The European internist – a promising prospect or an illusion?

H. S. L. M. Tjen, MD, PhD – Dutch delegate of the UEMS Management Council Former president of the UEMS Section and the European Board of Internal Medicine

History

Contemporary internal medicine evolved from "innere Medizin" in Germany and Austria in the early 1880's and it describes a discipline covering the specific scientific knowledge of organ pathophysiology. The primary mission of early internists was diagnosis and they were called in as consultants for the most difficult diagnostic cases.

Shortly after its introduction in Europe, internal medicine was adopted on the other side of the Atlantic. William Osler made the first reference to internal medicine in the USA. In 1897 he gave a lecture entitled "Internal Medicine as a Vocation".

Internal medicine developed as a consulting speciality with strong emphasis on biomedicine. After World War II the focus of medical research shifted to the United States. The identity of internal medicine was more firmly established when official certification of medical specialist was introduced.

European integration process started with the treaty of Rome in 1957 with involvement of economic interests and regulation of a free movement of services and persons within the European Union. There was also growing awareness that creation of a European market has indirect consequences for health care in the member countries. However, it was not until 1992 that the treaty of Maastricht and until 1997 that the treaty of Amsterdam legalised the involvement of the European Union herewith.

With regard to disease prevention, health promotion and health protection there is European consensus. However, curative medicine is still characterized by regional and cultural differences with national authorities as policymakers.

An important role is assigned to the "Standing Committee of European Doctors" (Comité Permanent), a platform of doctors and for doctors in the European Union and its associated countries. It is an umbrella organization with a mission of study and promotion of the highest level of medical training, medical practice, health care and free movement of doctors within the EU.

The philosophy of internal medicine

The European countries display marked differences in training programs and certification of medical specialists. Also, postgraduate training in internal medicine differs in the training time and content of training as well as in the common trunk. Even the definition of internal medicine is not univocal in different countries.

The European Union of Medical Specialists (UEMS) has recently defined a specialist in internal medicine as:

"A physician trained in the scientific basis of medicine, who specialises in the assessment, diagnosis and management of general medical problems, atypical presentations, multiple problems or system disorders. The physician is skilled in the management of acute unselected medical emergencies and the management of patients in a holistic and ethical way, considering all psychological as well as medical factors for enhancing quality of life".

The general internist is considered a well-rounded physician who is knowledgeable in all aspects of internal medicine, in and out of hospital, and does not limit the practice to a single subspeciality. The internist corresponds to a doctor with a holistic view of the patient. He is trained in

the classic deductive reasoning model of differential diagnosis and has also more empiric approach to clinical reasoning that is based on clinical epidemiology.

The evolution of specialities and sub-specialities within internal medicine has proceeded since the 1950s. It is a progressive process of fragmentation of internal medicine and evolvement of sub-specialties. As a consequence, it seems that general internal medicine has lost some of its identity as a specific area of expertise.

Medical developments and technological progress feed sub-specialities in claiming for specific expertise and hence strive for autonomy. Financiers who are willing to permit performance of certain examinations and treatments by certified professionals mostly support these developments.

Social forces, like patient's empowerment and autonomy, can be involved in decision-making regarding diagnostics and treatment. This can lead to the growing demand for referral to specialists with expertise in handling of alleged organ related complaints.

Managed care can acquire an important and sometimes undesirable steering function in the use of health care. To a certain extent, this encompasses the implementation of "hospitalists" in the health care system of some European countries. In-patient care forms an important part of the professional identity of most internists and introduction of the hospitalist could harm the speciality of general internist.

On the other hand, expected developments in the near future can support the firm position of internal medicine.

Current clinical internal medicine requires generalists. More and more multi-system diseases are emerging which need systemic approach.

Emergence of "new" diseases and an explosive growth of molecular biology and biotechnology in diagnostics and treatment will largely take place in the field of internal medicine.

Alterations in demographic situation lead to increase in medical care, provided by internists, due to ageing of the population.

Continuing intensification of medical education and promotion of research activities require a significant contribution of internal medicine.

The European internist

Discussion about the realistic future of the European internist seems to be relevant against the background of the above philosophy. Only with the help of the profession itself can a positive perspective be attained.

The representative organization of all medical specialists in the European Union (more than 450,000 doctors) is the "European Union of Medical Specialists" (UEMS) founded in 1958 in Brussels.

In view of its unique right to access to law making organizations as the Commission of the EU and the Standing Committee of Doctors, the UEMS has a privileged position in major discussions regarding medical practice and training of specialists within the EU.

The UEMS has founded 36 specialist sections. The sections consist of leading representatives from national scientific and professional organizations outside the EU and EFTA countries. Other European countries can delegate associate members and observers.

The sections work independently and report to the UEMS Management Council, which co-ordinates their activities.

The Section of Internal Medicine has three main objectives:

- Defining, defending and promoting of internal medicine.
- Harmonization of training and quality assurance.
- Establishment and harmonization of Continuing Medical and Professional Education including European accreditation.

The Section has established "The European Board of Internal Medicine", a working party responsible for defining the conditions required for the optimal training of internists and for the maintenance of professional standards.

The Section and the European Board of Internal Medicine have made slow but firm progress on the way to the establishment of the European internist.

European common trunk, basic education for internal medicine and the specialities related to internal pathology, is defined and accepted by national scientific organizations. The common trunk represents the basic package to which every physician belonging to the internal speciality must conform. It has a minimum duration of two years and the content is listed in a log-book ("training record").

In order to facilitate the implementation of the common trunk, the European Board has published the first volume of *"European Manual of Internal Medicine*". This manual is attuned to the requirements of the common trunk. The authors are well known European physicians, and scientists from all other member countries of the EU have reviewed the contributions.

The European Board is involved in the structure, process and quality assurance of *Continuing Medical Education programmes*. The Board has elaborated proposals for harmonization of CME in the EU member countries in affiliation with current CME systems.

The Section and the Board had an active participation in the elaboration of *professional documents* such as the Charter on Training of Medical Specialists, Charter on Continuing Medical Education, Charter on Quality Assurance and Charter on Visitation of Training Centres. These UEMS charters are consensus documents and are strongly recommended to all national organizations in the EU.

The future of internal medicine in Europe

Both the Section and the Board have striven, in close collaboration with the "European Federation of Internal Medicine" (EFIM), for firm and recognizable establishment of general internal medicine in Europe. This policy has received strong support from many critical observers in U.S. health care. Already in 1995 the American College of Physicians re-defined the role of the future internist and the internal sub-specialists. All organizations involved in internal medicine promote training in general internal medicine.

In order that general internal medicine would survive, we have to abandon current stereotypes and redefine the role of the internist. These redefined internists should be characterized by greater capacity to deliver care in more complicated situations and be familiar with special skills. Interdisciplinary shifting of simple procedures from specialist to nurse practitioners can diminish the workload of the internist and place more emphasis on specific activities of internal medicine.

Better knowledge of information technology will lead to increase in work efficiency and enhancement of quality through easy access to "evidence -based medicine".

The significant contribution of the Section and the European Board to the defining and implementation of quality assurance in the training and practice of the European internist will remain evident.

This will be realized by establishment of an Internal Medicine Outline Plan and a description of the end terms for the curriculum of internal medicine.

There will be participation in voluntary visitation programmes. Site visits serve as an important feedback instrument in the quality control of training centres, often coupled with national certification or re-certification of trainers and training centres.

A European Board of Qualification will be established, i.e. a system according to which an internist, already qualified in his own country, can obtain a European certificate of " Recognition of Quality in Internal Medicine ". A programme will be developed for upgrading the motivation of trainees and students for a career in general internal medicine, because internal medicine still has a problem with its public identity.

An active anticipation policy will be pursued on changes in manpower planning. More than 50% of those entering the medical profession are women.

This involves alterations in working conditions and creation of opportunities for flexible training. There is cooperation with the Working Group of European junior doctors (PWG), active in the field of manpower planning, working conditions, and boundary conditions for training in Europe, including working hours.

Conclusion

Harmonization of specialist training is a concept that has pervaded European Medical Organizations for at least a quarter of a century. Unfortunately, too little has been achieved in concrete terms. However, developments in the last years indicate the significant interest of the parties involved in medical specialist training, including national societies. We feel strongly that Europe should move forward. We need to learn from the variety of experience throughout Europe, not always striving for harmonization but to be inspired by the best practices we can find and to apply them on a wide scale. Decisive cooperation between professional and scientific European organizations is important for the revival of internal medicine in Europe, restoring the morale of the internist, and for cohesion within the speciality. The European internist will arise!

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