

FROM THE EDITORS' DESK

General Internal Medicine as an Engine of Innovation

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“More than any time in history mankind faces a crossroads. One path leads to despair and utter hopelessness, the other to total extinction.”—Woody Allen

Almost 10 years ago, *JGIM* published a seminal report from the Society of General Internal Medicine (SGIM) Task Force on the Domain of General Internal Medicine.¹ Boldly titled “The Future of General Internal Medicine”, the report challenged the field of general internal medicine to take responsibility for addressing the “chaos and dysfunction” the Task Force believed characterized medical care at that time. Many of the innovations they proposed, including team based care, enhanced information systems, and the abandonment of the fee-for-service financing model, seemed pie-in-the-sky at the time, but are now accepted by most as essential for improving health care delivery and curbing costs.

While much has changed in the past decade, in many ways, general internal medicine still stands at the crossroads. While the options may not be quite so bleak as Woody Allen suggests, general internal medicine continues to face some critical challenges in research, education and clinical practice. In this issue of *JGIM*, Armstrong et al. (on behalf of the 2012–2013 SGIM Council) articulate these challenges and present a vision for the future of general internal medicine.² They point out that the pressure to reduce health care costs and increase value along with the historic passage of the Patient Protection and Affordable Care Act (ACA) will lead to new initiatives in primary care and GIM, featuring population management, team-based care and innovative use of electronic health records. Changes in medical education spurred by duty hours reform and enhanced workforce diversity have resulted in a shift to more training in the ambulatory setting and a shift in focus to measuring competencies rather than medical knowledge. For researchers in academic GIM, they argue that these changes bring both challenges and opportunities. GIM researchers are ideally situated to study the impact of practice transformation and payment reform that will be

brought by the Affordable Care Act (ACA), but despite optimism fueled by the Patient Centered Outcomes Research Institute (PCORI), funding challenges will persist.

The United States spends almost \$3 trillion on health care. According to some analysts, up to 1/3 of these expenditures are wasted on inappropriate, equivocal, misapplied, or inefficient care. If just 1 % of health care payments were applied to scientific evaluation of what works and what doesn't in health care, a pool of \$30 billion would become available to generate answers our country sorely needs.

Several articles in this issue of *JGIM* showcase the value of rigorous empirical research in evaluating innovations in health care practice and policy. The Patient Centered Medical Home (PCMH) has been touted as a solution to the current crisis in primary care, but most evaluations to date have been observational. In two related articles, Fifield, et al. describe the implementation and experimental evaluation of the PCMH model in small-medium sized practices.^{3,4} In their cluster-randomized trial, most practices were successful in achieving NCQA recognition, but there were few consistent differences in processes and outcomes between PCMH and control practices. An accompanying editorial by Landon puts the data in context.

The PCMH has implications not just for patients and practitioners but for physicians-in-training. Chang et al.⁵ describe a consensus meeting leading to a set of 25 “entrustable professional activities” that residents will be encouraged to perform with varying degrees of independence. Some of the activities are familiar (e.g. “devise a longitudinal care plan for chronic disease”), but others (e.g., “lead an interprofessional health care team”) will require new skills and new curricula to support their development.

Workforce development is key to maintaining a robust primary care infrastructure, and medical schools must do their part. Are they contributing in fair measure? An article by Choi and Ayanian suggests not.⁶ Research intensive schools produce fewer primary care graduates than their less research-intensive counterparts. Lest readers be too quick to judge the Harvards of the world, a Capsule Commentary by Jackson points out that other factors besides medical school orientation (things like salary, prestige, and lifestyle) are likely to be much more important as causes of the primary care workforce crisis.

At least three more articles explore the potential of health information and communication technology to enhance care while showcasing the importance of rigorous empirical evaluation. Whether it be teleconsultation in HIV infection (Waldura et al.⁷), use of a web appraisal tool for family history (Baer et al.⁸), or electronic order entry to enhance prescription of calcium and vitamin D for patients on corticosteroids (Kohler et al.⁹), these innovations show promise for delivering expertise to the point of care, increasing primary care efficiency, and improving quality and fidelity in chronic illness.

So while many challenges remain, innovations in care delivery such as the patient centered medical home and new models of education that require turning the spotlight once again to the ambulatory setting are just some of the reasons for optimism. As Armstrong et al. conclude: “An overarching mission to transform health care delivery provides a unifying force for academic GIM at a time of tremendous opportunity and uncertainty.” We agree.

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