The Role of the Future General Internist Defined

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The Role of the Future General Internist Defined

American College of Physicians*

■ In this position paper, the American College of Physicians Task Force on Physician Supply examines the current and future roles of the ideal general internist. Discussed are the characteristics shared by all internists, whether engaged in general or subspecialty practice; current trends and the growing crisis in the supply of primary care physicians; and the practices and patient characteristics of both general internists and family physicians.

The Task Force considered four options for the future general internist but rejected them because they either maintained the status quo or were retrogressive: 1) allowing the community-based general internist to disappear; 2) strengthening the generalist's identity as a primary care–oriented physician who provides no subspecialty care; 3) becoming hospital-based generalists who act principally as consultants; or 4) becoming fully trained subspecialists who also provide primary care.

The Task Force proposes a new definition that reaffirms fundamental characteristics of today's general internists and adds characteristics that should be the hallmark of the general internist of the future. The paper describes characteristics that are shared by other generalist physicians and those that are distinctive to today's general internist. It then addresses characteristics that will be needed to prepare for the environment of medical care in the future. The new definition reaffirms that the general internist is an expert in the general care of the adult, but it also revives the concept of the general internist as a local authority on a specific topic in which he or she has special expertise.

The paper concludes with a discussion of some of the questions that its definition poses for graduate medical education. The Task Force suggests that changes in the educational system to produce the desired mix of skills required for the general internist of the future will increase the attractiveness of general internal medicine.

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Internal medicine is changing. Patient populations are changing. Patient care needs are increasingly shifting from short-term care to care for long-term illnesses and from inpatient hospital settings to outpatient ambulatory care settings. Dramatic and rapid advances and innovations have been made in the diagnosis and treatment of illness and in the organization and delivery of health care services. There is a growing appreciation of the need for primary care physicians, particularly for physicians such as general internists who can analyze and solve difficult, complex patient care problems that often involve multiple organ systems. Yet patients, medical school students, third-party payers, public policy makers, and even internists themselves have trouble defining the general internist and his or her appropriate role.

Health maintenance organizations and large group practices often define the general internist's role somewhat differently than do physicians in solo or fee-for-service practice. Geographic factors influence what the general internist does. Rural internists typically do more intensive care and procedures than do their colleagues in populous areas. Current ambiguity about the role of the general internist and the rapidly changing health care environment require that the role of the future general internist be more clearly defined, especially because the mission itself is changing.

The American College of Physicians convened its Task Force on Physician Supply to address the issue of defining the future general internist and several other related and pressing questions. Does the existence of family practitioners and internal medicine subspecialists leave any unique role for the general internist? How should graduate education in internal medicine change to address the growing deficit of general internists and the surplus of subspecialists in internal medicine? What are the roles of nurse practitioners and physician assistants in solving the nation's primary care crisis? We address the Task Force's first charge, to define the future general internist.

Members of the Task Force included general internists, internal medicine subspecialists and a surgeon, full-time practitioners and full-time medical school faculty clinician-educators, and a health economist-patient. The Task Force met four times. Before the second meeting, the members did several exercises designed to form a consensus about the relation of the general internist's work to the work of medical subspecialists, family practitioners, and nurse-practitioners and physician assistants. The Task Force defined the relation in functional terms, such as clinical preventive services, triage, and management of acute self-limited illness and advanced or unstable chronic disease. Each Task Force member then judged the extent to which each type of practitioner performed each function, both in the clinical practice of the present and in the future. These exercises brought the Task Force to a starting point for defining the role of the general internist.

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A physician who completes an internal medicine residency program lasting a minimum of 3 years is an internist. In this report, the Task Force uses the following terms to differentiate types of internists. For the primary care internist who provides comprehensive care to adult patients, the Task Force uses the term general internist. Others prefer the term "comprehensive internist" or even "internist." For the internist whose practice is limited entirely or in part to the care of patients with selected diseases (for example, cardiologists and endocrinologists), the Task Force uses the term subspecialty internist.

General Internists and Subspecialty Internists

The general internist and the subspecialty internist have much in common.

1. They are inseparable, complementary partners in providing health care to adults. General internists pride themselves on meeting most of their patients' needs for internal medicine care. However, most general internists have valued colleagues in each subspecialty of internal medicine. They rely on these physicians to give informal advice, to provide formal consultation, and, occasionally, to assume the care of the patient. The partnership between generalists and subspecialists assures each patient access to the full range of care.

2. The general internist and the subspecialty internist share common training in a discipline characterized by a time-intensive, painstaking, detailed approach to complex problems. This common stem creates a pluripotent physician who should be able to adapt to changing demands for different types of health care.

3. The distinction between the general internist and the subspecialty internist often is drawn too sharply. In fact, there is a continuum of practice styles along a spectrum bounded at one end by the pure general internist and at the other by the purely consultative or procedure-based subspecialist. Internists in some subspecialty disciplines often assume complete responsibility for comprehensive care of patients who need their specialized services (for example, patients receiving chemotherapy or renal dialysis and patients with human immunodeficiency virus infection). Many subspecialty internists have a mixed practice in which they provide primary care for many of their patients. On the other hand, many general internists, especially those in rural locales, have a special area of expertise within internal medicine and may do procedures that in urban areas are the exclusive province of the subspecialty internist.

Current Trends and the Crisis in the Supply of Primary Care Physicians

The aging of the population, expectations of universal health insurance coverage, expanded use of managed care and other changes in health care needs, the practice of medicine, and the delivery of health care services have increased the demand for primary care. The most efficient and effective way to use the physician work force is to rely on generalist physicians to provide the bulk of primary care to adults. However, the number of physicians electing to pursue a career in primary care has decreased, resulting in a physician work force crisis in the United States. The probable—and appropriate—response is to set a high priority on increasing the number of physicians who can fulfill primary care functions, with a complementary reduction in the supply of newly trained subspecialists. As society redresses its oversupply of subspecialists, there is a risk that it will devalue subspecialists and their role in the U.S. health care system. The Task Force believes that society should alter the balance of the supply of generalists and subspecialists while placing a high value on all types of physicians who contribute to our high standard of health care.

General Internists and Family Physicians

In a nation that values pluralism, it is fitting that medical students of different temperaments can choose among several approaches to the care of adults. Some prefer a practice that emphasizes the care of adults and seek in-depth training in internal medicine. Others prefer a practice comprising patients of all ages and seek training in many disciplines, such as that encompassed by family practice. The type of patient seen by general internists and family practitioners and the content of internal medicine and family practice training are good starting points for comparing these two disciplines.

The Medical Outcomes Study allows a comparison of the practices of general internists and family practitioners. The study was a prospective, cross-sectional analysis of slightly more than 20 000 patients seen by 349 physicians in 1986 in carefully chosen practice sites (1, 2). The study compared medical outcomes and resource use in patients of family practitioners, general internists, and two internal medicine subspecialties. The investigators adjusted for differences in the characteristics of patients seen by internists and family practitioners. The patients of general internists and family practitioners and the physicians' rates of resource use (adjusted for patient mix) are compared in Table 1. Patients of family practitioners are an average of 7 years younger than those of general internists. Only 10% of family practitioners' patients were older than 65 years compared with 20% of general internists' patients. The patients of general internists viewed themselves as sicker and less functional than patients of family practitioners. The internists' patients also had more chronic diseases. General internists used the hospital and diagnostic tests at about the same rate as family practitioners. The differences, although unmistakable, are less striking than one might expect from the stereotypical view of the family practitioner as physician to the entire family and the general internist as the physician of the chronically ill older person.

The content of residency training provides another perspective on general internists and family practitioners. The content of residency training as recorded in the *Essentials of Accredited Residencies* (3) is summarized in Table 2. Family practice residents spend a minimum of 10 months in rotations in pediatrics, obstetrics and gynecology, and surgery. They spend at least 8 months but no more than 12 months in internal medicine rotations. Internal medicine residents spend at least 24 months in internal medicine rotations in which they have direct care responsibility under the supervision of internists, and most use their elective time serving as consultants on

Table 1. Comparison of Family Practice and General Internal Medicine*

Variable	Family Practice	General Internal Medicine
Patient mix		
Family size, *n*	2.46	2.37
Mean age of patients, *y*	40.0	46.9
Older than age 65 years, %	10.0	20.0
Well-being (0–100 scale)		
Health perceptions	72.8	67.0
Physical functioning	88.7	83.1
Role functioning	84.9	78.5
Disease prevalence		
Chronic illnesses per patient, *n*	0.70	1.02
Any chronic disease, %	51.0	61.1
Adjusted resource use rates		
Patients hospitalized per year, %	4.77	5.59
Prescription drugs per patient, *n*	1.40	1.46
Mean annual charge for diagnostic tests, $	104	110
Office visits per year, *n*	4.64	4.42

* Information on patient mix, well-being, and disease prevalence was obtained from reference 1. Information on utilization rates was obtained from reference 2.

internal medicine subspecialty rotations. A family practice resident who wished to maximize time in internal medicine could spend as much as 18 months at the task, whereas an internal medicine resident could spend almost 36 months in internal medicine. The content of internal medicine training differs sharply from that of family practice training and offers a clear choice for medical students who wish to become generalist physicians.

This brief review shows that internists see somewhat older and somewhat sicker patients than do family practitioners and that internal medicine training provides indepth preparation for this task. In our pluralistic society, an important role exists for both internal medicine and family practice. Both disciplines should flourish in the coming era of cost-containment and growing entitlement to primary care. Their leaders should work closely to ensure that the two disciplines are meeting the varied needs of diverse practice environments and populations of adult patients. Family practice and internal medicine residents should tailor their training to meet the needs of the community they wish to serve and the form of practice that they prefer—solo, small group, or large group. Training programs in both disciplines must be flexible enough to enable residents to obtain the training that will best prepare them for their desired type of practice (4).

Options for the Future General Internist

The Task Force reviewed several options for the general internist.

1. Allow the past trend to continue: a decreasing number of general internists and an increasing number of pure internal medicine subspecialists blended with physicians who have a mixed practice. The community-based general internist might ultimately disappear, leaving the field to subspecialty internists, the occasional hospital-based general internist, and family practitioners. The Task Force believes that the disappearance of the community-based general internist would be an irreplaceable loss for adults with complex, severe illness.

2. Strengthen the general internists' present identity as a primary care-oriented physician who provides no subspecialty care. The distinction between this option and family practice is clear enough to internists but perhaps is not sufficiently crisp to help medical students, patients, and legislators make their decisions.

3. Become a hospital-based generalist who acts principally as a consultant. The Task Force feels that this vision of the general internist would make it much more difficult for adults to obtain convenient, continuing, comprehensive care when they become burdened with severe chronic illnesses.

4. Be a fully trained subspecialist who also provides primary care, as practiced today by many subspecialty internists. The Task Force feels that this strategy is not the right approach to meeting the country's needs for general physicians. Rather, U.S. academic medical centers should adjust their production of subspecialty internists downward until it is equal to the nation's needs for subspecialty care.

The Task Force believes that these options either maintained the status quo or were retrogressive. Furthermore, none responded fully to several facts: The United States needs primary care physicians; many internists enjoy being sought for their expertise; and, in many locales, patients must travel great distances to obtain subspecialty care.

Definitions: The General Internist Today and in the Future

Based on this background, the College Task Force on Physician Supply recommends the following evolution in the role of general internists. The Task Force envisions the general internist as a comprehensive provider for the health needs of adults and reaffirms several fundamental characteristics of today's general internist. Although several of these are features of other generalist disciplines, others distinguish the general internist from other physicians who provide comprehensive care to adults.

1. A primary care physician: the patient's first contact and a provider of comprehensive, continuing care.

2. A physician who evaluates and manages all aspects of illness—biomedical and psychosocial—in the whole patient.

3. An expert in disease prevention, early detection of disease, and health promotion.

4. The patient's guide and advocate in a complex health care environment.

5. An expert in managing patients with advanced illness and diseases of several organ systems. Equally effective in the office and in the hospital.

6. A consultant when patients have difficult, undifferentiated problems or when the general internist has special expertise to apply to their problems.

7. A resource manager who is familiar with the science of clinical epidemiology and decision making and can bring a thoughtful, lean practice style to evaluation and management.

Table 2. Comparison of Internal Medicine Training and Family Practice Training*

Variable	Internal Medicine	Family Practice
Total time in ambulatory setting, *mo*	≥9	≥10.5†
Time in continuity of care setting, *y*	3	3
Time doing continuity of care, *y*	3 preferred; 2 required	3 required
First year, *d per week*	Preferred but not required	1 half
Second year, *d per week*	1 half	2–4 half days
Third year, *d per week*	1 half	3–5 half days
Block ambulatory rotations	Not specified	Minimal
Time on inpatient rotations	Not specified	Not specified
Time spent in specialties		
Internal medicine, *mo*	36‡	8–12§
Intensive care, *mo*	1–6	Time not specified
Pediatrics, *mo*	None	5
General surgery, *mo*	None	2–3
Orthopedics	Advised, but time not specified	200 h
Other surgical subspecialties	Advised, but time not specified	40–80 h in orthopedics, ophthalmology, and urology
Obstetrics and gynecology, *mo*	None	3
Emergency medicine‖, *mo*	1.5–3	1–3
Dermatology	Advised, but time not specified	60–120 h
Electives, *mo*	No more than 12	6
Rotations acting as a consultant to other services	Specified	Not specified

* Information was obtained from reference 3.
† Minimum time in ambulatory medicine was calculated by adding the minimum time specified in the family practice center, the minimum time in emergency medicine, and the minimum time in dermatology, orthopedics, ophthalmology, and urology.
‡ There must be 24 months of rotations in which the house officer has meaningful patient responsibility (responsible for decision making that is subject to review by the attending physician). Ambulatory rotations count toward meeting this requirement, but elective rotations do not. Most internal medicine residents use most or all of their elective time to do internal medicine elective rotations.
§ If a family practice inpatient service exists, rotations on it count toward fulfilling the internal medicine requirement.
‖ In the emergency department, internal medicine residents see adults with internal medicine or undifferentiated problems; family practice residents see patients from all age groups and with all types of problems.

8. A clinical information manager who can take full advantage of electronically stored data and can communicate using the tools of modern technology.

9. A generalist in outlook who also possesses special skills that respond to the needs of a particular care environment.

Similarities of Today's General Internist to Other Generalist Physicians

1. A primary care physician: the patient's first contact and a provider of comprehensive, continuing care.

The Task Force strongly reaffirms the general internist's role as a primary care physician for the whole person. The general internist cares for adults from adolescence to very old age. In some countries, internists are hospital-based and spend most of their time caring for patients whose family practitioners have referred them for hospitalization or office consultation. This may describe the practice of a few U.S. general internists, but the Task Force rejects this model as a template for the future. General internists have the knowledge and depth of experience to play a central role in the primary care of adults.

2. A physician who evaluates and manages all aspects of illness—biomedical and psychosocial—in the whole patient.

This element of the definition emphasizes the breadth of the general internist's scope but perhaps does not sufficiently emphasize the depth of knowledge required to be a general internist. As the knowledge base of medicine continues to increase, the combination of breadth and depth might be too great a challenge were it not for the promise of the computer, with its ability to organize knowledge and make it quickly available. Internal medicine training programs have done well in preparing resident physicians for the depth of reasoning required to be a general internist. Now, they are addressing the task of educating resident physicians in the breadth of practice skills needed to be a general internist. Internal medicine must find a way to help medical students learn that physicians do cope effectively with the breadth of internal medicine practice.

3. An expert in disease prevention, early detection of disease, and health promotion.

Research in population-based medicine, especially disease prevention and health promotion, is bringing new knowledge at a remarkable rate. As new understanding has accumulated, physicians have realized that disease prevention is a complex activity that requires much knowledge and judgment. Disease prevention in older persons is a special challenge to the general internist. It is also a cornerstone of health system reform, which means that physicians will spend many more office hours on prevention.

4. The patient's guide and advocate in a complex health care environment.

The complexity of today's health care system is intimidating for many patients and families. Tomorrow promises to be no better for them. Other patients are victims of fragmented care. A key role for the personal physician is to organize their patients' care and help them gain access to the care that they need. The complexity of the modern health system is a particular problem for very old persons, who have many health problems and may have physical or intellectual disabilities that make them in special need of a vigorous advocate.

Distinctive Features of Today's General Internist

General internists have in common several traits that are also typical of subspecialty internists. These traits include eagerness to take on difficult problems and a fascination with the scientific basis of medicine and medical practice.

1. An expert in managing patients with advanced illness

and diseases of several organ systems who is equally effective in the office and in the hospital.

Caring for the most complex patients has always been the internist's special role in the community. Patients with advanced chronic disease require medical knowledge, judgment, and experience, as well as patience and skill in working with community resources. Internists typically obtain great satisfaction from helping sick people extend their functional lives and from helping them find dignity and tranquillity during the last months of life. This role is becoming increasingly important. People are living longer, and many face a long, gradual decline that poses many diagnostic and therapeutic challenges. Whether in the intensive care unit, the office, or the home, the general internist is increasingly concerned with using expensive resources wisely and in accordance with the patient's wishes. Managing sick patients efficiently in the hospital and immediately before and after hospitalization is a focal point of the general internists' training.

2. A consultant when patients have difficult, undifferentiated problems or when the general internist has special expertise to apply to their problems.

Many older general internists remember when they were sought-after consultants. For years, the term "diagnostician" was almost synonymous with "internist," reflecting a key role in the professional community as a solver of difficult diagnostic problems. Judging from the undiminished number of unexpected major findings at autopsy (5), diagnosis is still a difficult art despite improved imaging techniques and the growth of subspecialty medicine. Nevertheless, these developments have seriously eroded the general internist's role as a consultant, especially in large group practices and metropolitan areas. Other physicians and patients seeking another opinion often deal directly with subspecialty internists, despite the general internist's ability to deal with complex, undifferentiated problems.

The role of consultant can be rewarding for the general internist. The general internist will often be the best consultant for a patient with an undifferentiated diagnostic problem. The flow of referrals between the general internist and subspecialty internist can be in two directions, with the subspecialist asking the generalist to take over the management of a patient with multiple problems. The Task Force believes that the general internist consultant will play an important role in future health care, especially as the medical education system produces fewer specialists in internal medicine and as increasing numbers of general internists have an area of special clinical expertise.

The Future General Internist

The Task Force envisions that general internists of the future will differ in important ways from today's general internist. The Task Force identified several characteristics that should be the hallmark of future general internists. The first two characteristics respond to changes in the environment of medical care. The third is as old as the discipline of internal medicine.

1. A resource manager who is familiar with the science of clinical epidemiology and decision making and can bring a thoughtful, lean style of practice to evaluation and management.

Personal physicians will have to reconcile two strong forces: the wishes of the patient and the limits on health care resources. Clinical epidemiology, decision analysis, and medical ethics contain principles that can help the physician serve the patient's interests when resource constraints are present. General internists in academic medical centers have taken the lead in applying these principles in their research and in teaching housestaff and medical students how to use them. The application of these principles has led to many practical contributions to medical practice. Whether in caring for the individual patient or in working with colleagues to develop clinical guidelines, the internist who can apply the lessons of these disciplines to daily practice will be a leader in defining standards of care in the community.

2. A clinical information manager who can take full advantage of electronically stored data and can communicate using the tools of modern technology.

Modern information technology offers much hope for improving medical practice. The desktop computer will speed access to patient data, medical knowledge, and assistance in making difficult decisions. Analysis of electronically stored practice data will allow physicians to understand practice patterns and identify optimal practice style. Improved communication technology, such as electronic mail, two-way interactive video, and long-distance access to electronically stored patient records, will mean improved patient care, better relationships with colleagues, and greater enjoyment of practice. Modern communications will greatly facilitate consultation by internists. Internists-in-training must master the skills required to use these technologic advances.

3. A generalist in outlook who also possesses special skills that respond to the needs of a particular care environment.

Forty years ago, before the increase in advanced fellowship training and subspecialty board certification, general internists with an area of special interest provided internal medicine subspecialty care. Even now, general internists, pediatricians, and family physicians have areas of special expertise in which they serve the community as the local experts. In many rural settings, a small group of internists are the only physicians trained in internal medicine. Each one has acquired expertise in one or more areas of medicine, and many do invasive diagnostic procedures that in urban areas are the exclusive province of subspecialty internists. Patients in these communities do not have to travel far to get in-depth care in an organ-based specialty of internal medicine.

Even now, some far-sighted medical residents plan to spend extra time in a medical subspecialty to prepare for a niche in the community practice of general internal medicine. These residents try to learn the cognitive content of the field, obtain extra experience in diagnosis and management, and acquire the skills to do certain necessary procedures. The Task Force recommends that internal medicine training encourage this career direction by providing flexibility in the curriculum.

There are at least two categories of topics of special expertise:

1. Traditional, organ system-based subspecialties: The Task Force envisions many communities in which most or

all physicians trained in internal medicine will be general rather than subspecialty internists. Each general internist, whether a member of a small group practice or a solo practitioner, will also be the local expert in an organ-based subspecialty (for example, noninvasive cardiology, gastroenterology, endocrinology and diabetology, rheumatology, and clinical nephrology). These physicians will acquire their special expertise either during residency or by returning for additional training after a period in practice. This approach will be especially suited for a setting with few subspecialty internists. Large managed care groups might also benefit from asking general internists who are "generalists in outlook who also have special skills" to provide the first line of subspecialty care.

2. The new subspecialties of internal medicine: Many internal medicine topics are not directly related to the organ-based subspecialties. Expertise in these topics is valuable to the practicing community, whether it be in a rural locale or a large suburban or urban managed care practice. These topics include geriatrics, adolescent medicine, care of medical illness during pregnancy, substance abuse, women's health problems, and sports medicine. The future general internist might choose to acquire expertise in one or several of these topics either during or after residency training.

This element of the definition of the future general internist has implications for training, daily practice, and the shape of the physician work force. The Task Force expects that the United States will move toward training only enough subspecialists to satisfy the needs of referral centers. The general internist with expertise in a subspecialty of internal medicine can provide an important service in parts of the country that do not have easy access to medical centers. In addition, an education system that adds subspecialty expertise to a solid base of generalist attitudes and skills provides substantial advantages.

Discussion

The definition of the future general internist raises many questions about internal medicine education. Among the most intriguing are questions about subspecialty expertise: the level of subspecialty expertise, the amount of training, and the experience required to maintain the skills. A related concern is the timing of subspecialty learning. Can subspecialty training fit into a traditional 3-year internal medicine program, should it occur during a flexible fourth year (6-9), or should it be postponed until after a few years in practice, when local circumstances dictate the need for additional study (for example, if a physician takes a leave of absence from practice to engage in further training)? If subspecialty training is to occur within the traditional 3 years of residency, one must ask whether the amount of inpatient care experience currently required is really necessary to be a superb manager of the sick hospitalized patient. The role of elective subspecialty rotations may change. A restructured curriculum may require better-defined subspecialty rotation experiences, consolidation of many short electives into extended experiences in one or two subspecialties, or even elimination of short electives in favor of opportunities to learn skills that have a higher priority for limited curriculum time. Finally, there are many other reasons for curriculum reform in internal medicine. Creating an appropriate balance of learning in the hospital and in the office setting is but the most pressing of these issues. Internist-educators must begin to address these important questions.

The Task Force hopes that its revival of the concept of the general internist as the local expert on a special topic will lead to a spirited discussion. The concept of the general internist as the local expert on special topics in internal medicine precedes the emergence of most of the subspecialties of internal medicine. Many internists already live this role. They acquired their special knowledge during a 3-year residency; during a foreshortened subspecialty fellowship; by returning to training after a period in practice; or informally by extensive reading, attending subspecialty meetings, and shifting somewhat the focus of their practice. The Task Force hopes that its proposal will move this aspect of internal medicine training into the mainstream, making it much easier for internists to obtain well-structured learning opportunities, to be recognized as having special expertise, and to acquire the right to practice these skills in a hospital setting. Although the Task Force is trying to open still wider the door to these opportunities, it recognizes that some practice settings may provide limited opportunity for the general internist to practice special skills. Furthermore, many internal medicine residents will prefer one of the many other possible roles for the general internist. Not everyone will choose this route to a fulfilling career in internal medicine, but the Task Force believes that internist-educators should place much more emphasis on providing an opportunity that may attract many young people to choose internal medicine.

Far more important forces than mere nostalgia influenced the Task Force to emphasize a model in which many general internists are also the local expert in a focused area of medicine. Change is necessary. Continuity and integration of care, improved efficiency, and lower cost to the patient are among the driving forces for change. Better compensation, freedom from administrative hassle, and tort reform will help to restore the morale of general internists. However, changing these external factors will not address the general internist's crisis of identity. The Task Force's definition reaffirms the general internist as an expert in the general care of the adult and revives the concept of the general internist as the local authority for a relatively narrow topic. The Task Force believes that changing the education system to produce this mix of skills will advance medical care and will increase the attractiveness of general internal medicine to its practitioners, present and future.

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References

1. **Kravitz RL, Greenfield S, Rogers W, Manning WG Jr, Zubkoff M, Nelson EC, et al.** Differences in the mix of patients among medical specialties and systems of care. Results from the medical outcomes study. JAMA. 1992;267:1617-23.
2. **Greenfield S, Nelson EC, Zubkoff M, Manning WG, Rogers W, Kravitz RL, et al.** Variations in resource utilization among medical specialties and systems of care. Results from the medical outcomes study. JAMA. 1992:267:1624-30.

3. Directory of Graduate Medical Education Programs, 1992–1993: Essentials of Accredited Residencies. Chicago: American Medical Association; 1992.
4. **Kimball HR, Young PR.** A statement on the generalist physician from the American Boards of Family Practice and Internal Medicine. JAMA. 1994;271:315-6.
5. **Landefeld CS, Chren MM, Myers A, Geller R, Robbins S, Goldman L.** Diagnostic yield of the autopsy in a university hospital and a community hospital. N Engl J Med. 1988;318:1249-54.
6. **Stein JH.** Grand cru versus generic: different approaches to altering the ratio of general internists to subspecialists. Ann Intern Med. 1991;114:79-82.
7. **Levey GS.** Changing the curriculum for internal medicine residency training. Ann Intern Med. 1992;116:1046-50.
8. **Nuckolls JG.** Internal medicine practice in transition. Implication for curriculum changes. Ann Intern Med. 1992;116:1051-4.
9. **Barondess JA.** The future of generalism. Ann Intern Med. 1993;119:153-60.