Editorial

Clinical History: news of a death, widely exaggerated?

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With a well gathered medical history 90% of diagnoses are achieved, [1-3] creating the grounds for the logical argumentation underlying the differential diagnosis, *the Internist main offensive weapon* (Osler). The quality of the assistance given in Internal Medicine is therefore indissociable from an exemplary clinical process.

In a study published in this issue of the journal, we verified that in a district hospital like Évora, [4] the classical pattern of a medical history is in decadence being present only in 21% of the clinical files in year of 2005. Such value keeps lowering inclusively for 8.5% in the following year. Although the entry note is present in around 95% of cases on those very same years, the authors consider insufficient the number of medical histories taken, debating the consequences on the deterioration of quality in hospital care.

In the good old tradition of Internal Medicine, the clinical history has always assumed a preponderant role. Who doesn't remember the vehemence teaching anamnesis and semiology on the part of the great masters of the Portuguese Medicine as Carlos George, Ducla Soares, Napoles Sarmento or Nogueira da Costa, among many other brilliant clinicians of the time?

Since the 80ties that we see a reduction on the number of doctors in the wards, to the increasing weight of the Emergency Service in the Internal Medicine specialty and more recently the need of reducing costs in hospital budgets. The time available for the clinician towards his patients in the ward has become an even more precious commodity. These are the times of the hospital boards demanding clinicians an ever more reduced availability for their patients (appointments every 10 min; a daily maximum of 20 min in the ward per patient). A sacrifice demanded by the battle of productivity in an impoverished country. As the clinical process becomes computerized, physicians have been seduced to turn more to the computer screen and less towards the patient. In some cases the screen presence does oblige the doctor to conduct the anamnesis with his back turned to who should be the main point focal point of his attention.

Being the patient one of the excellent masters to the Internist (teaching constantly that there are patients and not diseases) we verify that the progressive disappearance of the medical history on the hospital clinical files has become one of main threats to the quality of Internal Medicine.

Is there a way of surviving to this *fast food* regime, which has been slowly imposed upon Internists?

The adaptation of old methodologies as the diagnosis reasoning guided by issues,[5] the use of entry notes, not as extensive as previously, but with an analytical content perhaps deeper, the careful planning and grounded as to the use of diagnosis auxiliary methods, or yet the weekly epicrisis rehabilitation, can become the modern replacement for the old medical history.

But what place will be reserved to the classical teaching of anamnesis and semiology in a specialty which demands more and more courses, communications, publications, post-graduations and doctorates? Graham Hugh Lucas asked in his lectures: *What can we learn from this patient?* Perhaps in those troubled times we live in, we became blind and deaf to his teachings?

The Internist physician will always be a deepwater fish. It is up to him the demanding mission of resisting pressure that everyday pushes him towards more superficial waters. Such waters where some small freshwater fish live comfortably, more enthusiastic and besotted with protocols and guidelines than with elegant and well gathered medical histories. ■

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