Editorial

We reached the 4th issue of *Medicina Interna*, the Internal Medicine Portuguese Society journal. *Medicina Interna* is one of Medicine most important supports at present. But on one hand there are a number of centrifugal forces exerted by the multiple medical subspecialties blinding somehow its importance and on the other hand, while dealing with several pathologies, it is within Internal Medicine scope the patient's evaluation "as a whole". Although at risk of redundancy, it is important to mention some of the Internist essential aspects: he is the one enduring the Emergency Services impact and approaching critical patients; having a clinical central science, regarding the specialties he is a consultant to other specialists; he is in charge of wider and continuous care whilst following up patients; it is his role to follow up not only common diseases, but also the rare ones which do not fit to subspecialties and all multiple and multiple organ diseases.

In the last few years, a great excitement was seen in our medical environment leading to the Internal Medicine Society expansion. For that purpose there was a major contribution from the effort of the last Boards as well as the organization of Regional Conferences and the three Internal Medicine Congresses. With the previous Board and for two years, a dynamic experience was carried out involving all Medicine Services of Lisbon Hospitals and some in Lisbon region. The Society started sponsoring a number of medical meetings. A crucial element was missing to the associates: the Journal. Its preparation was slow and hard but accomplished with its first issue published in June 1994.

Many physicians chose a continuous education methodology driving them to read medical journals, spending many hours reading them. Often before a puzzling clinical condition, a part of other information sources, we have to resort to endless papers from respected journals, in order to find some guidance to detecting a possible disorder. Although our hospital libraries are full of innumerous quality journals, namely Anglo-Saxon ones, it is difficult for most Portuguese physicians to succeed in publishing regularly their original articles, clinical cases, review articles, casuistry, letters, etc., in foreign journals.

The *Medicina Interna* journal was received enthusiastically by colleagues and criticism was made, both positive and negative, regarding all numbers, revealing a huge impact among our associates. In order to ensure its reliability and worth we took a decision to submit all articles to the appreciation of two medical personalities of acknowledged merit. It has not been always possible to publish some articles as such was the view of our referees, but both the refusals as the changes proposed, with some rare exceptions were duly documented, what gives our journal an important role in medical education. We all know how difficult it is to publish an article and it is certain that most of our colleagues were not taught how to do it. It would be good, if those whose articles were refused to convince themselves there was no hostility from the Editorial Board but the will of doing well. Some articles received show common situations, others do not comply with the publication rules, and there are clinical cases which are no more than a compilation of presentations, as if it was a clinical meeting. There are articles approaching casuistry which are badly structured, without introduction, or material and methods, without results with insufficient discussion and often not even related with the obtained data. Bibliography often is not referred in the text and so on and so forth.

The aim of the *Medicina Interna* journal is not only to be a place of meeting for Internists, but also acting on their continuous training.

Luis Dutschmann

The publication in the issue of the *Medicina Interna* journal of an article on the quality of the clinical processes, gives us an opportunity of pondering on some issues which for us are new topics to the internists' commitment.

First of all, it is evident a growing interest for clinical

documentation, well expressed in the recent organization, in Lisbon on the 1st Seminar on Clinical Documentation and the organization, still this year, in Amsterdam of an international congress on the same subject.

Such interest results probably of a perspective of the current formulae exhaustion of support and organization of the clinical procedure, old of many hundreds of years and the emergence of new solutions in the horizon.

The importance of the clinical process is today an established fact. It is a crucial basis for planning the medical care and evaluating such care. It enables the continuity observing the patient's condition and his/her treatment and the communication among the different health professional involved. The clinical process is still a precious training help, an irreplaceable basis to research and an essential support to the patient's, the hospital and health workers legal protection. Lastly, it is an indispensable instrument to hospital management.

In order to achieve such aims it should be of easy consultation, legible, complete, accurate, quick, and permanently accessible, have a confidential character and be unique for each patient. However, to achieve such functional conditions there are two main difficulties in the current reality.

The first, affecting most hospital organizations, it is the dispersion of the clinical records for innumerous consultations and services files, generated at the time of dividing Internal Medicine and General Surgery in multiple specialties and subspecialties. This is a situation which does not serve services, do not serve professionals and above all does not serve the patient, making his/her care difficult, in general. The same way that one can see an inversion in this trend, through the agglutination of specialties in great departments, also the implementation of the unique process in hospitals, although it can be a cyclopic task, is however unavoidable and unpostponable.

The second difficulty, also generalized, but more acute in more recent hospitals already with one single procedure, results of the enormous amount and complexity of the information contained in clinical procedures, making significantly more difficult its consultation.

This is a recent situation in Medicine long history and has been deteriorating in the last few decades, as a consequence of the progression in the knowledge of diseases, their diagnosis supplementary resources, in the monitoring techniques and in the possibilities of therapeutic intervention.

It is common, in hospitals with a single process, to be faced with a clinical file with hundreds of pages, when we see a chronic patient as an outpatient. The accumulation of all these documents and also of supplementary exams, in basements, corridors and stairwells in our hospitals, distributed in miles of shelves made impossible a long time ago the management of our files, originating true "information graveyards".

In order to solve these problems, there is only a possible way out, already started in some Portuguese hospitals, which is the creation of electronic clinical processes and electronic clinical files, resorting to microfilming of the procedures and supplementary exams, while the optical disk is not accepted as legal support.

Such solution will enable to solve the problem of such archives, to ease the processes consultations, to reduce the research time, to ensure all cases are located, to reduce the fees with repeated supplementary exams, increasing the confidentiality warranty, to enable an integrated electronic management and an extra-hospital communication through electronic mail. The implementation of such change, which will be necessarily delayed, should be made multidisciplinary, mobilizing doctors, nurses, computer workers, office staff and managers.

The second issue rose by the mentioned article, it is the use of the clinical process whilst an instrument to evaluate quality.

In reality, the clinical process is an indispensable tool, not only to evaluate the quality of care assistance, but also to detect the problems and monitoring the effectiveness of the implemented changes.

However, it was not that the aim of the published study although the title can be misleading, not even that of the evaluating the quality of the clinical records, but only to know that whether they were present or absent. It is understandable that this is the starting point, although being before a complete program of quality control, it would be necessary to have implemented corrective measures and made the reevaluation of such measures impact.

Some hospitals taking part, between 1991 and 1993, in the COMAC of the European Union, coordi-

nated in Portugal by Prof. Caldeira da Silva, developed and completed programs of quality improvement of clinical process, results which would be interesting to be published. Such project has enabled the initiation of many physicians in quality methodology. With the beginning of BIOMED I program, keeping this topic, other hospitals will have the opportunity of implementing programs based in clinical records.

However, it would be desirable if Internists started also using the clinical processes as an evaluation tool to the launching of programs with introduced improvements having been a direct repercussion on the patients' health. This is the current main guideline that internationally is intended to direct the quality programs.

Luis Campos