

Internal bickering over internal subspecialty

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Equal parts controversy and confusion are behind the Royal College of Physicians and Surgeons of Canada's delay on deciding whether to formally recognize general internal medicine (GIM) as a subspecialty of internal medicine, and thereby green light the accreditation of an optional two-year postgraduate training program.

Heated opposition to the change, fueled by widespread misunderstanding of what it will accomplish, as well as conflicts with the vested interests of existing subspecialty groups, prompted the college's committee on specialties to defer a verdict to the fall in order to give proponents from the Canadian Society of Internal Medicine time to defuse the latest fireworks in their 30-year war to attain GIM accreditation.

"There's a lot of support for the proposal, and I think the way it's formulated makes a lot of sense," says Dr. Ken Harris, education director for the royal college. "But there's a hurdle in presenting the proposal in a clear and concise way so that everyone fully understands what's on the table, and in defining the difference between a specialist in internal medicine and a subspecialist in general internal medicine."

Currently, medical students train four years in a college-accredited internal medicine program to become eligible for certification as specialists in internal medicine (the diagnosis and treatment of internal organs), or internists. Many students only complete the first three years of the internal medicine program before moving onto a two-year subspecialty program, such as those offered for cardiology. Students who "double count" the first year of their subspecialty training are also eligible to become internists, in addition to subspecialists in their chosen field.

The Canadian Society of Internal Medicine is proposing to create a new GIM subspecialty in which students



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The Canadian Society of Internal Medicine is proposing to create a new general internal medicine subspecialty in which residents would receive more-detailed and comprehensive instruction.

receive more-detailed instruction in skills related to high-risk obstetrics, complex perioperative care and caring for patients with multisystem disease.

Essentially, such students could also "double count" their fourth year, take an extra fifth year of training and become subspecialists, as well as internists.

"Many people who complete the

four-year program find that, when they begin their practice as internists, they end up needing skills that there just wasn't the time to address sufficiently during training," says Dr. Brian O'Brien, who as chair of the college's specialty committee in internal medicine has advocated the creation of a GIM subspecialty.

Medical student groups are opposed

to the change, as they suspect the Canadian Society of Internal Medicine is engineering a mandatory extension of training for all internists.

“Our position is the college should just keep internal medicine training under four years and those who want to undergo further training can just go ahead and do that, rather than mandating everybody to take five years,” says Dr. Tyler Johnston, president of the Canadian Federation of Medical Students. “That’s a year of deferred income in an era where we’re already experiencing very high medical student debt, and we’re not sure what the evidence is that adding a year will make us better internists.”

The Canadian Association of Internes and Residents echoed that concern in a recent position paper, stating that mandatory extension of training for internists would “delay entry to practice for all.”

But O’Brien says the creation of a GIM subspecialty would simply give students another option, rather than force them into an extra year of training. “There’s absolutely no interference. This isn’t a huge change we’re proposing. It’s a matter of providing an opportunity for students who do want and need the additional skills,” he says.

Other subspecialty groups also appear opposed to accreditation for GIM, apparently out of fear that it may prove more

attractive to students than their field, or simply result in more mouths to feed from the subspecialist pie.

As Dr. Finlay McAlister, president of the Canadian Society of Internal Medicine, notes, “the pie’s only so big, and any time you offer a new college-accredited subspecialty program, it’s going to draw trainees away from other specialties. It’s probably not politically correct to say that but I suspect that may play a role in some of the decision making.”

In the event a GIM subspecialty is accredited, medical schools would have the option of offering it, as with all subspecialties. But if it is formally recognized, the training would become subject to national standards.

Eight of Canada’s 17 medical schools already offer additional training in internal medicine in the form of an optional fifth year, but because that training isn’t accredited, there’s no national evaluation or quality standards for those programs.

“We want to have official recognition for those students that are spending the extra time and money to do the extra training, because currently they aren’t getting anything to show for it,” says McAlister.

O’Brien, meanwhile, is hopeful that evidence of the value of a GIM subspecialty will accrue from the successful

five-year programs running in Quebec, Alberta, Saskatchewan and British Columbia.

McAlister says that accreditation would also protect those existing programs from the vagaries of fair-weather funding. “Right now the provinces that have these programs are willing to fund the unaccredited fifth year because they see training internists as a priority, but the provincial funding climates could change and not having college accreditation is a liability,” he says.

The Canadian Society for Internal Medicine’s most recent bid for GIM accreditation has already advanced further than a string of similar applications over the past three decades. “We’ve been at this for about 30 years,” says O’Brien. “There had to be consensus among internists that this was necessary. We had to understand what the community needed and there needed to be some pilot models to show us how well this is going to work.”

The issue will resurface before the royal college’s committee on specialties in the fall. If it passes muster, it will move on to its education committee for further evaluation, and ultimately, to executive council for final approval. — Lauren Vogel, Ottawa, Ont.

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Report calls for overhaul of US food safety system

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Tainted peanut butter. Poisoned cookie dough. Deadly spinach. In an era of daunting problems with food-borne disease and illness, a prestigious scientific panel is recommending that the United States government overhaul its food safety system to zero in on the riskiest foods and target limited resources where they can do the most good.

A 500-page report by a committee of the Institute of Medicine and the National Research Council recommends, among other things, that the US Food and Drug Administration (FDA) shift “from a reactive approach to a risk-based approach” to food safety, set

up a central data analysis operation to more efficiently pinpoint problems and better coordinate inspection efforts with state and local governments.

The study, *Enhancing Food Safety: The Role of the Food and Drug Administration*, suggests the FDA is failing to keep up with new challenges and lacks the vision to ensure food safety (http://books.nap.edu/openbook.php?record_id=12892). While more than 15 US agencies have some role in food safety, the FDA oversees about 80% of the country’s food supply, including all produce, seafood and cheeses.

The importance of bolstering food safety efforts is evident in the latest statistics on food-borne illnesses — approxi-

mately 76 million people in the US are affected each year, causing more than 300 000 hospitalizations and 5000 deaths, according to the report. A number of recent high-profile outbreaks have heightened public interest in the problem, including a salmonella outbreak last year that affected hundreds, was suspected of causing nine deaths and resulted in one of the largest product recalls in history.

Robert Wallace, a University of Iowa professor who chaired the committee that wrote the report, says the FDA needs to “go where the problems are, and that’s why you need good data.” Better data, he says, should be the basis for everything the FDA does, including “where they put inspection resources, where they put