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President's Speech

Words given by Dr. Barros Veloso, at the opening of the 3rd Portuguese Internal Medicine Congress

The Organizing Committee of this Congress asked me, in my role as President of the SPMI, to open this inaugural session. The intention in doing so was, without doubt, to highlight the role the Society has played in adding dynamism to the scientific activities of Internal Medicine (IM) in Portugal.

Eleven years ago, at the initiative of a group of internists, a process was begun that led to the revival of our Society, which had been completely inactive for a number of years. Only four effective members were present, who were later joined by 120 others, admitted through a proposal that emerged during an emergency Annual General Meeting held at that time. It was from this small group that the Society, as we know it today, emerged, now with more than a thousand members and a high level of scientific, cultural activity.

But how did the situation to reach such a point in the first place, knowing, as we do, that IM, in the recent past, held enormous prestige, embodied in some of the biggest names in Portuguese Medicine?

What had happened, as we all know, is that IM, the common root of all clinical activity, branched off in various directions or medical sub-specializations which, following technological progress and the explosive post-war expansion of knowledge, acquired their own dynamic and ended up becoming fully autonomous. As these branches began to separate, IM became divested of its content, and the Society that represented it, abandoned by some of its members, was ignored and forgotten.

At the end of the 1960s, the medical sub-specializations entered a phase of unrestrained euphoria, followed by rapid growth, and won the attention of clinical medicine, relegating IM to a secondary, and often thankless role that all we internists felt keenly. As was only to be expected, this development brought enormous benefits, as it helped widen medical knowledge, and enabled more effective practice in various specialist areas. But by establishing itself to the detriment of IM, it had adverse effects which, over time, only increased and assumed negative proportions.

Firstly, it led to a tendency to forget that the patient is a holistic being, and rather than seeing the patient as a coherent entity in which everything is correlated, it began to see the patient as a sum total of tracts and systems, each belonging to a sub-specialization. This fragmented way of practicing clinical medicine, in the absence of a professional trained to coordinate and integrate the action of the various sub-specialists, has risks that we are all familiar with in our day-to-day activities.

On the other hand, the over-emphasis given to diagnostic and therapeutic techniques not only contributed to dehumanizing medicine, but also led to an uncontrolled increase in costs, sometimes without real advantages for the patient.

This trend towards sub-specializations was, therefore, without rival and young doctors were soon allured by a situation that gave them quick prestige and financial rewards.

As a result, the correlation between the number of internists and sub-specialists created a totally unbalanced situation in terms of the casuistic reality, which was predominated by patients who urgently needed a

global clinical approach, and whose problems could be resolved without the contribution of very sophisticated means. The exaggerated use of costly tests, which were inconvenient and sometimes aggressive, which in those cases proved even unnecessary, are today bringing ethical and financial problems that cannot be ignored.

This reality began to be imposed not only on doctors, but also politicians and even public opinion, and it was in this context that IM emerged as a practice characterized by the rigor of diagnosis, humanization of the medical act, and saving of resources.

Another aspect that is gaining strength today is the idea of a "common root" of IM in the basic training of all branches of clinical activity. For this reason, I would like to offer some initial reflections that justify this point of view.

Clinical activity has existed since the first doctor sought to understand and treat the first disease. But IM, which is rooted and is part of this tradition, did not emerge until the end of the 19th Century.

Why is this so? For millennia, Man only had direct access to what until recently was called External Pathology, i.e. that which was visible. Internal wounds were not accessible to observation, and the clinical conditions by which they were manifested were completely unexplained, and therefore the object of the most fantastical and fanciful interpretations. Hippocrates "theory of humors", later adopted by Galen and the Galenists, and Paracelsus' "cosmic anthropology" are just two of the most glaring examples of Man's frustrated attempts to understand that which he did not know, i.e. the true nature of internal wounds that could not be seen.

It was only with the development of experimental scientific methods' that the old myths and taboos began to fall away, and it became possible to see a development of anatomy-pathology, biochemistry, physiology, and bacteriology, and it became possible to correlate clinical states with anatomical wounds and physiopathological alterations. From there, and using "intelligent manipulation of standards" i.e. comparing a concrete clinical state with pre-established conditions, it became possible to see (in a figurative sense) what was previously invisible. Perhaps this is why it is still commonly said, nowadays, of internists who make brilliant diagnosis, that they have a Clinical eye.

This change, based on scientific progress, constituted, for me, the great cultural revolution in clinical medicine of the end of the 19th Century. Since then, it has become possible, based on the clinical signs and symptoms, to identify, i.e. diagnose, anatomical wounds and physiopathological disturbances that cannot be seen by direct observation.

This new "internistic" culture (if I may call it that) requires a knowledge of basic sciences, mastery of clinical semiology and practice of differential diagnosis. It requires a specific learning and the acquisition of abilities that are the essence of IM but which – beware! – are not exclusive to internists. They should be present, to a greater or lesser extent, in the professional training of all those who carry out clinical activity. Without this basic training, much of the effectiveness is lost or will give rise to dangerous distortions. For this reason, our Society defends the existence of a "common root" of Internal Medicine for all areas of medicine, and will not stop trying to influence decisions that will be taken in this field, in the future.

Before drawing to a close, I would like to add two small comments. As I step down as president of the SPMI, after belonging to its Administrative Board for eleven years, I would like to address some words to the members of the new Board of Directors. They are inheriting a valuable and enviable heritage that must include a harmony of ideas on the role IM should perform in the future, ideas that were planted over many years of shared experience, debate and discussions. I have no doubt that the new Directors will be well able to carry on the work that has been started, and I would like extend my sincere wishes that their action will be crowned with every success. Becoming, again, an ordinary member of the Society, I would like to express my availability to contribute with my work, to helping IM continue to grow and affirm itself.

Finally, I congratulate the Organizing Committee of this Congress, represented by its President, Professor Levi Guerra. The Directors of the SPMI, in placing their confidence in him have made a wise decision, and I have no doubt that their expectations will not be disappointed.

All that remains is for me to express my with that this Congress will achieve the scientific, cultural and social success that we all hope for.

Espinho, 25th May 1994