

Opinion Paper

GENERAL INTERNAL MEDICINE IN BELGIUM: TO BE OR NOT TO BE?

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On behalf of the Board of the Belgian Society of Internal Medicine

Does general internal medicine in Belgium have a future? This question, which was recently raised in an editorial in this journal (1), is pertinent. Medicine is becoming increasingly technical and complex, leading to progressive specialization and even 'super-specialization'. For instance, a cardiologist may focus on revalidation, transplantation, interventional cardiology, electrophysiology, echocardiography, or the like. Consequently, internal medicine is split in more and more pieces. This 'centrifugal' evolution may raise the questions: are we experiencing the demolition of internal medicine (fig. 1)? Is there still a need for general internal medicine? We believe there is. General internal medicine should reassume its rightful role at the core of internal medicine (fig. 2). A patient cannot be divided in several pieces. He or she is more than just his or her atrial fibrillation or his or her diabetes mellitus. A general internist is perfectly placed to deal with patients with combined pathologies, with complicated or multisystem diseases, or with ill-defined symptoms. Patients deserve an integral approach, including consideration of psychosocial issues. The general internist should be 'the master of complexity and co-ordinator of chaos' (2). He or she is the detective of



Figure 1: The break-up scenario.

medicine, generating and testing hypotheses. As general internists, we pretend to be able to deal with the great majority of problems within the field of internal medicine and to have an extensive knowledge on frequent and less frequent diseases. Of course, a general internist is not a stand-alone. On the contrary, he or she is ideally placed to seek the technical or clinical help of other specialties whenever deemed necessary and to make balanced choices within the vast diagnostic and therapeutic armamentarium, applying the skills of history taking, clinical examination and decision making. Indeed, cost containment will force tech-

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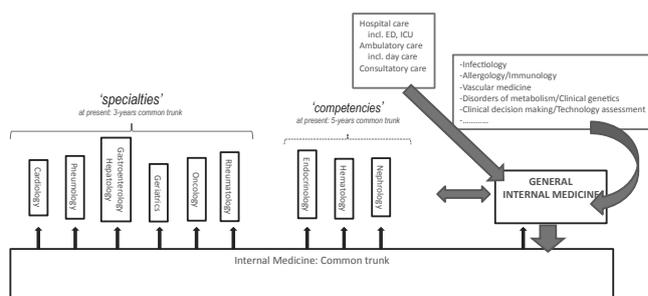


Figure 2: the proposed alternative scenario.

Abbreviations: incl.: including, ED: emergency department, ICU: intensive care unit.

nical medicine to make choices. The days that we can 'order filet mignon at every meal' are counted (3). The general internist, familiar with cost-effectiveness and other health system skills, can suggest priorities and organize referral if considered appropriate. As an advocate of the patient, not just of a disease, he or she may be a spokesperson to government and industry. As medications are among the most powerful tools of the general internist, a thorough knowledge of clinical pharmacology is a prerequisite.

While a general internist in turn may prove to be a vital support to other specialties (e.g. surgical specialties), he or she is more than just a hospitalist. He or she follows his or her own patients, in- as well as out-hospital, ensuring continuity of care. Also, in an emergency department or an intensive care, the 'general internistic approach' may be of benefit to the patient. No doubt, the main effort of the general internal medicine is intellectual and the plea for a better reimbursement of the intellectual act is long overdue. Yet, every general internist should be able to perform simple technical tasks. Punctures and aspirations can serve as an example: of superficial and deep veins, arteries, peritoneal fluid, pleural fluid, joints, cerebrospinal fluid, bone marrow,... The loss of these skills among internal medicine trainees should be countered (4,5). Of course, every general internist is not expected to excel in every aspect of the profession and the majority will cherish a particular field of expertise. Yet, the 'general internistic attitude', a broad, unbiased, evidence-based, patient-centered approach to the whole adult patient is the common theme that binds general internists.

As internal medicine is a dynamic science and art, general internal medicine can continue to serve as a nursery garden for new competencies (e.g. infectious diseases, immunology and allergy, vascular medicine, pain medicine and palliative care, inherited metabolic diseases in the adult patient, clinical genetics, clinical epidemiology,...). Some of these added skills will also claim a more independent position in the future.

The general internist has a key role in the first years of internal medicine training ('common trunk').

Still, general internal medicine is more than just the basics of internal medicine. It goes a lot deeper than just general medicine practiced in hospitals. That's why it is counterintuitive that a general internist, who deals with patients with polypathology, polypharmacy, complex and challenging diagnoses, can terminate his or her training one year before other specialties within internal medicine. The specificities of general internal medicine demand an advanced education. That's why the Board of the Belgian Society of Internal Medicine decided to organize, from the end of 2009 onwards, a 2-year educational program, that is announced in this issue of *Acta Clinica Belgica* (on the inside of the cover). We hope this course will arm the future general internist to overcome his or her challenging tasks, will promote the art of internal medicine, and will aid to re-establish the central role of general internal medicine. The program is primarily intended for trainees in general internal medicine (a presence of 80% is the aim), although the course welcomes every one with a heart for general internal medicine. Of course, the Board of the Belgian Society of Internal Medicine realizes that training not only includes lectures but also bedside teaching. A patient-centered and energetic specialty as general internal medicine cannot be learned just from books, universities or teachers; the patients themselves are a major and continuing source of knowledge and wisdom.

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