International Perspectives on General Internal Medicine and the Case for “Globalization” of a Discipline

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General internal medicine (GIM) has flourished in the United States (U.S.). Unlike other subspecialties of internal medicine, however, GIM’s evolution has not been global in scope, but rather appears to have occurred in isolation within countries. Here, we describe international models of GIM from Canada, Switzerland, Australia/New Zealand, Argentina, and Japan, and compare these with the U.S. model. There are notable differences in the typical clinical roles assumed by General Internists across these 7 countries, but also important overlap in clinical and academic domains. Despite this overlap, there has been a relative lack of contact among General Internists from these and other countries at a truly international GIM meeting; the time is now for increased international exchange and the “globalization” of GIM.

KEY WORDS: general internal medicine; primary care; hospitalists; human resources; academic medicine.


The evolution of GIM in the U.S. has occurred in parallel to the discipline’s evolution in other countries, where GIM appears to have taken a somewhat different course. Here, we briefly describe the profiles of GIM in Canada, Switzerland, Australia/New Zealand, Argentina, and Japan, all developed countries that have an identifiable specialty of GIM. These particular countries are described because 4 of them (Canada, Switzerland, Argentina, and Japan) are the only countries other than the U.S. that have a notable membership (i.e., more than 1 or 2 members) in the U.S.-based SGIM (David Karlson, personal communication March 23, 2004). The GIM model from Australia and New Zealand is also presented because it has been described in the peer-reviewed literature.

The merit of discussing international models of GIM relates to the discipline’s growth, both inside and outside the U.S. that will, we except, result in an eventual “globalization” of the discipline. The discipline has until now grown and evolved within countries, with relatively little “cross-pollination” across international borders. This is in contrast to disciplines like cardiology and gastroenterology that represent firmly established international entities, and for which large annual international meetings are staged. The U.S.-based SGIM certainly has some international members and attendees to its annual meetings, but many of these individuals developed their ties to SGIM through a period of academic GIM training in the U.S. or because they have been encouraged to attend SGIM meetings by colleagues who themselves gained first-hand exposure to SGIM while training in the U.S.

The potential benefits of globalizing GIM as a discipline are many, and a key first step toward such globalization is an improved collective understanding of both the clinical and academic elements of existing GIM models. The U.S. model has been comprehensively described by Levinson and Linzer. Below, we provide brief descriptions of GIM models from several other countries, with more detailed descriptions of each country available online (see References).

GIM in Canada

The clinical profile of GIM in Canada differs somewhat from that in the U.S., with the most notable difference being that Canadian General Internists rarely assume a primary care role. It has in fact been explicitly proposed that Canadian General Internists should avoid the primary care role to instead focus on providing consultative support to primary care general practitioners. Recognizing that subspecialties like cardio-
ology and gastroenterology also exist, General Internists in Canada have assumed a “secondary-level” consultant role in which they provide consultative support to general practitioners for certain problems, but also occasionally require further consultative support from subspecialists, particularly when high-technology procedural care is required. Because of their coexistence with subspecialty consultants, Canadian General Internists have tended to be consulted for patients with undifferentiated symptom presentations and/or multisystem disease—i.e., cases where single-system subspecialists may be less suitable consultants.

There are also some similarities between General Internists in Canada and the U.S. Most notably, many General Internists in Canada are hospital based and provide care for hospitalized adults in a role that is essentially identical to that of GIM “hospitalists” in the U.S.14,15 Many Canadian General Internists also provide outpatient care in parallel to their inpatient activities, while less commonly, some provide only outpatient consultative care without any inpatient role.

Meanwhile, the academic profiles of General Internists in Canada closely resemble those in the U.S., with activities in the areas of medical education, clinical epidemiology (e.g. promoting “evidence-based medicine”9,16), health services research, bioethics, medical informatics, and clinical pharmacology. These activities clearly identify areas of synergy with counterparts in the U.S.

GIM in Switzerland

General Internists in Switzerland have historically participated in hospital-based care, but the hospital care setting in Switzerland has seen a large penetration of subspecialists that has led General Internists to shift their focus toward a primary care role similar to that assumed by General Internists in the U.S. This trend is so pronounced that certain Swiss regions have seen their regional societies of GIM merge with corresponding regional societies of family medicine to create single entities representing the shared academic and professional interests of primary care physicians.

Some Swiss General Internists have, however, also assumed a clinical role that distinguishes GIM in Switzerland from all of the countries discussed here—that of staffing the non-surgical portions of emergency rooms. This arises partly from the fact that Switzerland does not have an independent specialty of emergency medicine. Instead, emergency room physicians emerge from Swiss internal medicine training programs that typically incorporate focused periods of training in the emergency room setting.

The academic profile of GIM in Switzerland closely resembles that of GIM in the U.S. and Canada, with academic activity in the areas of clinical epidemiology, health services research, and medical education. The emergence of the discipline is being increasingly recognized within Swiss academic medicine, as evidenced by the awarding of national prizes to General Internists in 2002 and 2003 for outstanding research presented at the annual Swiss Society of Internal Medicine meeting.17

GIM in Australia and New Zealand

The profiles of General Internists in Australia and New Zealand are described in the literature,6–8,18 and closely resemble those of Canadian General Internists. Specifically, General Internists in Australia and New Zealand have assumed a predominantly consultative role in which they respond to referrals from general practitioners, while coexisting with subspecialists. There is a formal mechanism through physician reimbursement schemes for General Internists to assume “indefinite care” for certain patients. In such situations, the General Internist assumes a de facto primary care role, although it still arises from their positions as consultants. Most General Internists have public hospital appointments and provide care to hospitalized inpatients in addition to their ambulatory practice activities, with the balance of outpatient versus inpatient activity varying from physician to physician.

The academic activities of General Internists in the region are generally in areas such as clinical epidemiology, health services research, and medical education.6 These academic activities are thus in keeping with those of General Internists in the other countries discussed.

GIM in Argentina

The development of GIM as a discipline in Argentina is relatively recent, as a result of coordinated outreach activities from the U.S.-based SGIM, and a primary care training program at the Mount Sinai School of Medicine. These U.S.-based groups began working with the University of Buenos Aires in 1987 to develop a training program focusing on outpatient primary care.23,24 Since then, the field of GIM has gone on to flourish in Argentina, with the formation of a society of GIM in Argentina that succeeds in attracting many into the discipline.

As a result of its history and links to U.S.-based GIM, the discipline’s emphasis in Argentina has been on outpatient primary care, with comparatively little involvement in the inpatient care setting. That said, there is a single training program, established in 1995, that has recently introduced training for GIM “hospitalists.”

The academic activities of General Internists in Argentina again overlap with those of General Internists in the other countries discussed. The outpatient emphasis of the discipline in Argentina steers the content areas of academic work toward primary care themes.

GIM in Japan

GIM is perhaps less well established in Japan than in the other countries discussed here, because until very recently, there has been a general lack of standardized training programs and societies to train and subsequently represent primary care physicians. As a result, primary care has historically been provided by hospital-based physicians from a variety of training backgrounds who move their practices to the outpatient setting in mid-to-late career.23,24 It is only in the late 1980s and early 1990s that formal training programs for outpatient primary care have developed, along with corresponding professional societies—the Japanese Academy of Family Medicine (1986) and the Japanese Society of General Medicine (1994).25–27 A recognizable discipline of GIM has emerged from these entities, and the typical profile predominantly involves outpatient primary care, although the short history of the discipline and heterogeneous nature of training paths taken by Japanese General Internists dictate that some are also involved in various forms of inpatient care, and even occasionally front-line emergency room care.