

## Rapid Responses to:

Editorials:

Harold C. Sox

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### Leaving (Internal) Medicine

Ann Intern Med 2006; 144: 57-58 [\[Full text\]](#) [\[PDF\]](#)

## Electronic letters published:

### ▼ Saving (Internal) Medicine

Richard L. Neubauer (23 January 2006)



### ▼ An Obituary for Internal Medicine?

Ashok V. Daftary (17 January 2006)

### ▼ Defining a future for General Internal Medicine

Juan C Larach (3 January 2006)

## Saving (Internal) Medicine

23 January 2006  Richard L. Neubauer,  
MD, FACP

The observation that the exodus from general internal medicine careers may be more rapid than previously recognized (1,2) comes as no surprise, and should be a warning to those interested in the health and welfare of our nation.

Send rapid response to  
journal:
[Re: Saving \(Internal\) Medicine](#)

As a practicing generalist, these observations validate what seems apparent in the day-to-day practice of medicine: doctors and trainees are speaking with their feet by fleeing generalist careers. Ironically, this is occurring at the very time when our country needs more generalists to coordinate the care of the growing elderly population with complex health care needs.

[Email](#) Richard L.  
Neubauer

Observations such as those reported and commented upon in the Annals are key to sounding the alert. I would submit that finding solutions will require a radical redesign of many key features of the medical infrastructure in our country ranging from medical school training to how and what we reimburse in the delivery of care. While some might argue that there is an inherent unattractiveness of being a generalist in our technologically oriented society, I would argue that the exodus from general internal medicine is mostly related to perverse incentives that pervade our system.

I submit that several stars will likely need to align if we are to find and execute effective solutions. First will be cooperation between the specialties and sub-specialties of medicine in recognizing the value of well-trained generalists, and the need to compensate them appropriately. Second will be identification of leaders with the courage to take a stand against those vested in maintaining a dysfunctional status quo. Third will be public recognition that new procedures and expensive technology are not the only things we need in medical care. Finally, articulate thought leaders in medicine need to propose comprehensive solutions such as the Advanced Medical Home concept, and Redesign of medical training papers being developed by the American College of Physicians.

The demise of general internal medicine unfortunately looms as a possibility. If that happens, it will be considerably to the detriment of the health and welfare of the nation. Physicians and our organizations need to work together to prevent that from happening.

1. Lipner RS, Blysm WH, Arnold GK, Fortna GS, Tooker J, Cassel CK. Who is maintaining certification in internal medicine – and why? A national survey 10 years after initial certification. Ann Intern Med. 2005; 144:29-36




2. Sox HC. Leaving (internal) medicine. Ann Intern Med. 2005; 144: 57 -58

Richard L. Neubauer MD Anchorage, Alaska 99508

### Conflict of Interest:

Member, ACP Board of Regents

## An Obituary for Internal Medicine?

17 January 2006   

Ashok V. Daftary,  
MD, FACP  
Sutter Gould Medical  
Group

A thoughtful editorial(1) bemoans a decline in the number of practicing internists but admits to a paucity of information in literature and among physician workplace researchers to explain its causes.

Send rapid response to  
journal:

[Re: An Obituary for  
Internal Medicine?](#)

[Email](#) Ashok V. Daftary

I have previously made comments (2) relevant to this problem. Thirty years of practice as an internist allow me to make further observations.

Academic medicine is the carpenter that fashioned the coffin of internal medicine. Instead of re-engineering internal medicine to accommodate change it cannibalized the discipline reducing its worth, creating the hospitalist and ambulatory care internist. These were both nails that helped seal the coffin, the former reduced the influence of the internist in the acute care environment the latter blurred distinctions between internists and even those without medical degrees practicing in ambulatory care settings.

Medical subspecialties nurtured in the ivory towers of academia further reduced the stature of the internist. Effective lobbying by them and commercial manufacturers of the medical devices they use assured them disproportionately higher reimbursement compared with that of their generalist colleagues.

Absent an identity the only role for the internist is thought to be the ambulatory care of the chronically ill whose medical problems are beyond procedural intervention and lucrative compensation.

A continuing decline in professional stature and income when coupled with deteriorating working conditions makes the continued existence of internal medicine untenable.

I am pessimistic that current political and professional interests will allow significant change to resuscitate internal medicine. Would it then not be opportune to draft an obituary for internal medicine and commission a requiem to its memory?

Sincerely,

Ashok V Daftary, MD, FACP.

1 Sox HC. Leaving (Internal) Medicine. Ann Intern Med 2006; 144: 57- 58

2 Daftary AV. Reimbursement. ACP Observer March 2004

### **Conflict of Interest:**

None declared

## **Defining a future for General Internal Medicine**

3 January 2006

Juan C Larach,  
MD  
The Permanente Medical  
Group, San Francisco

Dear Editors:

The editorial by Dr. Sox is well thought out and timely. It should be read side by side with the editorial in the December 2005 ACP Observer by our ACP President Dr. Hedberg.

Send rapid response to  
journal:

[Re: Defining a future  
for General Internal  
Medicine](#)

[Email](#) Juan C Larach

An intimately related area of research is the number of General Internists who cut back their clinical hours, not only for renewal and self-preservation (as Dr. Alan Jung exemplifies in the same ACP Observer issue), but rather to develop ways of transitioning to a more monetarily productive and less stressful mode of financial support. In my experience, many of my colleagues do not leave medicine altogether but limit their practice to engage in other more lucrative and less stressful activities in the non-clinical and non-medical world.

I also need to add that Dr. Hedberg may have hit upon the new term that should be the standard for us General Internal Medicine specialists. I would strongly support the title of Complex Care Specialist to define outpatient and post-hospital general internal medicine as it now exists. This is much more favorable than such current terms introduced by outsiders such as "ambulists" or "officists". I hope Dr. Hedberg and Dr. Sox can bear the standard of the Complex Care Specialist and charge ahead with it.

Sincerely,

Juan Cesar Larach, MD

### **Conflict of Interest:**

None declared