Points of View

A Perspective of Peripheral Hospital Assistance

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Although considering the article "Teaching and its evaluation after graduation in Medicine", by Oliveira Soares, MD, published in the Issue I, no. 2, 1994 of this Journal, it represents undoubtedly, in its entirety, one of the most lucid critics emerged among us on the educational role of Hospital Medicine, I did not resist the impulse of exposing my view, in some cases reinforcing and in others opposing several points of his arguments.

In the first place, I think better to inform, without a shadow of immodesty, that my hospital career has spanned for 10 years in Assistance Central Hospitals, 10 years in a School Central Hospital and almost 20 years in a designated district Hospital; such experience if complemented by some talent would place me in an exceptional position of authority to approach such subject.

Starting by the beginning, i.e., by teaching the Clinical Cycle in School Hospitals, I think as I have experience on a different methodology that the failure of such teaching is due, in a big part of it, to the existence of a Practical Class and School Assistant teaching it. Without the extinction of these two museum characters, creating one only School and Assistant Career and integrating undergraduate students in core specialties, there will never be an acceptable medical teaching therefore we will continue to have, as our colleague Oliveira Soares says, physicians without (a minimal) training at the time of graduation, with persistent negative reflexes throughout the whole of his/her future professional career. On the other hand, in order to allow such integration, theoretical classes should be given out of Nursing working hours, under the form of Specialties courses, preprogrammed and given by specialists of the respective area. Lastly, the Medical Course should be intended more to serve the teaching of students, than the conveniences of lecturers persisting in keeping privileged status, clearly unadjusted.

But the existing *numerus clausus* represents only another aberration among so many anachronisms. During the years of African wars, the frequency of the Medical course was widely opened to respond to the arguable military demand of a physician per unit. Afterwards, it was decided to drastically reduce the access to Medical Schools, with the unreasonable argument that teaching better with better students, without foreseeing that applying faulty methods, one would badly teach one hundred students or several hundred, at the same time.

Nobody reasonably gifted, even not being a physician can doubt that to estimate the *numerus clausus* in Medicine must be determined by the country healthcare needs.

Therefore, this estimate must respect 3 propositions, which I find dogmatic:

• Specialty Interns representing the main hospital workforce – as in football, after the 30 years of age (age corresponding to the end of the Internship), the hospital physician must be, above all, a guide, as he/she has already lost much of his/her enthusiasm, motivation and even physical ability to a direct intervention in the fighting field.

• Specialty Interns, as they are graduated physicians, are subject to the total responsibility of their medical procedures, in a way that their healthcare activity, although under tuition, must always be a priority regarding all training steps.

• The estimate number of Specialty Inters and, consequently, the *numerus clausus,* should be made regarding the general demands of the national hospital network, after correcting all the distinctive views among the different sectors, representing, almost always, a deplorable astigmatism of the central public hospital sector.

It is about this last aspect that the views from colleague Oliveira Soares, show a regrettable distortion, surely resulting of this error of a deforming perspective, with hints of superiority and excellence, fed by the so called Central Hospitals colleagues. I have also suffered of such malaise, in a time where it was more

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justified, i.e., at the time of Charity Hospitals, without medical careers or appropriate conditions.

At present, all hospitals are covered by a standard Medical Career, without reasons to a difference of proper means and subsequent quality among similar Hospital Sectors, Central or Peripheral.

To think that a Medical Service, of General Surgery or the Specialty, for being peripheral should have less Interns or Assistants, relating with the number of beds is, at least, to admit that country patients do not have the right to identical healthcare assistance than those in main towns.

The existence of ultra-specialized services is a totally different problem, which should be solved creating operating hospital regions and not only administrative ones, as the ones recently set up. This way, for instance a Hospital region covering Almada, Barreiro, Setubal and Montijo Hospitals would make up an autonomous hospital area, i.e., equipped with almost all specialties differentiated not needing the supplementary of the Lisbon Hospital Region, except in very exceptional circumstances, as organ transplant and LDL-apheresis, that the colleague has so enthusiastically quoted.

The so called Central Hospitals, different from what so many people think, are mainly major towns neighborhood hospitals, as the district ones, above all, city hospitals and surrounding boroughs.

If central hospitals keep on receiving an overwhelming number of patients, coming from peripheral hospitals, the reason for this to happen is that in these hospital areas, the essential Specialized Services were not yet created for lack of proper planning. What justification can there be, for example, for the so called Central Hospitals to have around 10 Endocrinology services (with over 100 Endocrinologists), while the peripheral do not have any duly dimensioned (and only around half a dozen of Endocrinologists)?

But the point colleague Oliveira Soares reveals a marked reality detachment is when he says that “Central Hospitals on their turn, should gather the multidisciplinary conditions to treat the very sick and the severely traumatized…” because as such entity of the “very sick” does not exist and admitting it is referring to the cases of more complex diagnosis, or of more intensive or differentiated treatment, the main Peripheral Hospitals, as mine, are much more qualified than the colleague thinks to solve them appropriately, needing only to resort to auxiliary tests or external treatment, in very exceptional circumstances, as for instances, magnetic resonance, microbial or differentiated autoimmune serology, neurosurgery, transplants what also happens with many Central Hospitals.

Therefore, my Hospital 2 Medicine Services have Pneumologists carrying out fibroendoscopies, pleural biopsies or percutaneous pulmonary cytology and spirometry, from nephrologists making renal biopsies and haemodialysis, as well as Neurology, Dermatology and Endocrinology teams. In this hospital there are Gastroenterology, Cardiology, Intensive Care, Imagiology, Immunology, Clinic Pathology and Pathological Anatomy with an excellent equipment, enough medical and nursing staff, and a high degree of production and quality. This without mentioning the surgical services, also with high capacity. Are we not able to treat the “very sick”?

As far as I am concerned whilst a Medicine 1 Service Director, I have not the faintest doubt that our working team would not fear quality and efficiency confrontations with any another Medicine Service in the country and that most Peripheral Hospitals Service Directors thinks rightly, the same way.

Without a doubt there are many Peripheral Hospitals of small size, which do not have a minimum of conditions to cope with subspecialties or internship, what could perhaps be solved by regular transfers, within the scope of the proposed hospital regions.

The designation of General Hospital should be perhaps be given to hospitals having enough medical staff, defined by criteria as, for instances, capacity to organize permanent teams in the Emergency Service in their main specialties – Internal Medicine, General Surgery, Pediatrics, Obstetrics, Orthopedics and Cardiology.

These hospitals which in their majority are located in district capitals, being much more humanized and less bureaucratic than central ones, due to their average dimensions, have optimal conditions of efficient healthcare, training and learning, resulting of the ease of intense cooperation and involvement of the sectorial teams in the appropriate solution for the concrete cases.

And no matter how hard this is to colleague Oliveira Soares, my view on the interns general opinion returned from the most varied Central Hospital Services is that usually it is not found there a better quality whether in the healthcare, whether in the training,

that in the origin peripheral services.

To end with, I must disagree of its critical too ironical and detrimental on the national clinical investigation, forgetting that all work on records, case assessment and publication or pathological series, correctly studied and presented, apart of corresponding in some form of investigation, represent the most reliable rate of valuing any clinical sector. And also, on this subject I can state that the Peripheral Hospital Sector has been imposing itself remarkably, as it can be proven, if one is interested reading the Scientific Journals of Medical Societies of District Hospitals.

For all this, I strongly recommend that he should try to get in touch with the current reality of Peripheral Hospital, to modify his view contributing with his outstanding analysis and communication ability to a uniform improvement of the Hospital Care of this small agglomerate with “500 km in the latitude sense” and only 10 million inhabitants. ■