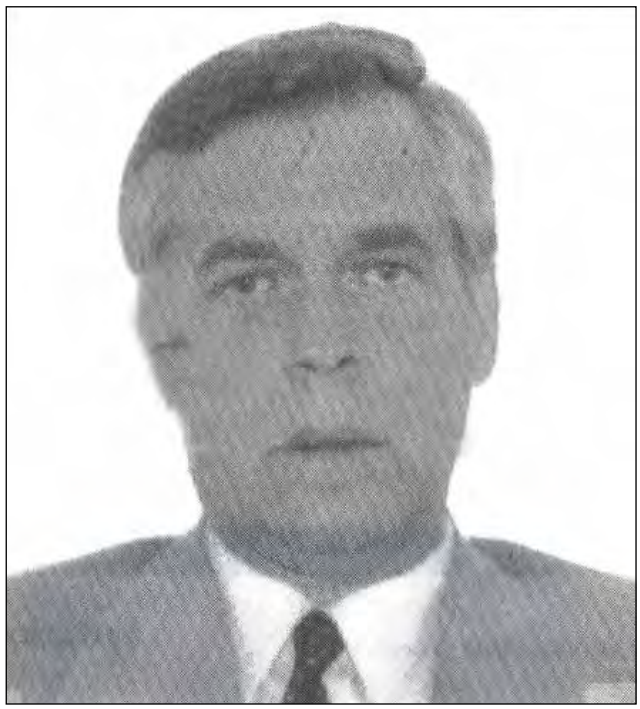
Editorial

It is in the 19th century that emerges the concept of Internal Medicine linked to the notion of internal organ diseases translated by symptoms and signs that in principle would not be solved through surgery. To the latter it would correspond the external pathology, treating surgical lesions. This wider concept of Internal Medicine in countries with a Western culture has as reference Sir William Osler. In Portugal two Masters marked our Internal Medicine: Pulido Valente, a pioneer on the creation of a scientific basis for Medicine in our country, and Fernando Fonseca, a great clinician and researcher, driving the teaching of infectious diseases. During this period, the diagnosis was based almost exclusively in an anamnesis and in the art of observation. The clinician would write his recommendations, prescribing a way of life, a diet and a potion of his own that would be produced in the pharmacy.

Taking arbitrarily World War II as reference, it can be seen that after that almost all sciences were subject to major transformations and Medicine has not been an exception. The theoretical and technical evolution forced the medical profession to adapt progressively to innovation. The physician has ever more the need to support his/her activity in a growing number of biochemical, haematological, image, cardiology, pathological anatomical and other information. Therefore in the second half of the century, before the growing number of scientific discoveries with technology evolving at a gigantic pace, a great deal of centrifuge forces emerged within Internal Medicine. In the 50s and 60s, Internists have assumed their interest besides of Internal Medicine, in some areas (such as cardiology, gastroenterology, haematology) that subsequently converted themselves into medical subspecialties. Quoting Robert Petersdorf, it seems that by the end of last century it was seen *The Dawn of Internal Medicine Gods,* and why? Effectively the proliferation of medical sub-specialities seems to empty Internal Medicine which is deteriorated by the shady contours when confronted with General Medicine. It is an established principle that a balanced health system needs assertive physicians with specialised knowledge. Before new knowledge and technologies, specialities get deeper, driving unavoidably to a reduction in the field of specialists. The narrow sub-specialization, for a great number of doctors, does

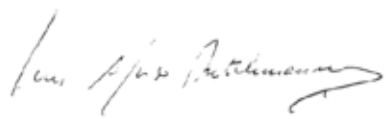


not seem to be safe and will have naturally unwanted consequences for patients, the society, the profession and the physicians themselves. In a few years a certain technology can become obsolete and not only new diseases can emerge as some of the old ones will fade away. If, on one hand such sub-specialisation can become negative to the specialist, on the other hand it also has negative consequences for the medical care as: most adults have more than one disease, each one involving more than one system; a differential diagnosis in a subspecialty includes diseases out of such subspecialty; the treatment of a specific disease can interfere with the treatment of others, causing complications in other systems; sometimes patients are referred to the wrong specialist; the specialist can see patients whose major problems are outside his field of expertise, only a relatively small number of patients, in regard to the general population has diseases requiring very specialised treatment. Arterial hypertension with repercussion on the target organs, diabetes, heart failure and rheumatoid arthritis are rare diseases and controlled by the internist. On the other hand new cases of ulcerous colitis or Crohn´s disease are not as frequent and the need for transplant is still rarer.

At present, Internal Medicine faces a confrontation with medical subspecialties and General Practice, and, within its own specialty some aspects of disenchantment are outlined. We, the Internists are mainly hospital physicians, and to achieve such position, we go through a long career that includes the graduation, a two years general internship and a supplementary internship of five years. We must defend as our attributes: common or rare, poly- or multi- systemic adult nonsurgical diseases non-allocated to medical subspecialties; a wide range of continuous medical care; liaison with other specialists and health care professionals; consultants of other specialties; acting in emergency and treatment of critical patients. To a certain extent, we are the cornerstone of hospital life. Without Internal Medicine specialists hospital emergencies would tremble, we correspond to the hospital´s infantry. The number of Internal Medicine specialists is negatively disproportional to the huge number of hospital beds which are being open regularly throughout the country. In central hospitals we see an ageing of staff. The emergency services in the hospitals are clearly in need. Internists' emergencies are stressing and demotivating. It is necessary to increase rapidly the number of Internists.

We are sure that the success of contemporary Medicine, brought along a proportional increase of its costs. It is important that Internists look into the healthcare policies, studying and criticising the cost/benefit and cost/efficacy of new technology and therapy. We also know that economic resources are not unlimited. Our great challenge to the future is how to allocate them with an ageing population. In a dynamic approach, it is up to us, to advocate what is the best for the patient, avoiding at all costs that hospital medicine is handled as a business when a profitable corporate regime is applied to hospitals. To save some cents in a bureaucratic path seems to me unethical, as the patient is neither a client nor a customer but before everything a human being who deserves all our consideration and the most modern medicine that we can provide.

Considering the situation in some hospitals, it is an undeniable fact that the Internal Medicine Specialist´s activity is multiplied by a number of tasks as: exhausting external emergencies services lasting for 24 hours, appointments taking a whole morning, internal emergency care to a high number of patients, caring for their patients whilst assisting different hospital departments, we understand that one of the Internist´s skills is at risk of disappearing. I refer to anamnesis with a sound collection of data. This scarce availability, associated to information that technology advances supply, may tempt the Internist, deviating from a good collection of anamnestic data and a careful observation. For the Internal Medicine Specialist the history is of capital importance both for the clinical exam as for the decision making. The information gathered during the interview to the patient by the physician cannot be obtained from another source. The medical interview reveals itself very advantageous: it enables to exploit and organise the clinical history; it conveys to the patient a positive attitude about his health; develops a good relationship and can be used to inform the patient. ■



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