Challenges for Internal Medicine as the American College of Physicians Celebrates Its 100th Anniversary

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As the American College of Physicians (ACP) celebrates its 100th anniversary in 2015, it is an appropriate time to reflect on the current challenges and opportunities that face internal medicine specialists and subspecialists, their patients, and American society. The panoply of changes in health care delivery, new and proposed payment models, increasing regulatory requirements for physicians, and the unsustainable costs of health care certainly raise questions about future directions for health care and, specifically, for internal medicine. I highlight what I consider to be 3 leading issues for internal medicine and for ACP as it enters its second century and strives to continue to meet the goals of its recently updated motto, "Leading Internal Medicine, Improving Lives." These issues, each of which is fairly broad in scope, concern defining the role of internal medicine within the health care system, addressing challenges to our professional satisfaction, and meeting our responsibility to control health care costs.

Defining the Role of Internal Medicine Within the Health Care System

In an article published nearly 30 years ago about issues in internal medicine, Rosemary Stevens highlighted "uncertainties about the relation between generalism and specialism, primary care and subspecialties, and internal medicine and general medicine" (1). This tension not only still exists but has been exacerbated by the emergence of hospital medicine; the entry of nonphysician clinicians, such as nurse practitioners, into the primary care space; and the current focus on team-based care delivery.

Over time, the traditional role of the nonsubspecialist internist as the expert consultant has often been subsumed by internal medicine subspecialists. At the same time, general internists compete for the role of primary care clinician with family physicians and, more recently, nurse practitioners. It is therefore incumbent on internal medicine to better define its roles within the health care system, taking into account a portfolio of clinical activities, types of practice, and professional responsibilities that are unrivaled by those of any other specialty.

The ACP has recently attempted to identify the common ground that binds all internists, independent of their ultimate scope of practice. The resulting definition characterized internists as "specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness" (2). This definition stresses the scientific and pathophysiologic basis of the specialty; at the same time, it calls out internists' ability to diagnose and treat patients with complicated medical needs.

In a policy statement about clinical care teams in primary care, ACP also notes that primary care has many facets, some of which are better suited for one type of primary care professional than for another (3). Two features that distinguish primary care general internists are their diagnostic skills for patients with undifferentiated or complicated presentations and the ability to provide and coordinate acute and chronic care for patients with complicated and often multiple clinical problems. The challenge for internal medicine is then to ensure that the public and other health professionals recognize the unique ability of its specialists and subspecialists to integrate the highest level of scientific evidence and reasoning with patients' needs, goals, and preferences as they care for adults over the breadth of nonsurgical problems and levels of acuity and complexity.

Addressing Challenges to Our Professional Satisfaction

Recently, the dissatisfaction of physicians—particularly primary care physicians—with their careers and professional activities has been receiving considerable attention (4). Although one can cite many components of this dissatisfaction, a major underlying thread centers around time (Table). For some physicians, particularly those in solo or small practices or rural environments, an additional factor is professional isolation resulting in loss of the intellectual stimulation, collegiality, and support provided by regular interactions with colleagues.

The ACP has begun to address this challenge through a Practice Enjoyment initiative, one of its highest priorities in 2015 and beyond. After ACP identifies the primary factors that contribute to physician dissatisfaction, we will focus our efforts on reducing administrative mandates that burden physicians without improving quality of care; providing information, tools, and resources to help physicians overcome these burdens; and developing opportunities for decreasing professional isolation. A component of this effort, which has been dubbed "Patients Before Paperwork," is specifically focused on time-consuming administrative and other burdens imposed on physicians, such as prior authorization, documentation requirements, and difficult-to-use electronic health records.

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Table. Time as a Unifying Stress Factor for Physicians

Pressure to increase productivity means less time for each patient.
Regulatory requirements (e.g., maintenance of certification, performance reporting, and "meaningful use" of electronic medical records) are viewed as taking substantial time but not adding value or improving quality of care.
Burdensome paperwork requirements appended to patient care (e.g., prior authorization and billing documentation) consume substantial time and are not reimbursed.
Electronic health records have typically not been designed for optimal usability and have added to time inefficiency.
Expansion of the amount of time needed for work has greatly impinged on personal time and negatively affected work–life balance.

MEETING OUR RESPONSIBILITY TO CONTROL HEALTH CARE COSTS

By consuming nearly 20% of the gross domestic product, health care has become an enormous burden on employers, federal and state governments, and individuals. Although the United States spends more per capita on health care than any other country, quality and mortality measures clearly indicate an insufficient return on this enormous investment. A relatively large component of health care spending, estimated to be 30 cents out of every dollar, is believed to be "wasted"–that is, adding to cost without benefiting patients (5). The challenge for the internal medicine community is to ensure that we minimize overuse and misuse of care, including unnecessary diagnostic tests and treatments, and consistently incorporate "value" (benefit relative to costs and harms) in our clinical decisions and the care that we provide (6).

Such efforts as ACP's High Value Care Initiative and the American Board of Internal Medicine Foundation's Choosing Wisely campaign, of which ACP was an original participating organization, have aggressively targeted reduction of overuse and misuse of care (7, 8). While applying its commitment to evidence-based, patient-centered care, ACP has focused on identifying low- or no-value care and educating clinicians, trainees, and patients about these clinical scenarios. Over time, however, the effort to reduce staggering health care costs needs to be expanded to additional areas, including decreasing unnecessary hospitalizations and emergency department visits. An important priority should be affording patients with chronic illness better and more timely access to outpatient care and helping them understand how to handle worsening symptoms and maximize opportunities for self-management.

As ACP enters its second century of existence, its position as the national organization for internal medicine and its subspecialties obligates it to face each of these issues. This is a challenge that we must, and shall, accept and address to meet the needs of our physicians, their patients, and the broader society.

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