Editorial

Internal Medicine emerges nowadays, within the scope of medical practice, with the strength of an important sector in Medicine which, having been relegated to a secondary role following the development of medical subspecialties, has now assumed a more prominent position.

Today's internists are the successors of the former general practitioners, the so-called family doctors, those practitioners chosen by each family who, in their professional devotion, happily traveled to the patient's home, gradually becoming part of the family. These were the real Family Doctors.

Up until the 1960s of the 20th Century, when Medical Careers first emerged, Medicine was practiced in previous centuries in practically the same form in all the civilized countries, particularly in the Western civilizations with Judeo-Christian roots.

Knowledge was scarce and treatments limited. It was the beginning of the scientific era of Medicine. Important discoveries were made, from Pasteur to Fleming, significant milestones that in no way detract from other important names and other remarkable discoveries.

In the past, the physician, and the image he conveyed to society, had a presence and knowledge that placed him somewhere between a magician and a deity, always a man of good and of hope, the advisor, always the man everyone wanted in all situations. In moments of pain and affliction, for the so longed for help; in times of social and family gatherings, for the high regard of his concepts and for his action in the wider or narrower scope of these gatherings, conversations, or events.

The family doctor, with the wealth of his practice that was, on the one hand, the application of his knowledge, and on the other, his devotion, disappeared.

Today the Family Doctor is in the Health Centers where, one cannot deny, he attends patients, with obvious respect and professional competence, but in a relationship that is cold and distant, without the integration with the family that was common in the past.

Internal Medicine, which as I mentioned earlier, is the modern term for the general practitioner, the physician with a vocation to look at and treat the

patient as a whole, receives impulses of affirmation that need to be analyzed in order to achieve correct judgment and a fair evaluation.

Internal Medicine, and internists, are seen at hospital level, particularly in developed countries, where health costs are quickly rising to unbearable levels, as agents for moderating costs and balancing budgets. It is mainly for this reason that they are sought out and well-paid, because they will, above all, contain expenses. I must admit that this reason is an essentially political one and is not, in itself, dignifying of the Internist.

In these countries, and we, in Europe, are fighting for a "common root" of Internal Medicine and the Subspecialties. This is the correct way to go.

In European countries, such as Germany, Switzerland, Holland and Finland, there is already a "common root", and in the United States, the general practice is to have three years of "common root", at the end of which one already has access to the Boards of Internal Medicine, i.e., one becomes a specialist in Internal Medicine. Thus, we are moving, and quickly,

towards a period in which subspecialists have the training of internists, similar to the Internists themselves, and therefore also have the capacity to look at the patient as a whole.

So where are the difficulties and differences between Internal Medicine and the Subspecialties? And between Internists and General Doctors? Internists and General Doctors may or may not be called generalists? So are they Internists in the Hospitals and General doctors in the Health Centers? Clearly, among us, careers are not coincident, and neither do they have the same programs. But shouldn't they have? I believe they should, without a doubt.

And the medical Subspecialties centered on the pathology of one organ, one system, or even in some cases, a pathology that is specific to just one organ; will they continue to be necessary, or are they essentially dispensable? And, I wonder, will Internists themselves end up dedicating themselves to restrictive pathologies, those that will be left over for them in the population of new patients that will emerge, such as geriatrics, terminal care and medical oncology?

This serves to conclude that discrepancies do exist in the concepts, and above all, in the practices and conducts. The General Doctors, who make up the largest portion of doctors in Portugal, must have the right to an internist training that involves intense practice and deep knowledge, carried out by an extremely committed, trained and duly supervised teaching body, particularly in hospitals, if not so much in Health Centers.

All health policies tend to be the least expensive possible. Care must be taken to avoid making the Internist just another preferred agent because he is less expensive, rather than because he treats patients better.

It is imperative to avoid, at all costs, "wars" between Internists and General Doctors, as occurs in Italy, while acknowledging that the curricula of subspecialties and general doctors should have the same common root as Internal Medicine.

In addition, there is the ethical and the deontological practice that must be based on a doctor-patient relationship that is respectful, competent and zealous.

It is the role of health policies to develop mechanisms that will lead to a competent and committed medical practice, and that maximize the benefits for patients and are the best value for money for the State, which does not necessarily mean they will lead to more restrictive budgets.

It is important to continue reflecting on these issues in an objective, real and urgent way. ■