Peer reviewed article

Will there be room for the teaching of internal medicine in a university hospital?

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Summary

To answer the question addressed, two working groups, one made of the staff of a University clinic, the other one composed of practising general internists, have discussed the assets and weaknesses of a University service of Internal Medicine for postgraduate training. The groups agreed on a number of points: patients' characteristics (complexity and co-morbidities), quality of teaching, method acquisition for clinical reasoning, as well as absence of exposure to ambulatory patients and of follow-up. The groups differed in their views related to the lack of training in psychiatry and psychosocial problems or to hospital dysfunctions. Opening of internal medicine to primary care appears to be necessary at the same time as individual qualities among the senior staff are to be developed, such as critical analysis and self-questioning.

Key words: primary care; ambulatory medicine; patients' typology

The question addressed would not have been considered as relevant ten or twenty years ago. The supremacy of academic services of Internal Medicine for the training of interns was undisputed, as was the statute of the discipline itself: Internal Medicine, the Queen of all the medical disciplines. The situation has dramatically changed in the recent past, especially in Switzerland. General Medicine, under the guidance of dynamic leaders, has become the paradigm of primary care, whereas Internal Medicine was slow to react to the changing character of the demands of society. Together with this increase in importance of primary care, the most appropriate sites for training are no longer considered to be the University hospitals and their wards for hospitalised patients, but rather outpatient clinics or other organisations devoted to the care of ambulatory patients. A major change in training sites has been advocated in many countries and has already taken place in some of them, the USA in particular.

In Switzerland, on the other hand, because of tradition and, also, of the number of postgraduate positions available for training, academic services of internal medicine with their stationary patients remain a quantitatively and qualitatively important site for postgraduate training. It is true that structures such as policlinics with a vocation for the care of ambulatory patients exist, either within the Departments of Internal Medicine or independently. But the number of residents that they can train is not adequate to satisfy the overall needs of the country, especially in view of the fact that, until recently, all the so-called subspecialties of Internal Medicine (Cardiology, Gastroenterology, Pneumology, Haematology, Oncology, Nephrology, Endocrinology, etc …) required up to three or four years of training in general internal medicine.

To try to obtain some information on this problem, the question of the relevance of postgraduate training in University services of internal medicine has been addressed to two types of audiences:

– one (= *staff*) made of 10 chief residents (chefs de clinique) and full-time hospital physicians from Medical Clinic 1 of the University Hospital in Geneva,

and

– the other one (= *practising general internists*) made of 8 former chief residents who had left the Hospital 5 to 15 years ago to enter into private practice, all but one were without training in structures specialised in ambulatory care.

Before answering the question addressed, these two groups had received, read and accepted the conclusions of the statement of the American College of Physicians [1], which can be summarized as follows:

The future general internist is

1. a primary care physician
2. a specialist in complex, undifferentiated situations
3. a resource manager, expert in reasoning and clinical epidemiology
4. a clinician knowledgeable in information techniques
5. a generalist who can adapt to specific problems

The Metaplan® technique, or visualised discussion, was used. In brief, each participant in each of the two groups was provided with 5 or 6 small sheets of paper to write his answers on. For each question, the answers were collected and reassembled on a large panel according to common general themes. The questions were:

– the *assets* of an academic service of internal medicine (to train the future general internist) …
– the *weaknesses* of an academic service of internal medicine (to train the future general internist) …

At the end of each session, for each question, the participants received three self-adhesive stars that they used to indicate, among all the answers, which ones they considered to have the highest priority. Thus, qualitative as well as semi-quantitative answers could be obtained.

Table 1 gives the answers of the present staff of a University service of Internal Medicine and of practising general internists, formerly members of the staff of the same service, to the question regarding the assets of an academic service of Internal Medicine. There was a strong general agreement between the two groups with respect to: access to and interaction with specialists, complexity of cases, method acquisition in clinical reasoning, quality of the senior staff, access to high technology. On the other hand, other features, such as presence of role models, emulation, quality of seminars, global care, were recognised by one group only.

Table 2 gives the answers of the same two groups to the question of the weaknesses of the academic service of Internal Medicine. Here again, there was agreement between the two groups, especially with regard to: lack of exposure to ambulatory care, lack of follow-up, typology of patients, autarky. But the two groups also differed in their views for a number of answers. The practising general internists, probably because of their present experience, were much more sensitive to a lack in training in the psychosocial field or psychiatry, the absence of preparation to loneliness and to finan-

Table 1

The *assets* of a University service of Internal Medicine in the training of the future general internist, and comparison of their priority scores as judged by the present staff of a University service of Internal Medicine and by practising general internists.

Staff (N = 10)	**score**	**practising physicians (N = 8)**	**score**
Access to and interaction with specialists	**6**	method acquisition in clinical reasoning	**7**
Method acquisition in clinical reasoning	**5**	quality of cases	**6**
		case-mix	**2**
Learning aids	**4**	access to and interaction with specialists	**6**
Role models	**4**	quality of teaching	**2**
Quality of cases and case-mix	**3**		
Quality of the senior staff	–	quality of the senior staff	–
Global care	–	emulation	–
Access to high tech	–	access to high tech	–
		quality of postgraduate training	–

Table 2

The *weaknesses* of a University service of Internal Medicine in the training of the future general internist, and comparison of their priority scores, as judged by the present staff of a University service of Internal Medicine and by practising general internists.

Staff (N = 10)	**score**	**practising physicians (N = 8)**	**score**
Inadequate exposure to ambulatory patients and lack of follow-up	**10**	different patients' typology	**5**
Autarky	**5**	lack of training in psychosocial problems	**5**
Problems of territories	**3**	lack of follow-up	**4**
No training in management	**2**	no exposure to ambulatory patients	**3**
		no training in psychiatry	**3**
No preparation to triage	–	disease > patient	–
No consumer relationship	–	no contact with money	–
Little knowledge of the "network"	–	rare encounter with a "virgin" patient	–
Cumbersome system	–	no preparation to loneliness	–
Autarky	–	autarky	–
Selection of cases	–		

cial matters, the lack of consideration for the patient as opposed to the importance of the disease, the rarity of exposure to a patient that had not been previously examined by several consultants … The present staff, on the other hand, expressed opinions probably generated from its present experience: the cumbersome system, the problems of territories, the lack of knowledge of the network, the absence of preparation to triage.

Tables 1 and 2 also give the priority scores obtained in the two groups of participants for the two questions on the assets and the weaknesses of a University service of Internal Medicine for the training of the future general internist. For the assets, although the priority order was not identical, most of the features were the same. This was certainly not true for the weaknesses. While both groups agreed on the inadequate exposure to ambulatory patients and lack of follow-up, the present hospital staff was somewhat influenced by their environment, as exemplified by the critical comment on the "ethological" components existing between and within services. Practising general internists were more influenced by their experience with patients presenting with psychosocial problems, hence the regret of having not benefited from more training in this field.

If both groups reached the same conclusion regarding the inadequacy of exposure to ambulatory care, why is it that very little has been achieved in terms of corrective measures? Several explanations can be offered:

- The organisation of the corporation has for a long time favoured conservative attitudes with respect to the predominance of an academic representation of Internal Medicine at the expense of an opening toward primary care. The organisation was also geared toward the needs of the management, and not of patients.
- Beds, in hospitals, are synonymous of power, hence the not so benign neglect of ambulatory care. This attitude is now certainly subjected to strong criticisms, especially from politicians for whom hospital care is associated with uncontrolled expenses.
- As already mentioned, problems of territories within the hospital and between the public and private sectors prevent access to sensible solutions.

It is true that it may not be very easy to substitute ambulatory-based training for hospital-based training, simply because of the limited number of positions available in Policlinics. The access to private practice for primary care exposure, although recognised by everybody to be essential, is fraught with financial difficulties. But, it would not be impossible to create more opportunities for training through a network comprising structures related to community medicine, psychiatry, some private emergency organisations, not to mention potential HMOs ... Such a change would require more flexibility for those who manage these structures, as well as a mutual respect for the requirements of all the partners. It would also better respond to the needs of patients.

For the time being, if this new type of organisation cannot be created immediately, especially in Switzerland, it may be important to insist not only on the acquisition of factual knowledge, particularly if it applies to conditions other than primary care, but also on an attitude: Attitude meaning the capacity to critically assess not only the available medical literature but also one's own type of practice, and the ability to adapt to new situations. It follows that formal training in clinical epidemiology and evidence-based medicine should be encouraged, not through formal lectures, but rather through discussions of real situations. The role of models in this regard is of primary importance, the teachers having to apply to themselves an attitude of self-questioning and openness to criticism. This effort must accompany structural reforms to recreate a learning environment adapted to the objectives of the mission of the general internist and to the needs of the patients.

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Reference

1 American College of Physicians. The role of the future general internist defined. Ann Intern Med 1994;121:616–22.

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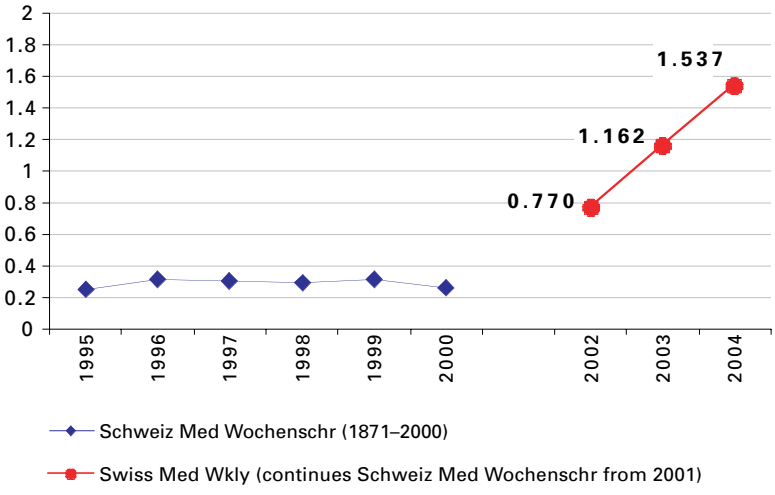

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