

The consequences of losing inpatient general internal medicine divisions

With the continuous aging of the population and the increasing number of older multimorbid patients admitted to European hospitals, General Internal Medicine (GIM) hospital divisions have come again into focus. Historically, large GIM divisions, which usually include various GIM subspecialties, have a crucial role in maintaining smooth patient flows within a hospital by admitting a broad spectrum of patients from the emergency department and the intensive care unit, the comprehensive, coordinated and continuous care of multimorbid complex patients, and the training of future generalist physicians. However, with the growing subspecialization of internal medicine, these GIM divisions were often fragmented into smaller subspecialty divisions focusing on a single organ or disease category. This fragmentation has been largely fueled by reimbursement inequalities in favor of (intervention-based) subspecialty medicine, which, from a hospital perspective, is more lucrative than the complex care of multimorbid inpatients who often have a prolonged length of stay. As a net effect, this development has led to diminishing GIM divisions and in some countries (e.g., Germany), the entire disappearance of GIM divisions from university hospitals. The negative consequences of this development are threefold:

- (1) **Fragmentation of patient care.** In the absence of GIM divisions, it is increasingly difficult to provide comprehensive, continuous, and coordinated care to inpatients with multiple diseases, leading to a fragmented care by multiple subspecialist. Care fragmentation usually results in a lower quality of care and higher health care costs. Alternatively, subspecialists will care for patients outside their specialty experience, with the potential of a resulting quality of care decrease.
- (2) **GIM divisions are ideal training fields for generalists,** given the great variety of patients with different pathologies hospitalized at such divisions. The lack of such divisions will have a negative impact on the postgraduate training of future generalists and primary care physicians, which will further contribute to the existing lack of primary care physicians and shift the physician work force composition towards more expensive specialty medicine.
- (3) **Diminishing numbers (or the total lack) of academic general internists** will have a deep impact on the way to train students. The single organ-and disease-based approach will become the norm, the specialist physician the predominant role model, which will further decrease the attractiveness of generalist medicine. Finally, the lack of generalist (health services) research will impede research and development of generalist medicine and research in multimorbid patients.

We propose the following countermeasures to preserve GIM at the hospital level and to avoid the negative consequences on patient care, training, and academia related to its disappearance.

- (1) As in ambulatory health care, a reasonable mix between inpatient general internist and specialist physicians (50%:50%?) is needed. Multimorbid patients should primarily be admitted to GIM divisions. General internists should lead the care of such patients, with the support of specialist physicians where needed.
- (2) The costly, resource-intensive care of elderly multimorbid patients should be adequately reimbursed by increasing their case weights within diagnosis-related group-based inpatient reimbursement systems. This would make GIM divisions financially more attractive from a hospital perspective.
- (3) Given the lack of generalist/primary care physicians in many Western health care systems, state subsidies for physicians-in-training should be primarily made available to GIM divisions, strengthening the position of inpatient GIM.