The art of medicine

Osler redux: the American College of Physicians at 100

Medicine, theology, and law were the principal subjects taught in medieval universities and thus became the learned professions. Their practitioners gained further esteem by helping people through difficult matters clouded with uncertainty. Medicine's marriage to science and technology has reduced uncertainty in diagnosis, treatment, and prognosis, thereby diminishing the role of opinion, judgment, and wisdom as opposed to purely technical expertise. The French medical historian Danielle Gourevitch greeted the new millennium in *The Lancet* by suggesting that physicians will soon be replaced by health-care technicians. She called Sir William Osler (1849–1919) "the last maître à penser for a noble-minded general medicine".

The American College of Physicians (ACP), the largest medical specialty society based in the USA with almost 141 000 members in nearly 130 nations, is currently celebrating its centennial. At the ACP's Centennial Meeting, in Boston, MA, USA, on April 30–May 2, 2015, attendees might well take selfies beside a life-sized representation of Osler, billed as "the father of internal medicine". Actually, Osler never claimed to have invented a new specialty. He understood internal medicine as a generalist-consulting specialty, a north American spin-off of the German *innere Medizin* with its promise of better understanding of disease through physiology and chemistry.

Internal medicine's boundaries were indistinct from the beginning. Dermatology, neurology, paediatrics, and psychiatry had already organised by 1885, when Osler and six other generalist-consultants met in New York City to form the Association of American Physicians. Osler advanced their cause by writing an encyclopaedic textbook, *The Principles and Practice of Medicine* (1892), which made him famous throughout the English-speaking world. In 1897, addressing the New York Academy of Medicine on "the importance of internal medicine as a vocation", Osler observed that "its cultivators cannot be called specialists, but bear without reproach the good old name physician: the physician proper", telling his audience that "the opportunities are still great, that the harvest truly is plenteous, and the labourers scarcely sufficient to meet the demand". The first seven or eight decades of the 20th century proved him right. North American internists served general practitioners as consultants in difficult cases but, unlike consultants in the UK, competed with them for primary-care patients in the outpatient arena.

The ACP resulted from the efforts of Heinrich Stern (1867–1918), a German-born New York City doctor who, impressed by an annual meeting of the Royal College of Physicians in London, met with six colleagues to establish the American Congress on Internal Medicine for "the purposes of facilitating scientific intercourse among physicians interested in internal medicine". The Congress convened in January, 1915, and its leaders incorporated the ACP in May, 1915. Buy-in came slowly; Stern died in 1918, and full-time faculty internists had by then two research-oriented organisations with restrictive membership: the Association of American Physicians and the American Society for Clinical Investigation, known respectively as the Old Turks and Young Turks. However, practising internists soon saw the value of the new college, whose *Annals of Internal Medicine* (founded in 1927) became indispensable for continuing education. In 1936, the ACP helped establish an organisationally separate American Board of Internal Medicine to administer certifying examinations. The ACP's conscious decision to abstain from certification explains in part why its power has never approached that of the three medical Royal Colleges in the UK.

Through much of the 20th century the ACP and the separate American Board of Internal Medicine burnished the image of internal medicine as an elite form of generalism. The college sought inclusiveness in membership but maintained rigorous requirements for advancement to fellowship. For many years the board required an oral examination for candidates who had passed the written examination. One well-qualified applicant allegedly flunked the oral examination because his black bag did not contain whole-leaf digitalis. At most USA medical schools chairs of medicine were more powerful than deans and the environment of top internal medicine training programmes was rigorous and often intimidating. The story goes that on one occasion the physician Eugene A Stead of Duke University, who has been called the last professor of medicine in the Oslerian mould, heard a resident present a case from the previous evening and asked: "What did the spinal fluid show?" The exhausted resident chirped that he'd been up most of the night, that other patients needed equal attention, and that the case was extremely confusing. "Doctor", Stead lectured, "You're telling me that life is hard. I already know that. I want to know what this patient's spinal fluid showed." Inspired by such uncompromising insistence on excellence, the best and brightest USA medical students disproportionately chose internal medicine through much of the 20th century. In 1959, the ACP's President could say accurately: "Internal medicine is the most important, the most rapidly growing, and the least understood specialty in the field of medicine." The historian Rosemary Stevens described this paradox as "institutional importance and definitional ambivalence".

During the closing decades of the 20th century, two challenges emerged to internal medicine's identity as an elite form of generalism. First, as the French traveller

Alexis de Tocqueville famously recognised during the 1830s, elitism does not sit well with most Americans. General practitioners wanted specialty status. Their appeals to the ACP for recognition and to the American Board of Internal Medicine for certification were turned down. The general practitioners responded by defining family medicine as a rigorous specialty based on a biopsychosocial model of disease, started the American Board of Family Practice (1969), and renamed their major organisation the American Academy of Family Physicians in 1970. Whereas the term "internal medicine" had always required explanation, family medicine promised definitional clarity as did a new specialty, emergency medicine. The second challenge to internal medicine came from its own proliferating subspecialties, of which 20 are now recognised by the American Board of Internal Medicine. By the 1970s most internal medicine residents sought additional training and certification. Subspecialists met many of their educational, social, and political needs through their own societies. Would internal medicine implode?

When writing about the history of American internal medicine, in 1986, Rosemary Stevens weighed the possibility that the field might be dissolved entirely, with primary-care internists and subspecialists forming separate alliances with other disciplines. She advanced four reasons to preserve the field, all of which have borne true. First, internists are past masters of uncertainty with a proven track record of resilient adaptation to change. Beginning in the 1990s, general internists carved out a niche as "hospitalists" specialising in care of inpatients and pleasing administrators by reducing lengths of stay and costs. Unlike the term "internist", the term "hospitalist" (coined in 1996) is easily explained to laypeople. Second, general internists and also internal medicine subspecialists provide a large portion of primary care in the USA, especially for older patients with chronic illnesses, and this is unlikely to change anytime soon. Internists constitute about one-fourth of the USA physician workforce. Third, internal medicine encompasses the entire spectrum from primary to secondary to tertiary care, explaining in part why many internists now assume leadership roles in health-care organisations. Finally, and perhaps most importantly, internal medicine has in many ways served as a conscience for the medical profession at large.

The early decision by the ACP to abstain from political controversy led to the formation in 1956 of a closely-allied American Society of Internal Medicine to represent internists' concerns in the halls of US Government. In 1998, the two organisations formally merged. In the meantime, in 1978, the ACP decided to engage more directly in public policy "as a fresh, scholarly, non-self-serving, medical voice that would become known as a valuable resource to legislators and regulators". Since then, the organisation has—in addition to its leadership in continuing medical education, medical ethics, and quality assurance—endeavoured to promote the public interest even when its recommendations might run counter to the financial best-interests of its membership. In 1990, the ACP called for universal health insurance and in 1992 it offered a specific plan. As its former President Clifton Cleaveland reminisces, "We were almost alone in this advocacy, bringing considerable criticism and chagrin from the AMA [American Medical Association] and other physician groups." The ACP went on to offer its support for the Affordable Care Act. Recently, the College launched a Center for Patient Partnership in Healthcare. In these and other activities the ACP's leadership functions as a think tank for new ways to serve the public interest.

Courtesy of American College of Physicians

Headquarters of the American College of Physicians in Philadelphia, PA, USA

The ACP currently defines internists as "physician 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". The internist's sphere as master generalist-consultant has shrunk considerably since Osler's day as subspecialties have proliferated and as newer laboratory and imaging methods have simplified diagnosis of many diseases. We cannot predict the extent to which digital technologies, robots, algorithmic approaches to health care, and ever-new innovations will foster replacement of physicians by technicians. We should, however, be optimistic that there will remain a place for "the physician proper", the broadly learned doctor whose opinion, judgment, and wisdom matter for individuals and for society. Celebratory meetings such as that for the ACP's centennial evince Osler's optimism that "the profession of medicine forms a remarkable world-unit in the progressive evolution of which there is a fuller hope for humanity than in any other direction".

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Further reading

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