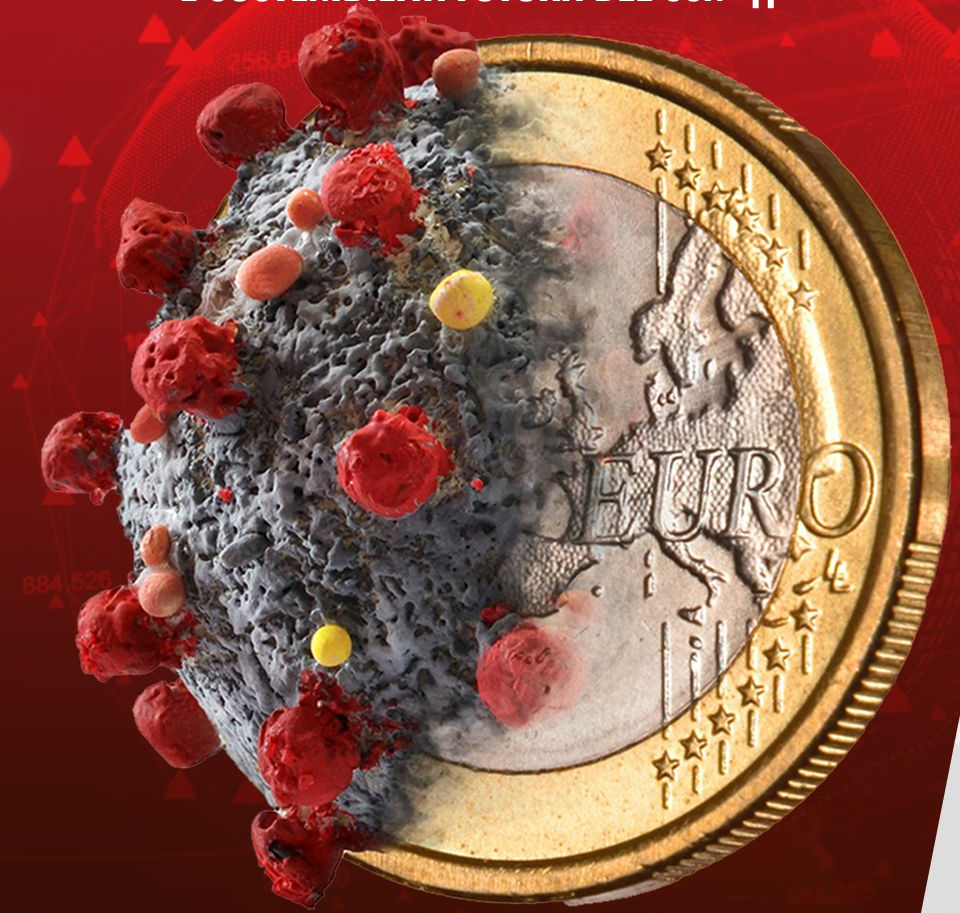
RECOVERY FUND, INVESTIMENTO IN SALUTE E SOSTENIBILITÀ FUTURA DEL SSN

26 GENNAIO 2021



Dario Manfellotto
Presidente Nazionale FADOI

Gli INTERNISTI in ITALIA

INFORMAZIONI DEMOGRAFICHE

SESSO

ETA' MEDIA

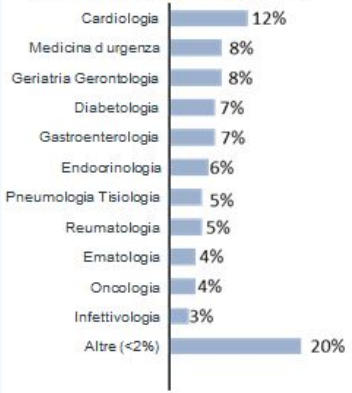
52
anni

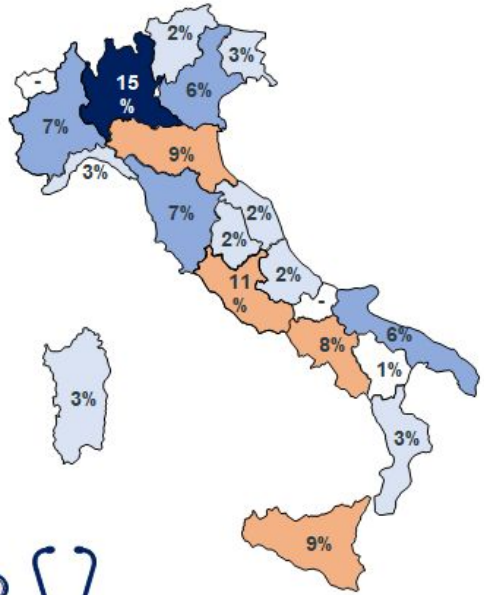
AMBITO DI LAVORO PREVALENTE

Fonte: OneKey

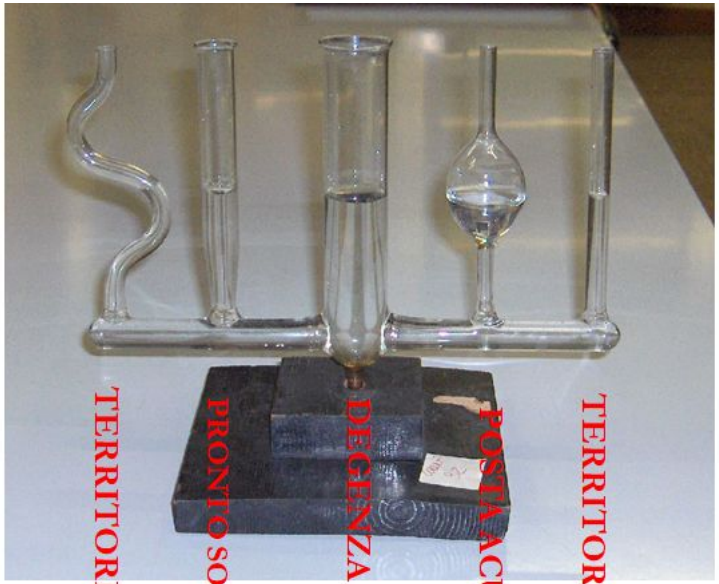
11.551
Internisti

Seconda specializzazione

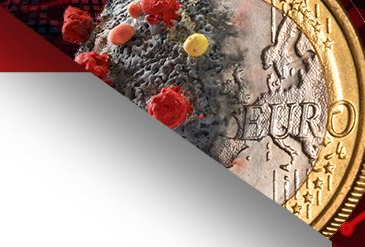




- Medicine Interne 1052 su 1137 ospedali
- Posti letto 28989 su 188451
- Area medica FADOI (M+P+Inf+G) 39910 letti
- Area medica Agenas (M+P+Inf+ extra) 55146 letti



La filiera del servizio sanitario



Criticità evidenziate all'inizio della pandemia

- Scarsissime conoscenze sul virus SARS CoV2
- Afflusso al PS non governato
- Risposta ospedaliera concentrata su reparti iperspecialistici (poi la malattia non si è rivelata solo infettiva/respiratoria ma MULTISISTEMICA)
- Difficoltà gestionale-organizzativa per la maxi-emergenza

In questo scenario una costante

- In era pre-COVID e tanto più in periodo di pandemia COVID in qualsiasi regione di Italia ed in qualsiasi ospedale vi è la presenza di una UO di Medicina Interna

  - Competenze multidisciplinari
  - Massima elasticità nella modulazione dei reparti
  - Forte integrazione con gli altri specialisti, dove presenti

Covid, in Sicilia stop ai reparti a "fisarmonica". Razza: «Ora fase 3 con hub e nuovi posti»

21/10/2020 - 12:18 - di **Mario Barresi**

Ospedale Cervello e S. Marco strategici, la mappa in Sicilia. L'assessore: «Pronti al primo picco entro metà novembre»

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Letter to the Editor

Non-SARS CoV2 positive critical patients: Sons of a lesser God?

As the number of confirmed cases of coronavirus in Italy continues to rise, the reorganization of the hospitals outlined by Grasselli et Al. [1] across the country made wards slowly emptied, elective activities interrupted, and intensive care units freed up to create as many beds as possible.

Simultaneously, in many small, non-hub hospitals, because of the chronic shortage of staff, internal medicine teams -doctors and nurses- often without any formal, adequate training, have been moved to the newly, hastily created COVID wards, where, beside caring for patients' general needs, they just implement the therapeutic protocol the hospital chose (if ever) to treat SARS CoV-2 positive patients, hoping that the drugs they're prescribing out of any evidence do more good than harm [2]. All the clinical competence of the teams most of the time has come down to watching out for clinical deterioration, when the patient is not responding to high-flow nasal oxygen or positive end-expiratory pressure (when available), trying not to miss the right moment to call the intensivist [3].

At the same time, what is left of the internal medicine wards has been clumsily staffed with doctors and nurses with different competences, bewildered and anxious about their new tasks when facing patients of all ages with a wide range of diseases and clinical presentations, from severe dyspnea to acute abdominal pain, from apparently accidental fall to general critical conditions, with different workups, differential diagnoses, prognoses and therapies [4].

Once again, in these small, non-hub hospitals, we are facing a floor-ceiling effect in human resources management: high skilled internal medicine nurses and doctors are (mis)used to take care of patients mostly admitted just because SARS CoV-2 positive and whose clinical course is often sadly dichotomous, whereas non-SARS CoV-2 positive critical patients, whose clinical course has yet to be inferred from medical history, clinical presentation and workup, are taken care of by nurses and doctors with competencies ordinarily developed and valuably implemented in quite different settings of care.

medical attention on treating affected patients, jeopardizing the ability to maintain the standard of care we were used to provide for non- SARS CoV-2 related disease. Public messages on social distancing make people refrain from seeking medical care going to the hospital. Moreover, procedures to protect caregivers from infection will impose to rule out SARS CoV-2 infection on any patient admitted, and any urgent procedure the internist would advise will be delayed awaiting for the results. Non-SARS CoV-2 patients might eventually pay a heavy, unexpected toll because of the dramatic change in practicing medicine we have been forced to. We hope, as Grasselli et Al. pointed out [1], that our health care system, not organized in collaborative emergency networks, will work toward one now, without prejudicing any longer and again internal medicine practice, the very heart of many hospital activity.

Declaration of Competing Interest

I have no actual or potential conflict of interest

References

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(5) Vergil, Aeneid, I., 563-4.

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JIM Letter to the Editor

doi: 10.1111/joim.13079

Carving out a place for internal medicine during COVID-19 epidemic in Italy

Dear Sir,

Internal medicine has been immediately involved in the coronavirus disease 2019 (COVID-19) epidemic in Italy, which started in late February 2020. The first few COVID-19 cases were suspected and diagnosed in internal medicine wards, including, amongst others, a young adult male from Codogno (referred to as 'patient 1'), who was later transferred to the intensive care unit of our hospital.

The rapid spread of the disease has put much pressure on the general population, patients, healthcare professionals and on the healthcare system as a whole, which was not prepared to face such an unpredictable event, especially in terms of number of patients needing admission to hospital all at once [1]. The San Matteo Hospital Foundation (Pavia, Italy), an academic, tertiary referral hospital, is located close to the first outbreak of Codogno, and also relatively close to nearby cities in Lombardy which were later hit by the epidemic, such as Bergamo, Brescia and Cremona. The Division of Infectious Disease, the Molecular Virology Unit, the Anaesthesia & Intensive Care Unit, the Emergency Department, the Pulmonology Unit and the Risk Management Unit dedicated all their efforts in order to overcome the growing epidemic, undergoing a rapid process of reorganization and expansion [2].

Internal medicine was also called to the front line and has proactively responded with great flexibility

divisions into departments dedicated to the care of COVID-19. Paradoxically, a discipline that has chronicity as the main object of study found itself at the forefront of an acute epidemic. At our hospital, two entire Internal Medicine Units, in a few days, were transformed into 'COVID' wards. Patients who were already admitted for reasons other than COVID-19 were either transferred to 'non-COVID' hospitals, or, when appropriate, discharged home within two-three days. During the first 20 days since ward transformation, 129 patients with COVID-19 have been admitted, three quarters of them requiring noninvasive ventilation.

the total number of beds in the two Internal Medicine Units is 76 and that the intensity of care markedly increased. One quarter of patients were discharged home after a mean time of nine days, whilst less than one in ten required to be transferred to the intensive care unit.

From a clinical point of view, the internist was not floored by this 'viral' event, as the management of pneumonia and respiratory failure still pertains to her/his field of expertise. Further, COVID-19, due to its heterogeneity, can be considered an internal medicine condition, as it is more than a single-organ disease, being the gastrointestinal tract, the central nervous and cardiovascular systems all possible targets. This disease can onset with varied and nonspecific symptoms, such as cough, muscle pain, ageusia, anosmia and diarrhoea, and can be complicated by myocarditis, acute hepatitis and kidney failure [3]. The internist is already prepared to treat this type of patients, as the management of complex diseases is the norm rather than the exception.

Important ethical and pragmatic principles are called into question, pointing at the need for transparency and inclusivity, as it has been recently stated [4]. Suffice it to say that Italy has one of the world's most aged populations, and multimorbidity is the main clinical feature of the elderly population. Ageing and multimorbidity are certainly the most important determinants of frailty, which is related to adverse health outcomes. In this scenario, internal medicine adaptability, spacing from a primary to a tertiary care setting, could also act as a link between hospital and territory medicine, especially for patients with multiple chronic conditions who cannot be left abandoned. The paucity of resources deriving from COVID-19, including medications, ventilators, available beds and physicians, forces us to carefully evaluate who to treat and how to treat. The elderly population is the most affected by COVID-19 according to preliminary data reported daily by the Italian Ministry of Health and the Civil Protection. The overall mortality rate is roughly 10%, and most deaths occurred in individuals aged more

Post-COVID-19
Ruolo della Medicina Interna

immediate problem and keep it from happening again' [6]. Paraphrasing this sentence, we may say that internal medicine could solve the immediate problem and could prevent it in the future. First, it has considered clinical reasoning prior over technical ability and technological instruments. Secondly, it has proved capable of adapting in relation to the various clinical settings and to the changing burden of disease. Finally, internal medicine has deemed humanism as an essential part of clinical practice [7]. Hence, this crisis may represent a great opportunity to rethink the healthcare system in a more rational and patient-centred way.

- Ripartire da quello che ci siamo lasciati dietro , almeno 700.000 ricoveri di Medicina Interna in meno (oltre alle altre specialità) rispetto al milione di ricoveri annui in Medicina di cui 56% cronici riacutizzati
- Follow-up del paziente COVID-19 ipotizzando conseguenze respiratorie ma anche cardiovascolari, aterotrombotiche, neurologiche , renali
- Accrescere le competenze per una risposta sub-intensivistica al momento delle emergenze (Reparti High-Care)
- Approccio di area medica in équipe multidisciplinare
- Riorganizzazione delle attività ambulatoriali stimolando la crescita della telemedicina
- Ospedale-Territorio un legame da rafforzare nel quale la Medicina Interna ospedaliera è il partner naturale della Medicina generale territoriale

Infine, ulteriore elemento da affrontare e non più rinviabile per il SSN riguarda il rafforzamento della compagine del personale sanitario, anche sotto il profilo formativo: l'Italia mostra un numero di infermieri inferiore ai Paesi OCSE (5,8 per 1.000 abitanti rispetto alla media europea di 8,8) e, nonostante il numero dei medici sia nel complesso superiore al valore europeo, è necessario colmare le carenze relative sia relativamente ad alcune figure specialistiche (in particolare in anestesia e terapia intensiva, medicina interna, pneumologia, pediatria) sia nel campo della medicina generale. In particolare, occorre rafforzare il ruolo del Ministero della salute e delle regioni nell'attività di programmazione dei fabbisogni formativi.

L'OSPEDALE MODERNO E «ANTICO» DOPO IL COVID

di **Dario Manfellotto***

Il Ministero della Salute ha pubblicato le *Linee di indirizzo* per la riorganizzazione degli ospedali dopo il Covid-19, con nuovi modelli assistenziali, strutture, dotazioni, e personale formato per altre possibili emergenze. Come sarà l'ospedale dopo la pandemia? Moderno, con altissime tecnologie, ma anche per certi versi «antico», pronto a concentrare i pazienti infetti in strutture dedicate, come i vecchi sanatori. Per riaprire ospedali sicuri, servono percorsi «puliti» fin dal Pronto soccorso e percorsi «grigi» per i casi sospetti, i più delicati, per non correre il rischio di nuovi focolai. Ma anche monitoraggio virologico di pazienti e operatori. Efficace collaborazione, non più ostacolata dalla burocrazia, fra ospedali e strutture del territorio. Il documento parla molto di terapia Intensiva e semintensiva, e di unità di area medica per recuzie da attivare a seconda della necessità: un ospedale modulare che si espande e si restringe come una fisarmonica, non più basato su unità operative separate. Sembra la descrizione, ma il documento non lo dice, del lavoro realizzato dai reparti di Medicina interna, che si sono rapidamente adattati per gestire l'afflusso di migliaia di malati Covid: solo in Lombardia quasi l'80% dei pazienti, nel 20% dei casi trattati con ventilazione non invasiva dagli internisti, in tutta Italia il 65% dei ricoveri per Covid. Il documento affronta in particolare il problema dell'insufficienza respiratoria, anche se riconosce che Covid-19 è una malattia sistemica, che non colpisce solo i polmoni. E un domani l'urgenza potrebbe essere cardio-vascolare, o emorragica, o renale. Ciò che serve in ospedale è la collaborazione fra specialisti, e non è strategico investire sugli uni e dimenticare gli altri. Speriamo che l'esperienza Covid serva a cambiare l'attuale impostazione aziendalistica e competitiva. Il Ssn può essere economicamente sostenibile, però si dovrebbe abbandonare la logica del budget a tutti i costi, per passare a quella dell'investimento nella produzione e tutela della salute.

**Osp. Fatebenefratelli, Roma*
President e Fadoi

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Dario Manfellotto

Corriere della sera 11/6/2020