

Medicina interna: passato, presente e futuro

Internal Medicine: past, present and future

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Internal Medicine comes from medical clinics and reached its edge in the ancient Hellenic and Roman periods (Hippocrates, Galenus and Aretheus). From the 2nd Century twilight and up to some year after the Renaissance, contributions were poor. In the 19th Century three medical ways of thinking arose in Europe and advanced medical knowledge: the anatomoclinic (France), the physiopathologic (Germany) and the ethiopatogenic mentality (United Kingdom); in the 20th Century the anthropologic conception, i.e. holistic medicine or medicine of the person, came out.

Thanks to the brilliant European medicine and particularly in France, the 20th Century was the golden century of Internal Medicine. Strümpell in Germany wrote the first Book on Internal Diseases (the expression "Internal Medicine" was born in Germany) and two years later, the First World Congress of Internal Medicine was held in the German City of Weisbaden.

The past century was the century of the medical specialties (doctors were general practitioners and had to know and do practically everything), that multiplied from the last period of WWII. Decades later the technological advances increased this trend. Someone believed machines would replace doctors.

It is noteworthy that clinical specialties (cardiology, pneumonology, gastroenterology, nephrology, endocrinology, neurology, etc.) were founded by great teachers of Internal Medicine who became more and more expert into a particular field or area of Internal Medicine. This could not happen with the later generations of doctors who enter clinical specialties usually without sufficient training and experience in Internal Medicine.

Internal Medicine was the unique specialty that received the purest clinical tradition and warranted the full development of semiology in hospitals, through the meticulous clinical history-making, the clinical methodology, the duty rounds, the magistral classes, the academic discussions, the cultural anatomoclinic sessions and many other activities.

Thomas Sydenham, the so-called English Hippocrates, praised the recapturing of observation at patients' bed, as it was in the hippocratic practice. The Dutch Boerhaave, who can be considered the father of modern clinical education, introduced the thermometer and highlighted the difference between objective symptomatology and subjective symptomatology (i.e. symptoms and signs). The Austrian Auenbrugger discovered thoracic percussion but it took 40 years for such technique to gain its universal prestige thanks to Corvisart, the founder of French clinics. Laënnec discovered the stethoscope and described the auscultation, thus beginning the instrumental clinical practice. The Austrian Skoda, famous for the blitzdiagnosen (immediate diagnosis), was a member of the "Second School of Vienna" and standardized the steps toward diagnosis.

It was the time of the great doctrinaires: Trousseau, Jacoud, Potain, Dielafoy, Laségue, Glenard and Vaquez in France; De Giovanni and Pende in Italy; Flint and Osler from the other side of the Atlantic Ocean, among many other doctors.

The teacher of Italian clinics, Giorgio Baglivi, contemporary of Sydenham, was the author of a famous sentence: "Young people will never find a more teaching and instructive book than the patient himself".

Up to Boerhaave every theory was first developed by adapting it to the experiments and the patient, but the Dutch taught the opposite: the patient was first examined and the disease studied, then, on this basis doctrine was built. The biographers say that in the hospital of Leyden, in two small rooms with only twelve beds, Boerhaave formed half of the European clinical doctors using this method.

It is wrong to believe that the internist specializes himself in the managing of the hospital-admitted patients only, while the ambulatory Internal Medicine is performed by general practitioners. Medical clinics existed for a long time and were a part of the general clinics or, under wider view, of the general medicine. Medical clinics had their origins in the ancient Europe and Internal Medicine in the modern Europe.

Today about 70-80% of adult patients in a general population are managed by Internal Medicine doctors. The so-

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ciety cannot ignore the economic aspects and/or that internists are clinical doctors with hierarchy and specialists who are highly qualified and trained in the pluripathology and clinical complexity of adults, and cannot be replaced by other specialists of general medicine. We are very far from William Osler's prediction who believed the internists to be the most complex, versatile and distinguished general practitioner, foreseeing a successful future for them. In the second half of the 20th Century the internist left his/her maximum range in the consulting steps of to other specialists and ultraspecialists. Ciril Rozman, president of the International College of Internal Medicine, thinks that the condition of great Internal Medicine teachers will not reappear, but he tries to rescue the suitability of the internist on an economic basis, since some patients are managed by many specialists while could be taken in charge by only one internist thus reducing costs. Rozman says that clinical exercise always implies some uncertainty and the internist possesses the best clinical art to take an appropriate decision in a complex situation of multimorbidity.

This is the classic differentiation between general internists and specializing (or subspecializing) internists.

Nevertheless the complete managing of a patient can only be offered by Internal Medicine. In the third millennium we are facing a series of challenges related to health, both public and private. The globalization forces us into an economic wild reality and in some cases there is a sharp gap between welfare doctors and financiers or managers of health. The internist must adapt to this new situation and to the emergent needs. Some of the modalities are units of brief admission, palliative care programs, units of quick diagnosis and home hospitalization. The welfare policies put the accent in the ambulatory care and in brief admissions. We need a new medicine: technically efficient, ethically correct, humanitarian, cheap and financially affordable. Internists neither can nor must ignore or underestimate administrative or management aspects, but should be led by their moral condition to favour the dignity of the patient over other factors. It is very important for internists to put some topics of our speciality in order. It is necessary that the professional schools and societies of Internal Medicine make a joint effort to recover the role of internists. The International College of Internal Medicine has taken this mission as a strategic aim.