



WHERE IS THE FUTURE OF INTERNAL MEDICINE HEADING? POSITION STATEMENT OF THE INTERNATIONAL FORUM OF INTERNAL MEDICINE (FIMI)

PARTICIPATING AUTHORS ENDORING THE DOCUMENT (161 from 43 countries)	SCIENTIFIC SOCIETIES ENDORSING THE DOCUMENT (52)
<p>Argelia: Nadia Oumnia- Farouk Benmediouni Argentina: Pascual Valdez- Luis Cámara- Marcelo Zylberman- Hugo Milione- Diego Brosio- Javier Pollán- Matías Mirofsky- Natalia Nachón- Rodrigo Sabio- Manuel Klein- Elías Chamale- Carlos Pressman- Carla Ambrosi- Silvio Payaslián- Raul Ledesma- Roberto Parodi- Susana Salomón- Adolfo Savia- Ricardo Valentini Armenia: Lamara Manukyan Australia y Nueva Zelanda: Michelle Downie- Ar Kar Aung- Doug Johnson Bélgica: Patrick Lacor- Steven Callens Brasil: Gustavo Miranda Filho- Flavio Pacheco- Marcus Villander- Jorge Carvalho Bolivia: Estela Titto Omonte- Iván Marcelo Garzón Torrejón - Soraya Ximena Cardozo Gira- Lenny Salguero Arciénega- Álvaro Tejerina- Luis Sequeiros Peña- Coral Cristaldo- Juan Carlos Calvo Pinaya- Rosmary Gross- Roxana Hiza- Evelyn Murillo- Oscar Morales- Felipe Melgar Cuellar- Eliana Vega Barbato Chile: Luis Rojas Orellana- Annelise Goecke Colombia: Homero Luis Puello Galarcio- Yazmin Abuabara- Tatiana Espinoza- Sara Socarras Costa Rica: Moises Fallas Wahrmann Cuba: Emilio Buchaca Fexas- Isis Betancourt- Miguel Blanco Aspiazu- Lays Rodríguez Amador- Belkis Magdalena Martínez Martínez- Caridad Chao Pereira Ecuador: Ricardo Hidalgo Ottolenghi- Santiago Carrasco Dueñas Egipto: Mona Ahmed Amin</p>	<p>AMERICAS (28)</p> <ul style="list-style-type: none"> • Sociedad Argentina de Medicina • Sociedad de Medicina Interna de Córdoba • Foro de Medicina Clínica Argentina • Sociedade Pernambucana de Clínica Médica Brasil • Sociedad Boliviana de Medicina Interna • Sociedad Cruceña de Medicina Interna Bolivia • Sociedad Boliviana de Medicina Interna Filial Tarija • Sociedad Pandina de Medicina Interna Bolivia • Sociedad Boliviana de Medicina Interna Filial Sucre • Asociación de Medicina Interna de Centroamérica y del Caribe • Sociedad Chilena de Medicina Interna • Asociación Colombiana de Medicina Interna • Asociación Costarricense de Medicina Interna • Sociedad Cubana de Medicina Interna • Asociación Ecuatoriana de Medicina Interna • Asociación de Medicina Interna de El Salvador • Society of Hospital Medicine. Estados Unidos • Asociación de Medicina Interna de Guatemala • Sociedad Hondureña de Medicina Interna • Colegio de Medicina Interna de México • Asociación Nicaragüense de Medicina Interna • Sociedad Panameña de Medicina Interna • Sociedad Paraguaya de Medicina Interna • Sociedad Peruana de Medicina Interna • Asociación Dominicana de Médicos Internistas • Sociedad de Medicina Interna de la República Dominicana • Sociedad de Medicina Interna del Uruguay • Sociedad Venezolana de Medicina Interna

El Salvador: Carlos Henriquez Carrillo- Jorge Contreras Monchez- Karen Cárcamo- Víctor Segura- Rubén Montufar

España: Monserrat Chimeno Viñas - Emilio Casariego Vales- Alberto Ruiz Cantero- José Manuel Porcel Pérez- Ricardo Gómez Huelgas

Estados Unidos: Ruby Sahoo - Chad T. Whelan

Francia: Luc Mouthon

Grecia: Nikolaos Tentolouris- Michael Samarkos- George Dalekos

Guatemala: Karina Linares Leal- Carlos Nitsch- Sergio Castañeda Cerezo- Ricardo Balleza Arenales

Honduras: Fabio Fuentes Mendoza- Lorenzo Díaz Salazar

Inglaterra: Nick Murch

Irak: Abbas Fadhil Hlailhel- Mudher Zaki AlKherialla

Islandia: Sigurdur Olafsson- Runólfur Pálsson- Signý Vala Sveinsdóttir

Italia: Francesco Dentali – Andrea Montagnani - Dario Manfellotto- Nicola Montano

Japón: Mizue Saita- Miyagami Taiju- Nishina Tsubara- Susumu Tazuma- Toshio Naito

Letonia: Ieva Ruza

Macedonia (Norte): Aleksandar Manolev- Bijana Ivanovska Bojadjiev

México: Carlos Lenín Pliego Reyes- Alejandro Cárdenas Cejudo- Ramón Barrera Cruz- Alfredo Cabrera Rayo

Nicaragua: Bismarck Pérez- Jafet Segundo Mendieta- Miguel Tellez Lopez- Tatiana Leiva Gonzalez

Pakistán: Aftab Mohsin - Tariq Waseem

Panamá: Omar Castillo Fernández - Katiana Castillo- Juan Barrios

Paraguay: César Elizeche Gonzalez- Tatiana Elizabeth Roy Torales- María Cristina Jiménez- Gustavo Arbo- Hugo Celauro

Perú: Alonso Soto Taragona - Luis García Carrion- Aland Bisso Andrade - Diana Rodríguez Hurtado- Sonia Indacochea- Manuel Calipuy Gálvez- Eduardo Penny Montenegro- Felipe Ignacio Cconchoy

Polonia: Jan Duława

Portugal: Luis Duarte Costa- Luis Campos

República Dominicana: Robert Díaz Bautista- Antonio Lizardo - Jorge Luis Volquez Alcantara- Juan Antonio Bazil Cerda - Jorge Soto Castillo- Vahid Nouri Kandany- Claudia Arias- José Galarza- María Fortuna- Víctor Abreu- Emilio Arias- Claudia Rodríguez

Rusia: Oxana M. Drapkina- Valentin A. Kokorin

Serbia: Dragan Lovic

Suecia: Christine Sävervall- Fredrik Von Wowern

Turquía: Serhat Ünal- İhsan Ertenli

United Kingdom: Nicholas Robert Murch- Vicky Price

Uruguay: Laura Fraga- Andrea Vaucher- Diego Graña- Franco Peverelli- Gustavo Bruno

Venezuela: Mariflor Vera- Jose Ayala- Fernando Carrera- Gener Marena- Virginia Salazar

EUROPE (17)

- Belgian Society of Internal Medicine
- Sociedad Española de Medicina Interna
- Société Nationale Française de Médecine Interne
- Hellenic Society of Internal Medicine, Greece
- Icelandic Society of Internal Medicine
- Internal Medicine Society FADOI (Federazione delle Associazioni dei Dirigenti Ospedalieri Internisti, Italia)
- Società Italiana di Medicina Interna
- Latvian Society of Internal Medicine, Latvia
- Macedonian Association of Internal Medicine (Macedonia Norte)
- Polish Society of Internal Medicine
- Sociedade Portuguesa de Medicina Interna
- Russian Scientific Medical Society of Internal Medicine
- Serbian Association of Internal Medicine
- Swedish Society of Internal Medicine
- Turkish Society of Internal Medicine
- Society for Acute Medicine, United Kingdom
- EFIM Federación Europea de Medicina Interna

ASIA (4)

- Armenian Association of Internal Medicine
- Thi-Qar Internists Association of Iraq
- Japanese Society of Hospital General Medicine
- Pakistan Society of Internal Medicine Society

AFRICA (2)

- Algerian Society of Internal Medicine
- Egyptian Society of Internal Medicine

OCEANIA (1)

- Internal Medicine Society of Australia and New Zealand

ABSTRACT

The International Forum of Internal Medicine (FIMI) presents a position statement aimed at analyzing the current state and projecting the future of Internal Medicine within a global context characterized by population aging, increasing multimorbidity, fragmentation of healthcare systems, and rapid technological transformation. This document was developed through a collaborative process involving 52 scientific societies of Internal Medicine from 43 countries, with active representation from all five continents, providing its conclusions with a plural and global perspective.

Based on data derived from previous research conducted in Ibero-America and on the integration of consensus among international society leaders, the document describes the current status of the specialty and its central role in comprehensive, longitudinal, and person-centered care for adults, particularly for complex and multimorbid patients. Key strengths of internists are identified, including integrative clinical reasoning, the ability to coordinate interdisciplinary care, and their contributions to education, research, and health system management. At the same time, persistent weaknesses are acknowledged, such as heterogeneity in training and certification systems, unfavorable working conditions, declining social recognition, and a high prevalence of professional burnout.

The document also analyzes the challenges and opportunities posed by the incorporation of new technologies, including telemedicine, point-of-care ultrasound, and artificial intelligence, emphasizing the need for ethical and responsible integration that preserves clinical judgment and the physician–patient relationship.

Finally, FIMI proposes an Improvement Plan with concrete and applicable guidelines, structured around the domains of clinical care, education, research, management, and professional well-being, aimed at strengthening the profile of the internist and consolidating Internal Medicine as a cornerstone of more integrated, sustainable, and people-centered health systems.

Keywords: Internal Medicine – Professional competencies – Patient-centered care – Multimorbidity – Scientific societies – International cooperation

TABLE OF CONTENTS

1. A Historical Overview of Internal Medicine
2. Introduction
3. Current Status
4. Internal Medicine Societies and Their Leaders
5. SWOT Analysis
6. What Type of Internal Medicine / Medical Clinic Specialist Is Needed?
7. The Future
8. Improvement Plan Proposed by FIMI
 - Methodology
 - Results
 - Measurable Operational Indicators
9. Discussion
10. Key Points
11. References

A Historical Overview of Internal Medicine

This brief section outlines why Internal Medicine is an integrative rather than a fragmentary specialty (1–5).

Internal Medicine is rooted in a medical tradition that conceives the patient as a biographical, clinical, and prognostic unity. As early as the year 620, Isidore of Seville stated that the physician should fulfill three fundamental missions: anamnesis, understood as the recognition of the past; diagnosis, as the understanding of the present; and prognosis, as the anticipation of the future. This triad early on expressed a comprehensive vision of medical practice that transcends the mere management of isolated disease.

During the Middle Ages, a progressive separation between medicine and surgery took place, establishing a distinction between clinical and surgical approaches that would shape the subsequent development of medical practice. In 1761, Giovanni Battista Morgagni introduced the concept of organic pathology by linking diseases to lesions of specific organs, inaugurating a form of medicine centered on the “solid” components of the body. Throughout the nineteenth century, this approach became consolidated within Clinical Medicine, based on signs and symptoms, with a progressive identification of organ-specific functions and diseases, thereby fostering the emergence of medical specialties.

Nevertheless, the need to preserve an integrative perspective led to the formalization of Internal Medicine as a distinct field. On April 20, 1882, the Congress of *Innere Medizin* was held in Wiesbaden, Germany, with the aim of defining an area of medical care distinct from both external pathology and the classical concept of Clinical Medicine of the time, which was limited to the study of disease rather than the person who is ill. This milestone marked the formal birth of Internal Medicine as a specialty oriented toward the comprehensive care of the patient.

Subsequently, in 1920, the German Society of Internal Medicine was established, consolidating its institutional development in Europe. In the United States, the founding of the American College of Physicians (ACP) in 1915—later merged in 1998 with the American Society of Internal Medicine (ASIM)—and the creation in 1936 of the American Board of Internal Medicine (ABIM) with the purpose of formally certifying specialists, reflected the growing professionalization, standardization, and recognition of Internal Medicine as a central discipline within modern healthcare systems.

Introduction

Medicine and healthcare systems are currently undergoing an accelerated transformation, driven by population aging, the increasing prevalence of multimorbidity and polypharmacy, the digitalization of scientific information, the emergence of artificial intelligence, and growing pressure on healthcare resources (6,7). These changes are compounded by the emergence of a new type of patient—more informed, digitally engaged, and participatory—who demands an active role in decision-making regarding their health. In this context, internists are required to manage an ever-increasing volume of scientific information while ensuring comprehensive, safe, cost-effective, and person-centered care, even in settings with limited resources (6).

In most Latin American and Ibero-American countries, Internal Medicine services share relatively similar organizational structures, although with variations determined by health policies, resource availability, and socioeconomic context. Despite differences in the formal definition of the specialist's profile, there is broad consensus that the internist is the clinical physician par excellence, responsible for the care of individuals from puberty through the end of life, whether healthy or ill, with an integrative approach encompassing prevention, diagnosis, treatment, and longitudinal follow-up, while also promoting the rational use of available resources and evidence-based preventive interventions (6).

However, a significant proportion of the population—and even healthcare systems themselves—lack a clear understanding of the profile and functions of Internal Medicine, which undermines the social recognition of the specialty and reinforces the need to strengthen its visibility and positioning by governments, universities, scientific societies, and internists (6).

The progressive advance of hyperspecialization has contributed to fragmentation of care, leading to increased costs, duplication of diagnostic studies, divergent recommendations, and unsafe transitions of care. In patients with multimorbidity, this model results in disjointed care pathways and a diffuse allocation of responsibilities, negatively affecting quality of care and system efficiency. In this scenario, Internal Medicine has consolidated its role as a key reference in diagnostic assessment and in the coordination of care for complex patients, particularly when fragmentation compromises clinical outcomes (8).

Internists are called upon to play a central role in the management of individuals with complex clinical conditions or unclear diagnoses, as well as in the co-management of critically ill or surgically treated patients through shared-care models and interprofessional teams. Likewise, continuity of care for chronic diseases requires close integration with primary care and nursing teams, incorporating innovative approaches to outpatient follow-up and the rational use of technological tools (9,10).

The training of new generations of internists represents a critical component of this process. Undergraduate education and residency programs must promote a broad, integrative vision adapted to contemporary challenges, incorporating mentorship, appropriate evaluation systems, and certification processes that ensure professional quality and ongoing updating (6). Within this framework, scientific societies play a strategic role in defining educational and organizational standards, respecting regional heterogeneity while preserving the core values of the specialty (7,11).

Looking ahead, a profound transformation of medical practice can be anticipated over the next two decades (12,13). Between 2025 and 2035, widespread adoption of telemedicine, electronic health records, and the increasing use of artificial intelligence to support diagnosis and clinical documentation are expected. Genetic testing and targeted therapies will expand, while mental health and chronic diseases will assume an increasingly central role, alongside emerging ethical and cybersecurity challenges related to health data (12,14).

In the period from 2035 to 2045, even greater disruption is anticipated, with more autonomous artificial intelligence systems, the consolidation of personalized medicine

based on genomics and epigenetics, smart hospitals, advanced models of home-based care, and emerging technologies such as remote surgery and nanomedicine. In this context, physicians—and internists in particular—will primarily act as coordinators of care for complex patients, with a reinforced role in communication, ethics, and decision-making under conditions of uncertainty (12,13).

The present document of the International Forum of Internal Medicine (FIMI) is situated within this scenario. FIMI is an international network of scientific societies, hospital services, and academic units that promotes education, research, professionalism, and clinical leadership in Internal Medicine through cooperative education and mentorship (15). This initiative arises from the need to define and harmonize the activities of the specialty in the face of heterogeneity observed between countries and among centers within the same country, and to strengthen the role of the internist in the care of patients with multimorbidity and in the coordination of complex healthcare systems (8). According to the World Health Organization, healthcare systems must adapt to population aging and the growing burden of chronic diseases (16).

The objective of this document is to build a common reference framework from which different scientific societies can establish, at the local level, recommendations regarding training pathways, professional profile, and the role of the internist, thereby promoting both the performance of their members and dialogue with health policy decision-makers (8).

The text is organized into two main sections. The first presents the current status of Internal Medicine, a SWOT analysis, the profile of the specialist required in Ibero-America, and a future projection, based on previous FIMI research and the collection of perceptions from key stakeholders within scientific societies (9). The second section proposes an Improvement Plan developed through a participatory process that included rounds of consultation by email, a face-to-face meeting, and a final round of revisions, with the participation of presidents and board members of societies from all five continents, as well as independent professionals (9).

In this way, the document articulates a comprehensive vision of challenges such as fragmentation of care, increasing multimorbidity, demographic transitions, growing clinical complexity, and pressure on human resources, offering a perspective that is relevant not only for Ibero-America but for Internal Medicine and healthcare systems worldwide (9).

Current Status

Based on data obtained from previous studies conducted by our professional group (17–20), the following situation is observed in Latin America (values correspond to regional averages, and heterogeneity between countries may exist):

- The specialty is obtained through more than one pathway: in over 90% of countries through medical residency programs, while in 25% it can also be accessed through university-based courses and in another 25% through an evaluation or certification examination.
- The specialty is awarded by different institutions: universities (85%), scientific societies (15%), ministries of health (21%), and medical councils or boards (15%).
- Recertification of the specialty is mandatory in 21% of countries, optional in 42%, and nonexistent in the remainder.
- Internal Medicine societies have developed or participated, together with Ministries of Health or other scientific societies, in the development of clinical practice guidelines or recommendations in 48% of cases.
- Eighty percent of scientific societies have affiliates, districts, or regional representations within their countries.
- Fifty-eight percent of societies have a scientific journal, of which 80% are indexed in Latin American databases.
- Thirty percent of internists work exclusively in the hospital setting, 22% in the private sector (including private practice), and 48% in both settings.
- Economic income derives from inpatient care in 40% of cases, outpatient care in 55%, and teaching activities in 5% (a small fraction also corresponds to inpatient care). In this item, no distinction is made between the public and private sectors.
- The average weekly workload is 60 hours during the first 10 years of professional practice and 54 hours thereafter.
- Fifty-two percent of internists have completed a second clinical subspecialty.
- Overall satisfaction with the specialty is 54%.
- Fifty-two percent of internists are involved in undergraduate university teaching, and when postgraduate teaching is also considered, this proportion rises to 61%.
- Thirty-seven percent have given presentations at conferences and/or published scientific papers within the past three years.
- The training quality of residency programs in each country receives an average rating of 7.
- The economic situation of internists working exclusively in the public sector is considered reasonable by 37% and fair or poor by 63%.
- Internists consider themselves highly competent in: hospital medicine (89%), outpatient medicine (68%), care of older adults (73%), adolescent care (68%), hospital management (16%), and care of chronic diseases (84%).
- Internists also work in other areas—either complementarily or exclusively—such as palliative care, pain management, research, teaching, perioperative medicine, tropical diseases, in-hospital and out-of-hospital emergencies, information and communication technologies, hospital administration and other healthcare facilities, management and marketing in pharmaceutical laboratories, publishing and editorial work, advisory or consultancy roles in healthcare, educational or pharmaceutical institutions, development of digital tools, medical auditing, occupational medicine, and legal expert practice.
- Care settings for the clinical internist include: the community, ambulances (transport or emergencies), home care, institutional or private outpatient clinics, community or

primary care centers, emergency departments, general inpatient wards, and intermediate care units.

- Forty-two percent believe that the future of the internist is promising and that the specialty will grow.
- Ninety-four percent believe that it is necessary to empower the internist and place them at the center of patient care.
- Multiple job holding reaches an average of 4.3 work settings per professional.
- During professional training, physical violence within hospital staff has been reported in 5–10% of cases, and violence by patients or relatives in 33%. Psychological violence within institutions ranges from 22% to 56%, and from patients or relatives reaches 63%. Workplace abuse by superiors is reported as frequent by 20%.
- The average number of physical health problems occurring after the start of professional activity is 4.8 per professional.
- Twenty-nine percent state that, if they were to graduate again, they would not choose the specialty of Clinical Medicine or Internal Medicine.
- Regarding burnout dimensions, internists present high levels of depersonalization and emotional exhaustion, and moderate levels of professional accomplishment. The number of dimensions with high burnout was: none (25.23%), one (36.57%), two (24.59%), and three (13.59%).
- Available structures and care modalities include: medical day hospital (43%), palliative care services (57%), perioperative medicine (67%), shared care with other medical services (90.5%), short-stay hospitals or beds (48%), continuity-of-care units linked with primary care (33%), and hospital-at-home programs (28.5%).
- A significant number of general practitioners perform functions typically associated with internists, even self-identifying as such.
- There are also internists who did not complete formal residency training but practice as such, as well as professionals who completed residency training but did not obtain official registration of the specialty and nevertheless work as internists.

Internal Medicine Societies and Their Leaders

Most Internal Medicine societies have, or have had, among their leaders and active members individuals who perform leadership roles across multiple domains, including:

- Ministers of Health
- Ambassadors
- Directors of hospitals and other private healthcare institutions
- Heads of Internal Medicine or General Medicine departments
- University authorities
- University professors
- Researchers holding doctoral degrees (PhD)
- Professionals holding a master's degree
- Directors of postgraduate university programs
- Directors or coordinators of residency training programs
- Researchers
- Authors with publications indexed in PubMed
- Professionals awarded scientific prizes
- Directors and members of editorial boards of scientific journals

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

Focusing on the SWOT analysis derived from previous research conducted in Ibero-America, the following situation can be summarized (17–20), as presented in Tables 1–4:

Table 1. Strengths of Internal Medicine (authors' own elaboration)

Strengths of Internal Medicine
<ul style="list-style-type: none"> • Comprehensive view of the patient: internists are trained to manage complex and multimorbid patients, with a humanistic and cost-effective perspective. • High level of technical competence, particularly in hospital medicine, outpatient care, emergency medicine, care of older adults, and chronic diseases. • Educational and academic capacity: 61% are involved in undergraduate and postgraduate teaching, with active participation in scientific congresses. • Involvement in public health: 48% of societies have developed clinical practice guidelines, and 47% have participated in health policy initiatives. • Territorial presence: 80% of societies have active regional branches or affiliates. • Ethical and social commitment, with a strong humanistic component oriented toward equity and comprehensive adult care. • Structured training through residency programs and universities. • Participation in multicenter research initiatives. • Holistic approach to multimorbidity, with flexibility to adapt to different clinical scenarios, as demonstrated during the COVID-19 pandemic. • Owing to their integrative perspective, internists are well positioned to understand and effectively use artificial intelligence tools and other cutting-edge technologies. • Training that facilitates development in other clinical and non-clinical fields, such as hospital administration, education, medical auditing, epidemiology, and public health, among others. • Ability to manage patients across diverse socioeconomic and healthcare contexts. • Operational capacity to conduct field research, registries, and multicenter epidemiological studies. • Capacity for synthesis and complex diagnostic reasoning, enabling the identification of rare or difficult-to-diagnose conditions. • Expertise in managing clinical complexity and multimorbidity. • Adaptability and versatility: in Latin America, internists often work across multiple levels of care, ranging from high-complexity hospitals to intermediate care centers. • Leadership within healthcare teams. • Ability to respond effectively in resource-limited settings, prioritizing and rationalizing the use of technology to ensure quality care across diverse environments.

Table 2. Opportunities for Internal Medicine (authors' own elaboration)

Opportunities for Internal Medicine
<ul style="list-style-type: none"> • Positioning itself as a leader of an integrative care model in the face of fragmented healthcare delivery, reducing hospitalizations, costs, and errors, while contributing organizational capacity and multidisciplinary management. • Designing and participating in strategies for follow-up and care outside the hospital, ensuring continuity of care. • Increasing the impact of scientific societies on public health. • Interpreting population aging and designing actions at the micro (clinical), meso (management), and macro (health policy) levels. • Developing evaluation systems and credit frameworks for certification processes. • Strengthening recertification processes. • Actively participating in editorial boards and scientific production. • Promoting teaching and research. • Leading undergraduate and postgraduate education, training professionals with an integrative vision capable of addressing complex problems. • Improving residency training programs and assessing “under-resourced” or unprotected training settings.

- Leveraging new technologies (telemedicine, point-of-care ultrasound, artificial intelligence).
- Incorporating occupational health and burnout detection into curricula.
- Training in artificial intelligence with an ethical and responsible approach.
- Influencing healthcare systems to train clinical professionals who lack a background in Internal Medicine.
- Training in High-Value Care (HVC).
- Accessing greater employment opportunities in administrative positions, advisory and consultancy roles, education, research, and marketing within public and private organizations.

Table 3. Weaknesses of Internal Medicine (authors' own elaboration)

Weaknesses of Internal Medicine
<p>Training and certification</p> <ul style="list-style-type: none"> • High heterogeneity in training and certification systems across countries. • Only 21% have mandatory recertification; in more than 40% it does not exist. • Moderate training quality of residency programs (average score: 7/10). • Limited availability of mentors and structured assessment processes. • Insufficient training in bioethics, particularly at the end of life. <p>Medical students</p> <ul style="list-style-type: none"> • Limited understanding of the internist's professional profile. • Increasing enrollment without sufficient clinical training sites. • Educational deficiencies at entry into residency programs. <p>Working conditions</p> <ul style="list-style-type: none"> • Excessive working hours. • Low income in the public sector. • Multiple job holding. • Reduction in human resources. • High clinical workload and burnout. • Violence and mistreatment during training. • Weak integration with primary care and post-discharge follow-up. <p>Devaluation of the role</p> <ul style="list-style-type: none"> • Limited public visibility. • Perception of the internist as a "referring physician." • Risk of displacement by subspecialists or technology. • Fragmentation of care. • Reduced appreciation of the integrative approach. <p>Shift toward subspecialization</p> <ul style="list-style-type: none"> • More than 50% pursue a second specialty. • Economic, academic, or dissatisfaction-driven motivations. <p>Loss of vocation</p> <ul style="list-style-type: none"> • Declining number of entrants into the specialty. • Twenty-nine percent would not choose the specialty again. <p>Professional society engagement</p> <ul style="list-style-type: none"> • Limited dissemination of the role of Internal Medicine. • Low sense of professional belonging. <p>Research</p> <ul style="list-style-type: none"> • Lack of training and funding. • Low publication culture. • Limited institutional support. <p>Technology</p> <ul style="list-style-type: none"> • Limited access. • Low level of digital innovation. <p>Perioperative medicine</p> <ul style="list-style-type: none"> • Role not formally recognized. • Resistance from other specialties. <p>Geographic distribution</p> <ul style="list-style-type: none"> • Urban concentration of internists.

Table 4. Threats to Internal Medicine (authors' own elaboration)

Threats to Internal Medicine
<ul style="list-style-type: none">• Low professional satisfaction.• Increasing subspecialization.• Failure to adapt to social changes.• Failure to adapt to technological changes.• Lack of recognition of the internist's managerial and care coordination role.

In relation to strengths, internists, by virtue of their profile, training, and professional attributes, are well positioned to perform clinical, academic, research, and managerial roles. Dr. Flavia K. Borges (McMaster University, Canada) highlights that many internists lead clinical decision-making, teaching units, outpatient clinics, hospital units, and research projects, with the ability to improve efficiency and patient experience by facilitating care flow and connecting patients with appropriate resources (21).

Likewise, the development of new leaders requires the integration of leadership training from undergraduate education through residency, with the aim of strengthening skills to guide multidisciplinary teams, improve quality of care, and propose economically sustainable models.

One study showed that many Internal Medicine residents in the United States practice components of High-Value Care, although they rarely incorporate cost considerations into clinical decision-making. Exposure to faculty who discuss High-Value Care during clinical encounters was the factor most strongly associated with these practices, representing a clear opportunity for improvement in training (22).

Technological development also offers concrete opportunities. The use of point-of-care ultrasound (POCUS) has expanded among internists and residents; Tierney and colleagues demonstrated that its selective use is associated with a significant reduction in total hospitalization costs, radiology expenditures, and the number of chest radiographs performed (23).

With regard to artificial intelligence, Mansoor et al. demonstrated differences in the perception of its impact across specialties, underscoring the need for transparent, interpretable tools tailored to each discipline in order to promote responsible adoption (24).

Regarding threats, in many countries between 70% and 80% of residents attempt to migrate toward subspecialties, primarily due to dissatisfaction, excessive workload, limited access to continuing education, and perceptions of lower economic and professional recognition. This trend negatively affects quality of care and the physician–patient relationship. Higher levels of professional satisfaction have been shown to be associated with greater patient satisfaction (25).

What Type of Internal Medicine / Medical Clinic Specialist Is Needed?

The specialist profile shows many similarities across countries (17–20). Although regional variations may exist depending on context, the core profile of an internist in any region of the world can be defined according to the following domains:

- ❖ General characteristics of the internist
- ❖ Healthcare delivery
- ❖ Emerging infectious diseases
- ❖ Mental health in patients with chronic conditions
- ❖ Public health and epidemiological action
- ❖ Teaching, research, and management roles
- ❖ Ethical values and the physician–patient relationship
- ❖ Skills and competencies
- ❖ Other considerations and challenges

General Characteristics of the Internist

- The specialist in Internal Medicine—also referred to as a general physician or internist—is a professional dedicated to the care of adults (from adolescence through the end of life), whether healthy or ill, hospitalized or in outpatient settings, within the context of their family and community. Additionally, the internist assumes responsibility for the collective care of groups of individuals at risk, whether healthy or ill, adopting a socio-health perspective on health problems.
- The term *general physician* or *clinician* is often broader in scope, as it encompasses both inpatient medicine (Internal Medicine, hospital medicine) and outpatient care; however, each country has its own legislation regarding the official designation of the specialist title.
- The scope of practice of Internal Medicine is broad, as it encompasses— to a greater or lesser extent— all levels of adult healthcare. It is also complex, as it is not defined by the care of a specific organ or system, but rather by the comprehensive approach to all adult diseases across diverse life circumstances.
- The internist is the professional capable of providing and coordinating medical care from adolescence through old age, across the different stages of the health–disease–care process, promoting and protecting health while implementing efficient, ethical, and humanistic care strategies.
- Maintains a balance between scientific knowledge, technological advances, and the patient considered as a whole.
- Applies a scientific approach to the health–disease process from a biopsychosocial perspective.
- Practices person-centered and personalized medicine.
- Integrates the clinical method, a holistic view of the individual, and longitudinal follow-up, acting as the primary reference for patient care.
- Upholds philosophical, humanistic, and ethical values, with sensitivity, integrity, altruism, and social responsibility.

Healthcare Delivery

- Is capable of caring for adult patients in both inpatient and outpatient settings, as well as in other healthcare scenarios.
- Provides continuous care across different levels of the healthcare system: primary care, emergency services, secondary and tertiary care, and across diverse healthcare institutions.

- Can practice in both extrahospital settings (primary care, referring physician roles, prehospital emergency services, outpatient clinics) and intrahospital settings (general wards, emergency departments, outpatient hospital clinics), as well as act as a consultant for other services.
- Performs horizontal follow-up of hospitalized patients, including surgical patients with medical complications, preoperative risk assessment, and perioperative management.
- Manages patients with one or multiple chronic diseases.
- Provides end-of-life care and palliative medicine for both acute and chronic patients.
- Cares for complex and multimorbid patients, avoiding unnecessary interventions by multiple specialties, duplication of diagnostic studies, and drug–drug interactions.
- Manages patients with systemic diseases and those at high vascular, metabolic, renal, hepatic, or cardiac risk, ensuring quality of care.
- Provides, at least initially, care for individuals with rare diseases, integrating into networks, registries, and coordinated care pathways.

Emerging Infectious Diseases and the Role of the Internist

- Emerging and re-emerging infectious diseases are a critical component of Internal Medicine practice, particularly in Latin America and Ibero-America.
- Internists must assume a central role in the detection, clinical management, and coordination of conditions such as dengue, chikungunya, Zika virus infection, leptospirosis, influenza, drug-resistant tuberculosis, and zoonotic threats.
- The experience of the COVID-19 pandemic highlighted the need to strengthen competencies in epidemiological surveillance, data analysis, and decision-making under conditions of uncertainty.
- Internal Medicine represents a fundamental pillar in preparedness and response to public health emergencies.

Mental Health in Patients with Chronic Conditions and the Role of the Internist

- Mental health is a central component in the care of adults with chronic diseases.
- Depression, anxiety, cognitive impairment, and other mental health disorders are common in the context of multimorbidity.
- Internists are strategically positioned to identify mental health conditions, initiate interventions, and coordinate mental health care.
- This integrated approach improves quality of life, reduces hospital readmissions, and strengthens the physician–patient relationship.

Public Health and Epidemiological Action

- Participates in health promotion, prevention, treatment, and rehabilitation.
- Applies primary, secondary, tertiary, and quaternary prevention strategies.
- May pursue training in both clinical subspecialties and public health.
- Leads screening initiatives and community-based coordination efforts.

Teaching, Research, and Management Roles

- Integrates clinical care, teaching, research, and management.
- Provides undergraduate and postgraduate education.
- Develops continuing medical education programs.
- Leads field-based research, registries, and clinical trials.
- Engages in lifelong learning.
- Manages clinical services.
- Exercises professional leadership.
- Coordinates interdisciplinary teams.

- Facilitates collaboration among specialists.
- Participates in medical boards and professional councils.

Ethical Values and the Physician–Patient Relationship

- Respects patient autonomy, values, and beliefs.
- Maintains confidentiality and honesty.
- Applies the principles of non-maleficence, justice, beneficence, and autonomy.
- Uses artificial intelligence in an ethical manner.

Skills and Competencies

- Adequate technical, ethical, and professional training.
- Evidence-based practice.
- Diagnostic accuracy and technological prudence.
- Cost–benefit assessment.
- Integration of clinical, communication, technological, and humanistic competencies.
- Rational use of information and communication technologies (ICT).
- Teaching and assessment of soft skills (Table 5).
- Knowledge, interpretation, and performance of clinical procedures according to the level of proficiency (Table 6).

Other Considerations and Challenges

- Prevention and management of burnout.
- Reassessment of professional fees and remuneration.
- Consideration of population aging, climate change, access gaps, and the tension between longevity and quality of life.

In Summary

The internist is the professional who provides comprehensive and continuous care for adults, exercising clinical, educational, research, and managerial leadership, with both transversal and specialty-specific competencies, grounded in evidence-based practice, ethical values, and social responsibility.

Table 5. Soft Skills (Adapted from 26)

Soft Skills	
✓	Assertive communication (oral and written, with colleagues and the public), including active and passive listening, non-verbal communication, and eloquence.
✓	Reporting in complex cases and communication of bad news.
✓	Control and management of negative emotions.
✓	Tolerance to frustration, perseverance, and self-esteem.
✓	Positive attitude.
✓	Emotional intelligence.
✓	Empathy and supportive care.
✓	Awareness of personal strengths and weaknesses.
✓	Identification and creative resolution of problems.
✓	Critical thinking and reasoning.
✓	Initiative, creativity, and innovation.
✓	Motivation.
✓	Planning skills.
✓	Teamwork.
✓	Group dynamics.
✓	Positive leadership.
✓	Leadership that fosters a positive work environment.

- ✓ Clinical debriefing.
- ✓ Time and agenda management.
- ✓ Flexibility and adaptability.
- ✓ Stress management and tolerance to pressure.
- ✓ Conflict management and negotiation skills.
- ✓ Burnout prevention.
- ✓ Resilience.
- ✓ Ergonomics and occupational health.
- ✓ Decision-making and skills related to harmonious coexistence.
- ✓ Research and teaching.
- ✓ Bioethics.

Table 6. Procedures According to Level of Proficiency (Authors' own elaboration)

Procedures According to Level of Proficiency
<p>Know: specialized techniques that the internist will not perform directly but must understand in order to indicate them appropriately and interpret their clinical usefulness (e.g., cardiac catheterization, PET-CT).</p> <p>Interpret: studies that the internist must be able to read, contextualize, and discuss with sound clinical judgment (e.g., echocardiography, pulmonary function tests, colonoscopy, arterial blood gas analysis).</p> <p>Perform: procedures that the internist must master and carry out safely (e.g., paracentesis, thoracentesis, intubation, central venous catheter placement, point-of-care ultrasound, cardiopulmonary resuscitation).</p>

The Future

Where are we heading?

This question involves two dimensions: the capacity to actively shape our own professional future, and the need to understand the role that healthcare systems assign to us.

The main trends regarding the future of Internal Medicine can be outlined through the following scenarios (17–20):

- Increasing subspecialization, driven by academic, professional, and economic factors, with economic considerations being the most determinant.
- Accelerated population aging and a growing burden of non-communicable chronic diseases—such as cardiovascular disease, cancer, diabetes, and obesity—which constitute the core of internists' clinical practice.
- A progressive decline in the number of internists, with the associated risk of being replaced by sophisticated technologies.
- A tendency to assume more administrative than clinical positions.
- A reduction in the number of applicants for teaching positions.
- A decline in the number of entrants into residency programs.

What should we do, or what should we aim to achieve?

The proposed strategic goals are as follows (17–20):

- To remain the central integrative pillar of healthcare delivery.
- To achieve recognition from the public, policymakers, Ministries of Health, governments, and private institutions, with a tangible impact on remuneration.
- To attain salary improvements that allow internists to work exclusively in the public sector without the need to migrate to the private sector or to hold multiple positions.
- To create incentives for participation in congresses and continuing professional development activities.
- To regulate the number of positions in subspecialty training programs.
- To ensure public funding for professional training.
- To promote integrated and non-competitive collaboration between internists and subspecialists.
- To empower the role of the internist, enabling them to resolve cases in both outpatient and hospital settings, including the ability to request diagnostic tests without unnecessary restrictions.
- To lead the care of patients with systemic multimorbidity, integrating autoimmune, cardiovascular, metabolic, respiratory, renal, and infectious diseases.
- To coordinate care among different specialties, ensuring a patient-centered, evidence-based approach with a holistic perspective.
- To implement time-limited remuneration contracts for post-residency physicians in Internal Medicine areas.
- To modify and rationalize on-call duty systems in order to reduce occupational stress.
- To actively participate in decision-making regarding models of care at the governmental level.

- To regulate care delivery parameters, such as the number of patients per hour in outpatient clinics, the number of inpatient beds per internist during hospitalization and on-call duties, and workload in home-based care.
- To transform the prevailing hospital-centered model toward one that incorporates outpatient care, competencies in information and communication technologies, evidence-based medicine, clinical economics, population health, service management, teamwork, and lifelong learning, using student-centered educational methods.
- To guarantee to society and healthcare systems a specialist with high problem-solving capacity, strong principles, and cost-effective practice.
- To reaffirm that Internal Medicine is the cornerstone of integrated healthcare in the face of the fragmentation of current health systems.

The following core domains should always be present in our activities:

- ✓ Integration of personalized medicine.
- ✓ Focus on preventive medicine.
- ✓ Telemedicine, digital technologies, and artificial intelligence.
- ✓ Chronic diseases and population aging.
- ✓ Multidisciplinary approach and teamwork.
- ✓ Diagnostic advances.
- ✓ Evidence-based medicine and decision-making.
- ✓ Person-centered care.

Likewise, minimum training settings should be considered:

- ✓ Outpatient care in Internal Medicine.
- ✓ General inpatient care.
- ✓ Emergency departments.
- ✓ Critical care units.
- ✓ System-based services: cardiology, pulmonology, nephrology, gastroenterology and hepatology, endocrinology, rheumatology, hematology, medical oncology, infectious diseases, geriatrics, among others.

Based on all of the above, the internist has a high capacity for managing health and disease and is qualified to lead healthcare institutions of varying levels of complexity.

Improvement Plan Proposed by FIMI Members

Our distinctive identity is centered on the care of older adults and patients with multimorbidity and high clinical complexity, grounded in broad and in-depth knowledge of pathophysiology, diagnostic reasoning, and therapeutic approaches, aimed at maximizing clinical benefit through the efficient use of resources. Looking toward the future, Internal Medicine must adapt to new scenarios without losing its core strengths, values, and essential competencies.

It should be noted that the discussion presented thus far primarily refers to Ibero-America, the region in which the research underpinning the theoretical framework was conducted. However, the Improvement Plan outlined below emerges from the joint contributions of internists and executive boards of Internal Medicine societies from all five continents, thereby providing a truly global perspective.

Methodology

In August 2025, the FIMI Executive Board established a working group composed of three physicians from scientific societies representing countries that are members of FIMI. The selected individuals had prior experience in the management of scientific societies and in the development and/or implementation of clinical guidelines or consensus documents in different areas within their respective countries.

Between August and October 2025, this group conducted a non-systematic review of TRIP Database, PubMed, Embase, and LILACS. This search was complemented by reference tracking of the retrieved documents and by direct contact with experts in the field, including the incorporation of results from previous research conducted by FIMI. Based on this process, preliminary outlines of the thematic axes to be developed and proposed improvement strategies were generated. These initial documents were discussed and refined through successive consultations with 161 selected experts from 52 scientific societies across 43 countries, representing all five continents. Countries with multiple societies contributed a larger number of experts.

The consultation process was carried out in three stages. First, through email correspondence or videoconference meetings (individual or in small groups) with the selected experts. Second, through weekly videoconference meetings (October–November 2025), with the participation of presidents of Internal Medicine societies from all five continents. Third, some societies conducted internal discussions with their boards and members, and independent professionals from those countries also contributed ideas and perspectives.

Once the base document was consolidated, a three-round DELPHI methodology was used to achieve final consensus, involving 25 experts selected from the original group of 161, using a five-point Likert-scale questionnaire.

Consensus on recommendations was defined as being achieved when the proportion of responses rated as “agree” or “strongly agree” reached $\geq 70\%$ and $\geq 85\%$, respectively.

Finally, an in-person meeting was held in Buenos Aires in November 2025, with the participation of presidents from 18 societies, allowing for a final round of agreements prior to submission for publication. The manuscript was completed in January 2026.

Results

The core domains of the internist's profile comprise five axes, which are presented in Table 7.

Table 7. FIMI recommendations regarding occupational health, training pathways, professional profile, and the role of the internist (authors' own elaboration)

STRATEGIC AXIS	DOMAINS	RECOMMENDATIONS
Occupational Health, Well-being, and Professional Satisfaction	<ul style="list-style-type: none"> • Professional satisfaction and pride • Improvement of working conditions • Burnout prevention 	<ul style="list-style-type: none"> • Improve organizational climate and promote respectful hierarchical relationships. • Ensure protected time and funding for continuing education activities. • Regulate clinical workload, on-call duties, and the number of patients per internist. • Ensure adequate rest and recovery periods between on-call shifts, with a reduction in excessively long working hours. • Appropriately size staffing levels and guarantee protected time for teaching and research. • Improve salaries and incentives to prevent multiple job holding and migration toward subspecialties. • Monitor workload indicators and periodically adjust staffing positions. • Implement institutional well-being programs with a preventive focus—particularly addressing occupational stress and environmental health—and create protected spaces for professionals' emotional health. • Conduct periodic well-being surveys using validated instruments. • Develop peer-support networks and dedicated spaces for emotional support.
Education and Training (Undergraduate, Postgraduate, and Continuing Education)	<ul style="list-style-type: none"> • Undergraduate education • Training and professional development • Continuing medical education and academic networks 	<ul style="list-style-type: none"> • Recognize Internal Medicine as a guiding discipline in medical education. • Incorporate internists into university faculty staff at the undergraduate level. • Establish admission and assessment criteria for residency training programs. • Integrate into curricula: clinical reasoning, rational use of resources, critical thinking, and a humanistic perspective. • Establish regional residency standards (shared minimum regional standards), with competency-based accreditation and EPAs (<i>Entrustable Professional Activities</i>), including periodic (ideally annual) self-assessment of training programs. • Incorporate mentorship, periodic assessment, simulation-based training, and academic portfolios. • Include competencies in Evidence-Based Medicine, information and communication technologies, clinical economics, ethics and communication, palliative care, perioperative medicine, medical humanities, applied clinical pharmacology, artificial intelligence, and responsible digital health, along with review of local regulations on Good Clinical and Prescribing Practices, malpractice considerations and patient safety, pharmacovigilance, and systematic reporting of adverse events. • Incorporate applied clinical epidemiology and biostatistics. • Promote continuing medical education and universal recertification.

<p>Clinical Care and Models of Care</p>	<ul style="list-style-type: none"> • Clinical care and the role of the internist • Organizational innovation and new care settings • High-Value Care • Technologies and digital health 	<ul style="list-style-type: none"> • Develop regional certification and recertification programs. • Reaffirm the internist as the reference professional for comprehensive care of complex and multimorbid patients. • Develop comprehensive care protocols and longitudinal follow-up pathways for complex and multimorbid patients, under the leadership of internists, promoting the creation of areas of special interest within the specialty in which some internists focus on clinical care and clinical research production, thereby contributing to improved quality of care and the generation of applied knowledge. • Lead outpatient care, perioperative medicine, home-based care, and transitions of care. • Implement progressive care models within hospitals. • Establish internist-led clinical units (e.g., cardiometabolic, multimorbidity-focused units). • Coordinate multidisciplinary teams across intra- and extrahospital settings. • Incorporate principles of High-Value Care and efficient use of resources. • Train residents in cost–benefit analysis and rational decision-making. • Integrate artificial intelligence, telemedicine, and point-of-care ultrasound with a critical, ethical, and non-dehumanizing approach. • Prevent excessive reliance on algorithms, artificial intelligence bias, fragmentation of care, privacy risks, technological gaps, dehumanization, digital fatigue, and inadequate infrastructure.
<p>Research, Knowledge, and Scientific Development</p>	<ul style="list-style-type: none"> • Clinical research and health services research • Clinical practice guidelines and implementation 	<ul style="list-style-type: none"> • Strengthen training in hospital-based research, clinical registries, and systematic reviews. • Promote interdisciplinary, multicenter, and multinational research groups. • Develop registries for prevalent diseases and conduct field-based studies. • Generate clinical consensus documents with a focus on sociosanitary variability. • Develop clinical practice guidelines contextualized to local healthcare systems. • Evaluate implementation and measure the clinical and organizational impact of clinical practice guidelines.
<p>Management, Leadership, and Professional Positioning</p>	<ul style="list-style-type: none"> • Clinical management and leadership • Institutional empowerment and representation • Integration of regional contexts 	<ul style="list-style-type: none"> • Strengthen the internist’s leadership in clinical management and continuous quality improvement based on performance indicators. • Incorporate metrics such as clinical workload, number of beds per internist, on-call duties, teaching, research, and procedures performed. • Ensure participation in public policy development, academic settings, and executive leadership positions. • Grant greater clinical autonomy and problem-solving capacity in diagnostic and therapeutic decision-making (e.g., ordering diagnostic tests and initiating treatments without unnecessary co-signatures, and participation in decisions regarding the acquisition of relevant equipment). • Promote institutional campaigns to position the internist as a central pillar of the healthcare system. • Create channels for interregional articulation and cooperation across diverse contexts. • Acknowledge challenges in remote regions and in resource-limited healthcare systems.

Measurable Operational Indicators

The Improvement Plan can be strengthened through the incorporation of clear operational metrics—such as key performance indicators (KPIs), milestones, and prioritization levels—that facilitate implementation, monitoring, and evaluation by national societies and healthcare systems. Some illustrative examples are proposed below.

1. Clinical and Organizational Performance Indicators (KPIs)

- Average time to diagnostic resolution.
- Percentage of patients with multimorbidity under longitudinal follow-up in Internal Medicine services.
- Rate of avoidable hospital admissions through internist-led interventions.
- Proportion of services implementing integrated care models (co-management, structured consultations, among others).ç

2. Milestones

- Formal implementation of recertification programs in Internal Medicine.
- Adoption of updated training curricula with an emphasis on clinical reasoning, multimorbidity, and person-centered medicine.
- Progressive incorporation of digital tools and associated training programs.
- Development of institutional strategies for the prevention and management of professional burnout.

3. Prioritization Levels

Actions within the Improvement Plan can be classified according to their time horizon:

- **High priority (1–2 years):** strengthening clinical reasoning, improving continuity of care, preventing burnout, and standardizing training programs.
- **Intermediate priority (3–5 years):** expansion of integrated care models, responsible digitalization, and development of evaluation and recertification structures.
- **Long-term priority (5 years or more):** consolidation of international collaborative networks, promotion of multicenter research, and development of global comparative indicators.

Discussion

This document reflects the position of FIMI on the fundamental organizational aspects and functions of Internal Medicine services within the hospital setting and is applicable to centers in the countries that endorse it. The final text was unanimously accepted by all signatory societies, and we believe it may be useful for the effective development of these services. This initiative arose from the need to define and harmonize the activities of the specialty, given the heterogeneity identified by FIMI among different countries—with diverse cultures and regulatory frameworks—and even among different centers within the same country. The ultimate objective was to achieve a broad and robust agreement that would enable the provision of appropriate, high-quality organization of care for the population.

Several relatively recent topics have emerged that are common to the work of internists regardless of the country or institution in which they practice, including clinical complexity, telemedicine, artificial intelligence, point-of-care ultrasound (POCUS), and environmental stewardship (27–31).

Accordingly, this document is not intended as a rigid guideline, but rather as a set of basic recommendations that are flexible and adaptable in their application. The benefits of adhering to these recommendations are evident at multiple levels. At the clinical level, they provide a framework of proven quality across multiple areas in which Internal Medicine has already demonstrated its value. At the legal level, they support activities that are regulated differently across countries. At the administrative level, they offer a basic organizational framework that can be adapted to local needs. Finally, at the levels of education and clinical research, they provide a shared developmental framework based on common foundations. This initiative also aims to achieve other equally important objectives, such as strengthening the institutional positioning of Internal Medicine vis-à-vis public policy decision-makers and healthcare system managers; providing a consensual technical framework to facilitate dialogue with health authorities; and promoting the organization of services, allocation of resources, and development of regulations based on clinical, scientific, and quality-of-care criteria. In this regard, the document seeks to serve as a reference for health planning, professional regulation, and the defense of care models centered on comprehensiveness, continuity, and equity of access.

When evaluating this document, certain limitations must be considered. First, clinical activities and modes of care delivery evolve rapidly; therefore, the period of validity of the recommendations is limited. The authors consider that a thorough review of the document will be necessary within a maximum period of three years. Second, the analysis focuses on the hospital setting in selected countries; consequently, its conclusions may not be applicable to other contexts. Finally, administrative and legislative support for these medical activities may differ across countries. For this reason, we suggest that the scientific societies that have reached this consensus assess their national contexts and initiate the necessary actions to adapt local regulatory frameworks accordingly. The overarching goal is to provide the highest possible quality of healthcare while ensuring compliance with the prevailing regulations in each country.

The benefits of adhering to these recommendations are evident at multiple levels, particularly in improving care coordination for complex patients (32,33). Moreover, a shared framework facilitates interprofessional collaboration, continuing education, and the production of high-quality scientific knowledge (34,35). Nevertheless, it must be acknowledged that the implementation of consensual recommendations faces contextual barriers that require local adaptation and ongoing evaluation (36).

In conclusion, this document represents a milestone in the construction of a shared global vision for the future of Internal Medicine, resulting from the consensus of 52 scientific societies from 43 countries, reflecting diverse healthcare, cultural, and regulatory realities. Its recommendations constitute a roadmap to guide health system planning, hospital service

organization, workforce training, and professional regulation, placing the internist at the center of comprehensive, longitudinal, and patient-centered care. By offering a technical framework grounded in evidence, international experience, and shared professional values, this agreement provides scientific societies with a legitimate tool to engage in dialogue with policy-makers and to promote public policies that prioritize quality, sustainability, and equity in healthcare. Progressive implementation and periodic review will allow these recommendations to adapt to epidemiological, technological, and social changes, thereby contributing to more resilient, integrated health systems oriented toward the real needs of the population.

Key Points

- Reaffirmation of Internal Medicine as the cornerstone of coordinated, patient-centered care.
- Emphasis on strengthening clinical reasoning, longitudinal follow-up, and continuity of care.
- Recognition of training needs, recertification, interdisciplinary collaboration, and digital transformation.
- Dedicated attention to burnout, workforce sustainability, and professional identity.
- The Improvement Plan, which provides concrete and applicable guidelines to strengthen Internal Medicine at a global level.

Referencias bibliográficas

1-Cooke M, Irby DM, O'Brien BC. Educating physicians: a call for reform of medical school and residency. San Francisco: Jossey-Bass; 2010. ISBN-13: 978-0470457979.

2-Fox RC. Time to heal medical education? Acad Med. 1999 Oct;74(10):1072-5. doi: 10.1097/00001888-199910000-00007.

3-Morgagni GB. De sedibus et causis morborum per anatomen indagatis. Venice: Remondini; 1761. [consultado 1 noviembre 2025]. Disponible en: <https://www.christies.com/en/lot/lot-4414386>

4-Nuland SB. Doctors: The biography of medicine. New York: Vintage Books; 1989. [consultado 1 noviembre 2025]. Disponible en: https://books.google.com.ar/books/about/Doctors.html?id=hVePdRGsX2sC&redir_esc=y

5-Bean WB. Occasional notes. Origin of the term "internal medicine". N Engl J Med. 1982 Jan 21;306(3):182-3. doi: 10.1056/NEJM198201213060332.

6-Palencia VRJ. *Medicina interna y sus retos en el siglo XXI. Por una medicina ética, integral, profesional y humanista*. Med Int Mex 2009;25(3):229-32

7-Ramírez-Perea N, Orozco-Beltrán D. Present and future of internists in the Spanish public health system. Rev Clin Esp (Barc). 2025;225:250-1.

8-Smith SM, Soubhi H, Fortin M, Hudon C, O'Dowd T. Managing patients with multimorbidity: systematic review of interventions in primary care and community settings. BMJ. 2012; 345:e5205. doi: 10.1136/bmj.e5205.

9-World Health Organization. *Framework on integrated, people-centred health services: Report by the Secretariat (A69/39)*. WHO. 2016 [consultado 1 noviembre 2025]. Disponible en: apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf

10- Ruiz-Cantero A, Baron-Franco B, Domingo Rico C, Sánchez Mollá M, Salazar de la Guerra RM, Gómez Narvárez Y. Proceso asistencial de pacientes con enfermedades crónicas complejas y pluripatológicos. ISBN 978-84-695-8874-1. Dpt. Legal M-29849-2013. Multimédica Proyectos, S.L. [consultado 1 noviembre 2025]. Disponible en: www.fesemi.org/sites/default/files/documentos/publicaciones/proceso-asistencialenfermedades-cronicas-complejas.pdf

11-Wu J, Zhang H, Shao J, Chen D, Xue E, Huang S, et al. Healthcare for Older Adults with Multimorbidity: A Scoping Review of Reviews. Clin Interv Aging. 2023;18:1723-35.

12-Topol E. *Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again*. Basic Books.2019.

13-European Commission. *White Paper on Artificial Intelligence: A European approach to excellence and trust*. 2020. [consultado 1 noviembre 2025]. Disponible en: https://ec.europa.eu/info/publications/white-paper-artificial-intelligence-european-approach-excellence-and-trust_en

14-World Health Organization *Global strategy on digital health 2020-2025*. 2021. [consultado 1 noviembre 2025]. Disponible en: <https://www.who.int/publications/i/item/9789240020924>

- 15-Zapatero Gaviría A, Campos L, Gómez Huelgas R, Araújo Correia J, Díez-Manglano J., Barreto V. La Medicina Interna y su futuro en los sistemas de salud. Declaración de Posicionamiento de la Sociedad Española de Medicina Interna y la Sociedad Portuguesa de Medicina Interna. *Revista Clínica Española*. 2019; 279: 79-80.
- 16-World Health Organization. *World Report on Ageing and Health*. Geneva: WHO; 2015. [consultado 30 diciembre 2025]. Disponible en: <https://www.who.int/es/publications/i/item/9789241565042>
- 17-Varios. *Panorama actual de la Medicina Interna en Latinoamérica*” (en prensa en la Revista Argentina de Medicina, RAM).
- 18-Varios. *Investigación del FIMI sobre Burnout en internistas de ibero-américa antes de la pandemia* (en prensa en la Revista Argentina de Medicina, RAM).
- 19-Varios. *Estudio del FIMI sobre Burnout durante la pandemia en ibero-américa* (en prensa en la Revista Argentina de Medicina, RAM).
- 20-Varios. *Especialistas de Medicina Interna en LATAM y Europa Sur. Encuesta FIMI* (en prensa en la Revista Argentina de Medicina, RAM).
- 21- Borges F. Leadership in General Internal Medicine: Are We Leading or Managing? Liderança em Medicina Interna Geral: Estamos a Liderar ou a Gerir?. *Internal Medicine* 2024; 31(4), 166–7.
- 22- Ryskina KL, Smith CD, Weissman A, Post J, Dine CJ, Bollmann K, Korenstein D. U.S. Internal Medicine Residents' Knowledge and Practice of High-Value Care: A National Survey. *Acad Med*. 2015 Oct;90(10):1373-9
- 23- Tierney DM, Rosborough TK, Sipsley LM, Hanson K, Smith CS, Boland LL, Miner R. Association of Internal Medicine Point of Care Ultrasound (POCUS) with Length of Stay, Hospitalization Costs, and Formal Imaging: a Prospective Cohort Study. *POCUS J*. 2023 Nov 27;8(2):184-192.
- 24- Mansoor MA, Ibrahim AF, Kidd N. The Impact of Artificial Intelligence on Internal Medicine Physicians: A Survey of Procedural and Non-procedural Specialties. *Cureus*. 2024 Sep 10;16(9):e69121.
- 25- Haas JS, Cook EF, Puopolo AL, Burstin HR, Cleary PD, Brennan TA. Is the professional satisfaction of general internists associated with patient satisfaction? *J Gen Intern Med*. 2000 Feb;15(2):122-8
- 26-Milione F, Valdez P. Competencias blandas en la medicina interna. En Cabrera Rayo A, Valdez P, Palencia Vizcarra R. *Medicina Hospitalista. Disminuyendo la morbimortalidad en medicina interna*. Tomo 3. Ed DISTRIBUNA (Colombia). 2024. ISBN impreso 978-628-7673-35-9 ISBN digital 978-628-7673-34-2 pp: 291-296
- 27- Ruiz-Cantero A. Complexity based medicine. *Rev Clin Esp (Barc)*. 2025; 225(4):181-3.
- 28- Casariego-Vales E, Palencia-Vizcarra R, Bolaño J, Cámara L, Valdez P; TELE-FIMI Working Group. Executive summary on the use of telemedicine in the hospital setting: Recommendations from the International Forum on Internal Medicine. *Rev Clin Esp (Barc)*. 2023;223(1):50-5.
- 29- Kandany VN, Valdez P. Inteligencia artificial en medicina: retos éticos y recomendaciones desde Latinoamérica. *Rev Arg Med*. 2025;13:195-9
- 30- Tierney DM, Rosborough TK, Sipsley LM, Hanson K, Smith CS, Boland LL, et al. Association of Internal Medicine Point of Care Ultrasound (POCUS) with Length of Stay, Hospitalization Costs, and Formal Imaging: a Prospective Cohort Study. *POCUS J*. 2023;8:184-92.

- 31- Campos L, Chimeno-Viñas MM, Carretero-Gómez J, Santos L, Cabrera-Rayó A, Valdez PR, et al; en nombre de las sociedades, colegios, y asociaciones de Medicina Interna de los países de habla hispana y lusa. Recommendations of the Spanish-Portuguese Internal Medicine services in the fight against climate change and environmental degradation. *Rev Clin Esp (Barc)*. 2024:S2254-8874(24)00023-7. doi: 10.1016/j.rceng.2024.02.005.
- 32-Tinetti ME, Fried TR, Boyd CM. Designing health care for the most common chronic condition-multimorbidity. *JAMA*. 2012;307(23):2493-4. Erratum in: *JAMA*. 2012;308:238.
- 33-Bayliss EA, Bonds DE, Boyd CM, Davis MM, Finke B, Fox MH, et al. Understanding the context of health for persons with multiple chronic conditions: moving from what is the matter to what matters. *Ann Fam Med*. 2014;12: 260-9.
- 34-Zwarenstein M, Reeves S. Knowledge translation and interprofessional collaboration: Where the rubber of evidence-based care hits the road of teamwork. *J Contin Educ Health Prof*. 2006; 26:46-54.
- 35-Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010;376:1923-58.
- 36-Glasziou P, Altman DG, Bossuyt P, Boutron I, Clarke M, Julious S, et al. Reducing waste from incomplete or unusable reports of biomedical research. *Lancet*. 2014;383:267-76.