units of service generally increases total spending, even if the same reform (for example, care by telephone) might reduce costs if the payment structure rewarded success in reducing total costs for physicians' services. Any change that increases total spending seems unlikely in our present financial environment. Therefore, Lar-

son and the SGIM Task Force need empirical justification to make their case persuasive. If general internists can show that paying a case-management fee or paying for care given by telephone or e-mail will lower total patient care costs, they will be much more persuasive.

Bundling services for specific chronic diseases is a strategy to get paid for previously uncompensated services. Paying for all services involved in treating a patient with diabetes for 1 year, for example, would make it easier to include the costs of currently uncompensated services. Whether this strategy succeeds depends on the details, such as the cost of the services that the payer includes in the bundled payment. This type of payment restructuring has recently occurred for home health care under Medicare, which now pays for a 60-day episode of care rather than paying on a per-visit basis.

Physicians and policymakers are equally frustrated with the way Medicare currently pays physicians, although perhaps for different reasons. Restructuring payments to cover groups of services may make good sense to both parties, but implementation will be difficult and controversial. It took Medicare several years to construct each pro-

spective pricing system now in use, and some systems, such as the payment system for nursing homes, remain very controversial.

Covering the cost of services that occur outside the personal visit is easiest to imagine in a world of capitated payments, where groups of physicians are at financial risk for providing all of the services patients need. But the United States is not heading in this direction, at least not for now.

I am glad that the authors have endorsed the use of outcomes- and quality-based reimbursement. Making these changes operational, however, will probably be controversial because budget neutrality is likely to be the driving principle. This means that paying more for above-average quality will mean paying less for below-average quality.

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*Ann Intern Med.* 2004;140:662-663.

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## Customizing Residency Education

For more than 2 decades, leaders in internal medicine have called for residency education reform (1). Somewhat surprisingly, little has happened. The current state of the medical care environment inspired Larson and the Society of General Internal Medicine (SGIM) Task Force to propose a new paradigm for residency education, which is reported in this issue (2). Its basic premise is that residency programs should provide future internists with expertise that matches the requirements of their future practice site. Larson and the SGIM Task Force propose tailoring training to the setting in which the resident will ultimately practice—as a subspecialist or generalist, in a rural or urban environment, in a predominantly outpatient setting, or as an inpatient hospitalist. The idea is that residency programs should adapt to individual career goals in order to best prepare internists to meet their ultimate role with the depth, breadth, and mastery that has historically characterized internal medicine.

To achieve the needed depth requires time: time for repeated exposures to a clinical problem, for direct experience, and for thoughtful study and reflection. The authors outline several topics that all internists are now expected to master: informatics, quality improvement, enhanced communication, and team leadership. In addition to these vitally important areas, the principles of scientific discovery and their application to the individual patient have been, and should be, the cornerstone of internal medicine. Translating scientific advances to the patient creates an exciting environment for training (3). Many physicians can sustain this excitement over a lifetime in practice.

The authors' proposal has important merit and poses substantial challenges. Several fundamental ingredients must come together for this proposal to work. Obvious

issues arise related to accreditation, certification, and graduate medical education financing. Department chairs, program directors, and residents must take the lead in crafting a new, more complex residency experience. Ultimately, however, the most important issues relate to individual resident career guidance and mentoring. The proposal demands a higher level of individual career advising and mentoring than is currently the norm in most programs. It requires much greater faculty expertise in guiding a new generation of physicians who will train in a system that will be unfamiliar to faculty. The proposal also exacerbates an already existing problem: making career choices too early in residency. Currently, many residents prefer to defer choosing between careers in general internal medicine or a subspecialty until well into their third year of training, whereas most fellowships encourage applications early in the second year of residency. In fact, residency program directors are working closely with subspecialty program directors to move the decision making for fellowships from the second year to the third year of residency for precisely this reason (Ibrahim T. Personal communication). Therefore, tailoring training to ultimate career plans early in residency may simply be impossible because the natural history of resident career maturation may be out of synch with an earlier timetable.

While the proposal points out the challenges and opportunities borne of our current chaos, making major changes in residency education will be difficult. In fact, the authors acknowledge this challenge by calling for the convening of a group of educators to establish concrete guidelines creating the ideal residency education program for the future internist. To move these ideas forward, education leaders must examine the entire spectrum of medical edu-

cation. The wide variety of required educational experiences during the fourth year of medical school and the increasing debt of our medical school graduates are important parts of the calamity of medical education. To revamp the internal medicine residency without examining the interfaces with other parts of the spectrum of medical education may ultimately prove to be a missed opportunity.

Today's internists will shape tomorrow's internal medicine. While we work to build a patient-centered health care environment, medical training is an essential building block. As educators, we face the challenge of capitalizing on the scientific foundation of internal medicine and the growing ability to translate discovery into direct patient care. At the same time, we must allow for careers in which physicians can balance the responsibilities of home and profession (4). The people of the United States have a large stake in a successful outcome for internal medicine education. We must be bold.

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*Ann Intern Med.* 2004;140:663-664.

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