PERSPECTIVES

Principles to Consider in Defining New Directions in Internal Medicine Training and Certification

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SGIM endoreses seven principles related to current thinking about internal medicine training: 1) internal medicine requires a full three years of residency training before subspecialization; 2) internal medicine residency programs must dramatically increase support for training in the ambulatory setting and offer equivalent opportunities for training in both inpatient and outpatient medicine; 3) in settings where adequate support and time are devoted to ambulatory training, the third year of residency could offer an opportunity to develop further expertise or mastery in a specific type or setting of care; 4) further certification in specific specialties within internal medicine requires the completion of an approved fellowship program; 5) areas of mastery in internal medicine can be demonstrated through modified board certification and recertification examinations; 6) certification processes throughout internal medicine should focus increasingly on demonstration of clinical competence through adherence to validated standards of care within and across practice settings; and 7) regardless of the setting in which General Internists practice, we should unite to promote the critical role that this specialty serves in patient care.

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Internal medicine professional societies are currently debating whether we should create separate areas of mastery within the specialty of General Internal medicine that are defined by practice setting. Advocates of such a demarcation hold that the knowledge base and skill sets of physicians who deliver care only in the inpatient setting differ significantly from those of physicians who provide patients' health care in ambulatory settings or coordinate care across different practice settings. To foster these distinct aspects of internal medicine, proposals have been put forth to create separate tracks within residency training as well as to establish distinct paths for certification. It could be argued that such modifications to the training and credentialing process would increase that value that General Internists offer to the health care delivery system and lead to a revitalization of the field of General Internal medicine.

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As one of the professional organizations representing physicians who practice this specialty, the Society of General Internal Medicine (SGIM) is concerned that this debate diverts us from unifying our efforts to advance our profession. General Internists' special expertise resides in delivering comprehensive, coordinated, and superior care for all patients regardless of health care setting. We offer special expertise in treating the rapidly growing population of complex, chronically ill patients. All General Internists, regardless of practice setting, struggle to care for a challenging patient population despite increasingly severe resource constraints, eroding reimbursement, and declining professional recognition. In the current climate of abbreviated hospital stays, many patients receive outpatient care for conditions that have heretofore required inpatient care. Thus, diagnostic or therapeutic health care expertise has increasingly blurred between inpatient and outpatient settings.

Certification plays a critical role in demonstrating mastery of a body of knowledge and skills that clearly add value to health care. Ideally, it should reflect important differences in the management of patients across health care settings while not unduly fragmenting internal medicine. In the case of mastery in inpatient versus comprehensive ambulatory general internal medicine, the most important criterion for special certification concerns whether these are distinctly different areas of clinical expertise versus components of a spectrum of expertise within the specialty.

Certification mechanisms are tightly linked to the underlying organization and functions of internal medicine training programs and to mechanisms promoting life-long learning. Proposed revisions to internal medicine training would have third-year residents focus practice in particular areas (e.g., inpatient, outpatient, a combination, or some other aspect of internal medicine), in lieu of greater exposure to diverse aspects of internal medicine. After the completion of training and initial certification by the American Board of Internal Medicine (ABIM), it has been suggested that the ABIM should provide some form of special certification or recognition within several years after residency to demonstrate further mastery in a specific area. However, many health care systems have already organized care around physicians who focus their practice in either the inpatient or ambulatory settings. These partnerships between General Internists who provide predominately inpatient care (i.e., hospitalists) and those who provide comprehensive, long-term care (i.e., comprehensivists) permit the

former group to orchestrate the breakneck speed of inpatient care while freeing the latter group to concentrate on managing often highly complex patients. In many academic centers, hospitalists and comprehensivists are united in the same divisions of general internal medicine and collaborate closely in clinical, educational, and research endeavors undertaken by their divisions as well as their institutions. Working collaboratively, these 2 types of General Internists strive to smooth the challenging transitions across settings of care.

Unfortunately, the hospitalist-comprehensivist union is far from complete. In some academic settings, hospitalists have sought to differentiate themselves from their General Internist colleagues by forming separate divisions within their departments of medicine. Such structures strain the ties that should link all General Internists in the same institution. In addition, in many academic and nonacademic settings, General Internists still prefer to manage their own patients throughout the continuum of their acute and chronic care. These physicians may believe that the value of their relationship with and knowledge of their own patients outweigh the challenges associated with coordinating both inpatient and outpatient care. This model of care continues to be viable while empirical evidence supporting the value of hospitalist care remains equivocal. Early published studies found that hospitalist care resulted in shorter lengths of stay without untoward effects on patient outcomes[1,2] but a more recent multisite trial failed to demonstrate a reduction in length of stay.[3] Interestingly, the latter study included at least 3 academic medical centers that had earlier reported such reductions. Although it is plausible that patients benefit significantly from hospitalists' care, the evidence falls short of demonstrating that this is true.

Given this equivocal evidence and above noted tensions, we should remain cautious about undertaking any dramatic changes in the specialty of General Internal Medicine that would restrict well-trained General Internists from managing patients when and where they see fit. The short history of the hospitalist movement should give us pause when considering sweeping changes to the certification process that might *de facto* hinder highly qualified physicians from providing continuous care across in diverse settings.

In SGIM's prior report on the Future of General Internal Medicine, Larson and colleagues[4,5] endorsed the value of distinct areas of mastery within our broad specialty. However, we submit that the current structure of residency training makes a parallel path to mastery in ambulatory care unattractive. The first 2 years of training offer a limited, discontinuous exposure to ambulatory care, often in poorly staffed clinics lacking even an electronic medical record. Many residents resent having to address the needs of relatively stable outpatients while working on a busy inpatient service. This dysfunctional ambulatory care experience is an important factor behind the recently plummeting interest in general internal medicine, especially ambulatory care. On the other hand, residency training as currently structured in most programs produces residents who have substantial expertise and comfort with practice in the inpatient setting. Therefore, the current structure of internal medicine training programs implicitly encourages residents toward becoming hospitalists if they are not planning on a subspecialist career. If the medical profession values the role of Internists who have expertise in managing the most complex ambulatory patients, we must insure that any changes in training and certification do not compromise our currently limited ability to attract trainees to this comprehensivist career.

Therefore, SGIM proposes 7 guiding principles when considering changes in training and certification in internal medicine.

Principle 1: Internal medicine requires a full 3 years of residency training before subspecialization. The ever-increasing complexity of the practice of internal medicine demands that all internal medicine residents, regardless of their career plans, complete a full 3-year program. The concept that subspecialists in internal medicine need only minimal knowledge of other specialties outside of their own is dangerous and shortsighted. Recall Osler's words: "The good physician treats the disease; the great physician treats the patient who has the disease."

Principle 2: Internal medicine residency programs must dramatically improve support for training in the ambulatory setting and offer equivalent opportunities to train physicians in both inpatient and outpatient medicine. At a minimum, residents need to experience the satisfaction of long-term, continuous management of complex, challenging, but rewarding patients. Although increasing their exposure to the practice of ambulatory care is essential, it is not sufficient. We must also increase financial support for ambulatory training by distributing graduate medical education training funds more equitably between inpatient and ambulatory training. Importantly, the clinics and outpatient practices where residents train must meet high-quality standards such as having electronic medical records, adequate staffing, and excellent patient accessibility.

Principle 3: In settings where adequate support and time is devoted to ambulatory training, the third year of residency could offer an opportunity to develop further expertise or mastery in a specific setting of care. The third year of training may be restructured to increase exposure to a specific aspect of care. After adequate preparation in the first 2 years of training, residents could then proceed to develop the skills necessary to lead multidisciplinary teams caring for patients in both inpatient and outpatient settings and to develop fluency in improving health care through systems management, quality assessment, and continuous quality improvement. Currently, the ambulatory blocks of existing primary care programs serve as a good example of fostering specific types of mastery in areas such as research, education, quality improvement, and global health. Development of specific areas of mastery is equally important for future cardiologists and other subspecialists. As leaders of a health care team, all internists must learn the interpersonal management skills that underpin a collegial sharing of expertise necessary for effective, high-quality health care.

Principle 4: Further certification in specific specialties within internal medicine requires the completion of an approved fellowship program. In the absence of tested mechanisms for insuring high-quality training experiences outside of formal training programs, certification for emerging subspecialties within internal medicine should occur within the framework of approved fellowships. We should not create a second-class system of certification through another method of defining specialization.

Principle 5: Areas of mastery in internal medicine can be demonstrated by modified board certification and recertification

examinations. SGIM believes that certifying examinations can recognize mastery in a particular setting or types of care. The ABIM examination must evaluate core competencies in internal medicine but could also offer a selection of modules focusing on knowledge and decision making in inpatient care, ambulatory care, or other specific content areas such as quality improvement and medical education. Some physicians may choose to demonstrate mastery in multiple settings of care or content areas. Thus, the certificate would be equivalent to a "major" in internal medicine and a "minor" in a specific area or areas of mastery.

SGIM does not endorse a process whereby residents would need to certify at the end of residency and again within several years to demonstrate mastery. Such a plan is onerous and likely create new barriers to entering General Internal Medicine. If necessary, an alternative would be to delay the initial certification for several years to allow physicians to gain expertise in their setting(s) of choice. Then recertification would then proceed at the usual pace of every 6 to 10 years.

Principle 6: Certification processes throughout internal medicine should focus increasingly on the demonstration of clinical competence through adherence to validated, appropriate standards of care within and across practice settings. This objective has many hurdles to overcome before it can become operationalized. Although the science of quality measurement has advanced significantly in recent decades, nearly all measures promoted by expert panels have been disease specific. To date, few measures are relevant to the care of patients with multiple complex comorbidities whether it be in the outpatient or inpatient setting. As recently highlighted, the application of disease-specific measures to such populations may have significant unintended clinical consequences.[6,7] Consequently, high-research priority should be placed on developing and evaluating a broad array of quality measures necessary to demonstrate processes and outcomes of care in specific settings and specialties of internal medicine.

Principle 7: All General Internists, whether they practice in the inpatient, outpatient, or another setting, need to unite to promote this critical specialty. As previously noted, trainees' interest in general internal medicine has been waning in recent years for a variety of reasons. However, SGIM regards all General Internists as partners in promoting the value of our specialty to trainees, patients, payers, policy makers, and other health care stakeholders. General Internists play a unique role in the health care system by bringing to bear broad-based clinical expertise in treating adults. This expertise is especially relevant to adults with complex comorbidities who stand to benefit the most from having one physician oversee and coordinate all of their care.

In conclusion, General Internal Medicine as a specialty should focus on insuring that patients receive the most comprehensive, continuous care possible. Training and certification mechanisms need to advance this mission. Nationwide, patients are seeking a physician to coordinate their care and to partner with them in maintaining their health and minimizing the adverse consequences of disease. Unfortunately, the rapidly shrinking number of comprehensivists with expertise in complex patient care will compromise this key role. The opportunity to recognize areas of special proficiency in General Internal Medicine allows us to reconfigure the training and certification process to enhance the attractiveness of the comprehensivist career as well as to unite with hospitalists to deliver the care that adults need.

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