What Is Internal Medicine?

You have had those moments of uncommon richness: the sudden intimate connection with a friend, or the birth of a child, or the irresistible impulse to thoughtfulness. (Why are they so few, these epiphanies? Is it because we get caught up with the ordinary, intending to save these special moments, yet never quite return to them? Do we get sidetracked, never to get back to that special divergence that might give life meaning?)

Medicine is no different. We have our special moments in medicine, moments laced with a sense of privilege. There is that first day in the dissection room where a mystery unfolds. The human body opens before you and you find you are not repulsed after all. It even holds your interest. But more than that. Its symmetry, its efficiency of design, its universality, and above all, its poetry, strike you as marvelous. And behind this wonder lies the realization that few can ever experience this, that you are special even to be there.

That first day in the operating room holds the same specialness and similar privilege, as you watch technology and human hands repair, re-form, and cure. There is ritual here too, and history. There is drama. There is the miraculous. Standing just so, exactly where you have been told by that severest of nurses, The O.R. Supervisor, you are careful not to touch, not to sneeze, not to move, and yet still you cannot help feeling a part of it.

There is another such moment, seldom seen these days by students of medicine, to their own loss. It is the moment of the master clinician at work—that moment of connection between patient and doctor, the moment of caring, the moment of diagnosis. These consummate physicians are everywhere, palpating, percussing, auscultating, diagnosing, thinking, and most of all, talking to patients. The best of these seem to have a sixth sense about disease. They feel its presence, know it to be there, perceive its gravity before any intellectual process can define, catalog, and put it into words. Patients sense this about such a physician as well: that he is attentive, alert, ready; that he cares. No student of medicine should miss observing such an encounter. Of all the moments in medicine, this one is most filled with drama, with feeling, with history. We have been touching patients and listening to them since before recorded history. And we have gotten better at it every day. It is what medicine is all about.

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This master clinician is the internist, the diagnostician, the doctor trained in the basics of subspecialty medicine, someone totally familiar with the heart, the lung, the bowel, and the kidney, someone trained to decide if a skin problem is a result of joint disease, if the murmur might represent cancer, someone who understands the aged, knows when to welcome Death and when to fight, knows how both to hold a hand and pound the chest, someone able to step beyond the boundaries of an organ system or a technique into the realm of diagnosis. And his or her gift of diagnosis flows from a sound knowledge of the science of the subspecialties, and from the art of medicine. Watch these doctors in action and ask how it was they arrived at the answer. The best of them will seem to have intuited the solution to the problem, yet will explain retrospectively the logical steps to the answer—as does the mathematician who skips several steps in his proof.

This internist will consult for surgeons, and for family practitioners, on matters relating to infectious diseases and antibiotic use, on questions of endocrinology and whether the thyroid is enlarged and overactive or just so. He or she will counsel families in distress, know his or her way around the intensive care unit, and do most of the teaching of young doctors. He or she will treat patients, not diseases.

It is not an easy choice, not an easy path—this one of general internal medicine—not free of trouble or anger, not free of moments of profound sadness, and loss, and lawyers after you, not free of subspecialists with half the responsibility earning twice as much. I am not talking here about romance. But it is a life uncommonly rich, a profession in the truest sense of the word, a way of life itself. Nothing else comes close.

It is a love affair: a lifelong relationship of satisfaction, where happiness is distinct from pleasure; a relationship where both parties grow and change and adjust, both you and medicine, and where each of you contributes to the growth of the other; a relationship filled with epiphanies and punctuated by periods of sadness where, on the one hand, you cannot imagine doing anything else with your life and, on the other, you have sworn to leave it in the next moment. And by this love affair I mean one with open eyes, not one where one participant is blind, having been seduced into a relationship not right for her. And if by the romantic it is meant someone who does not know where she will be in a year, then I do not mean romance, because it does require commitment, and staying power.

What can internal medicine offer you? Young students worry often about something called "intellectual challenge." One argument goes something like this: *The subspecialties with their science offer the physician intellectual challenge, whereas general internal medicine does not.* Let's examine this for a moment.

The entire spectrum of general internal medicine is the study of the whole patient, the care of that patient, the *complete* care of the human being. As such, it is an approach to an understanding of ourselves. Internal medicine affords a profound opportunity for self-discovery. No other discipline, within medicine or without, comes close. You find these eternal questions staring you in the face, questions about yourself: Do you care for your fellow human beings? Will you make the effort to understand them? Can you recognize your anger for

another and stifle it for the higher good? Can you put what is Good above gold? Will you do what is right rather than what is expedient or profitable? When you have ascended to that position of power, power over your patients who wish you to have it, who willingly bestow it on you, will you exercise that power justly, without the corruption attendant with that power? Can you be paternalistic when it is proper to be so, and a friend to your patients when the situation demands it? Can you never close your heart to your patients, even though they all, every one of them, will eventually die? Can you do your best, and pride yourself on doing so, even though Death will ultimately defeat you?

This is the self-discovery of internal medicine. Tell me of a higher intellectual challenge.

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Descartes liked to say that content followed form. What he was getting at was something like this: If you first decide, for example, that yours will be a rural life, a life predicated on independence, and let's say, involved with animals and the caring of them, a life of mending fences and fixing things—a farmer in other words—then the form of your life will dictate its content: the animal warmth of a barn in winter, the sweet breath of a Holstein, swallows setting up shop in your outbuildings every spring and low milk prices and summer pasture and getting in the hay against the rain. One becomes a farmer out of love for the out-of-doors, out of the need for freedom from the indoors. That is as it should be. And the same is true for medicine. One chooses an area of medicine because of that same gut instinct. Or one should. One should feel that need to discover, the drive to think, to figure things out, to sort out signs and symptoms, and though often working against the rain, find the solution to help his patient live, and live as best he can. From this need should come the power to decide your path in medicine, from this should come choice.

But I think not enough thought is given to choice these days. Actually, I don't think there is very much thinking at all. Too often we let others do our thinking for us. Too often we let words do our thinking, make our decisions. (Advertisers are quite good at exploiting this.) We respond to words and their slightly judgmental, slightly pejorative sense and then believe that we are thinking, believe that we are making decisions when we are only reacting, responding to such words and phrases as: *generalist, specialist, private practice, academia, primary care, local medical doctor, lifestyle, prestige*, and especially the tired: *too broad a discipline, impossible to master.*

Have you noticed how little direction there has been for help in sorting out these things? No one will tell you, for example, to think for yourself. No one will tell you:

—to listen to your heart.

—that the dream you had of being a real doctor is the best sort of dream of all.

—that patient care is a frightening prospect, an awesome responsibility, demanding a great deal of courage, which a few people have, which others can develop, but which most never seem to bother to search for. Or that you have the potential for such courage.

—that university life is a sheltered life, and not the real world, and so is specialization, and that such a sheltered life is an easier approach to the profession than that of the generalist, who is too often patronized and treated condescendingly. Or that universities are beginning to realize that they both want and need the general internist.

—that it *is* extremely difficult to be a general internist. Or that you are capable of it. Or will tell you how to achieve that goal. And no one will tell you that there is no better calling in medicine.

But I am telling you this:

—that you should, in choosing your life's path, consider the motives that caused you to go to medical school in the first place, motives that may now be overshadowed by the opinions and beliefs of others.

—that you are now a product of those beliefs, those opinions of others that you cherish and hold fast to because they are fashionable and because they are believed by others attractive to yourself, and not because they are true, hold any sort of internal consistency, or match the beliefs you once had when you first intended to be a doctor.

—that no one will tell you that what patients *want* may not necessarily be what they *should have* and that you will need to know the whole patient to determine this.

And I wish to tell you this secret: that the medical specialties, the divisions among internal medicine, are at best artificial, that patients do not conform to them, that a patient's problems may well run across the line of many disciplines, requiring either one complete physician or several subspecialists, that the latter is the much more expensive, less personal route to go; that where there is power, there is greed, and where business is born, professionalism may barely survive, and *that* is a sickness of Medicine, and one to be avoided; that there are ways to avoid it, and those ways involve Reason, and Principle, but that we do not have time for seminars dealing with these things, caught up as we are in membrane biophysics and oxygen dissociation curves. In fact no one, not anywhere in medical school or residency, will talk about What Is Good, What Is Bad, What Is True, What Is Beautiful, What Is Right or Wrong, but they will assume that you have gotten this in some other education, which of course you have not, or that you simply are the embodiment of these principles because you are or will be A Physician, which of course is also not true, and that medicine itself is diseased, to the extent that society is diseased, but you will not be offered any modes of therapy for this disease.

And what will be left to you then? Why, you can maintain the status quo, voice and echo popular opinions of the day, argue that "everyone else is doing it" and "what is wrong with making money anyway," and secretly or openly state that "it's someone else's problem," thus perpetuating the disease.

Or you can think for yourself.

Descartes also said that there are only two groups of people in the world: those interested in learning things and those bent on making money. That applies to this

whole business of making a life's choice, a decision about what you want to be. Now, I do not intend that everyone should necessarily decide on internal medicine in the sense and idea that I am trying to convey to you. Nor am I trying to polarize this decision, attempting to say that the one choice, Learning, for example, is Good, whereas Money is Bad. But I have come to believe that much unhappiness in life, as in medicine, comes from a person's choosing the wrong *form*, and then having that life, that form, filled up with a *content* in the main displeasing to the individual.

When one decides that being an internist might be the right sort of life, when the intimacies of patient care, the closeness of families, the intensity of working with nursing personnel and the specter of death do not frighten, when using science to care for patients in a direct hands-on sort of way is most appealing, then I believe one should decide on that form and let the content take care of itself. As it will.

Let me give you an example: Here we are, my partners and I, in this village of 4000 people, serving as internists for a county in western Maine larger than Rhode Island. We have willingly chosen this life, this area, these people. That is the form of our lives. And so our days are spent in this way: We manage the intensive care unit; we will be challenged by the young woman with lupus, the middle-aged man with new-onset Parkinson disease, the elderly lady with muscle pain and a high sedimentation rate, and will put our heads together to puzzle out the unusual rash, adenopathy, and malaise in a teenage boy; with every new patient encounter we will exercise our powers of diagnosis; while I may be implanting a permanent pacemaker or floating a right-heart catheter, one of my partners is doing a gastroscopy while another performs a bronchoscopy and a third, an echocardiogram. I will leave the O.R. to talk to the family about the new pacemaker and answer their questions about microwave ovens and electric toothbrushes, may then do a liver biopsy on my patient with chronic active hepatitis, and run to the office to supervise adjuvant chemotherapy for a patient with breast cancer. My partner will call me about the colonoscopy he has just completed on another patient of mine. Her ulcerative colitis is doing better, thank God. I schedule a thallium treadmill (to be performed by me), talk to a young couple with marital problems, adjust antianginal therapy in another patient, check the urine sediment on a young woman with chronic renal failure, and that is my day.

That is its content.

When choosing the form of a medical life it has been helpful to me to remember the following:

- *Patients do not wear a diagnosis on their foreheads; diagnosis is best done by good general internists.*
- *An internist without skills in physical diagnosis is only half a doctor.*
- *True prestige comes from within.*
- *Procedures can be done by the generalist.*
- *An internist without basic knowledge of pathophysiology and science is no doctor at all.*
- *An internist who doesn't care for his or her fellow human being is no internist.*

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To be a general internist, what does one need in the form of an education? What type of residency should one choose? What sort of other education will provide you the staying power you need? Well, in a sense, we have in medical school already headed down the wrong road, because medical schools demand a heavy curriculum of basic science in the undergraduate years. This has been exacted at the expense of the humanities. That is a mistake, an imposition that medical schools are slow to change. Yet one needs a life's philosophy, a sense of history, an ability to be a person of ideas rather than a person who reacts to hype, to advertising, to slogans. Physical chemistry, biochemistry, biophysics, and molecular biology in the undergraduate years will not give you these. So, you need a journal club. But a different sort of journal club. Instead of medical journals, I suggest Tolstoy and Twain, Dostoevsky and Donne, Keats and Kierkegaard. Their "journals."

And one needs a mentor. (However impossible this might be for women in medicine these days, women should fight this trend as well and find the right, correct teacher.) But not someone who must make you into the same specialist he or she is, for purposes of self-affirmation, rather someone who is a person of ideas, generous enough to allow you to become what you want to be.

Young doctors have concerns for the future. Rightly so. We are rapidly approaching the time when, with our advancing technologies, we will be capable of rapid, detailed, whole-body scanning, giving us anatomical and biochemical analyses about patients we have never before dreamed possible. The resulting database, even for the normal annual physical examination of the patient, will be incredibly detailed. Who will assimilate this? Who will sift and sort this data? Who will direct the care of the patient, given this data? The radiologist? I think you know. The general internist, with the discipline borne of training and history, will be at the focus of this technology.

Is general internal medicine too broad, the discipline "too hard" to master?

Is life?

You do what you can do. In your medical education you learn an approach to the literature. You have at your elbow in practice a sound medical library and computer-links to the latest medical literature, no matter where you are. At the other end of the telephone are the best university professors whose job it remains to teach and support you. That is enough. You do not need to know an exhaustive list of possible diagnoses for a patient with cryptogenic cirrhosis; it is all written down. It is in the textbooks. That is enough.

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Many years ago when my children were young I took them to a lake in northern Maine for some fly fishing. We were at the other end of the lake in the middle of the finest mayfly hatch you could imagine, trout feeding everywhere. Suddenly, we saw the camp boat coming at us at high speed, frothing up the water, creating such a fuss the trout would be put down for days. They needed me at the camp in a hurry. Someone had a fish hook in his eye. We hurried back across the lake. There was the fisherman sitting on the porch of the lodge, a

Royal Coachman prominently hooked in his right upper eyelid. Sitting next to him was a cardiologist I knew, chewing nervously on his cigar.

"I had them go and get you, Mike," he said with some agitated rocking of his chair. "I figured you were a lot closer to this than I am."

"Yeah," said one of my sons, "my dad's a doctor."

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Annals of Internal Medicine. 1993;**118**:384-387.

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We are all weary of discussions of state medicine, of the high cost of medical care, of the adequacy of medical care for the indigent, of the shortage of hospital beds for those who can pay, of the shortage of nurses, and so on. But these are, in part, our problems; if their solution is to be to our liking, we must be active in them. The spector of state medicine is continually raised before us. Greater participation, by the federal, state and local governments in matters of health seems inevitable, although most of us think it is important to retain in some manner or other the principle of private enterprise. Change of some sort will come; it is evident that unless we ourselves reorganize the practice of medicine, it will be reorganized for us.

W.L. Palmer
"Gastroenterology, Internal Medicine, and the General Practitioner"
In: *Gastroenterology* (1947;9:119-24)

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