

Venezuela's Chapter

Governor's Newsletter

ACP

AMERICAN COLLEGE OF PHYSICIANS

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Venezuela's Chapter Governor

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1. **Editorial: "Internal Medicine Concepts and Doctrines". Dr. Israel Montes de Oca. (MD, FACP)**

It has been very stimulating for us to read Drs. Ramón Soto, Pedro Armas Nurse, and Italo Marsilia articles regarding the physician-patient relationship.

Many factors have emerged in the last decades, which have changed specialty conceptions and doctrines. Specialties have evolved under the influence of investigation and its consequences - technology and its application for disease diagnosis and treatment. Very few specialties have escaped to this influence but the Internal Medicine Specialists have understood that their precepts remain unchanged and that their actuation centers around a single element, the patient. The most essential concern is subject complaint and suffering, which are heard and soothe by the Internist.

We have opened the way for the above mentioned articles, to demonstrate with doctrinaire solidity that Internal Medicine maintains and equilibrium between the modern applied technology and the ill man, with the human suffering being the genuine representative of Internal Medicine raison d'être,.

2. **Doctrinaire Article: "Internal Medicine in the Twenty First Century" (Part II). Dr. Ramón Soto (MACP)**

We will address now the profile that the ACP has delineated for the Twenty First Century Internists:

1. Internists should provide their patients with a continuous, specialized and comprehensive health care during all adult life, in order to keep patient healthy. This will be done by the application of any type of treatment, whether the disease is acute or chronic, simple or complex. Preventive guidelines will also be offered. The Internist does not practice surgery, obstetrics, gynecology or pediatrics, which makes the difference with the family doctor and general practitioner (GP).
2. The internist is called to practice that medicine organized for professionals actively interested in adult assistance, scientific research and teaching.
3. The internist develops clinical expertise by rigorous training and dedication to study, and acquires and maintains a deep knowledge of physiology and pathophysiology scientific basis.
4. The internist recognizes that technology (lab methods, ECG, and images as x-rays, echosonogram, CAT scan, RMI, etc.) applied to

medicine for the diagnosis and treatment of diseases is related to the ethical care of patients as individuals and members of families, groups, and communities.

5. The internist should be an up-dated professional with vast scientific resources, who masters medical art, clinical epidemiology and decision making, and who evaluates and conducts patients with a practical, balanced, austere, careful and considerate style, taking into account current high medical care costs.
6. The internist coordinates other specialists involved in patient diagnosis and treatment, and takes care of simple or difficult problems that patients may present.
7. The internist should be studious and versed in obtaining scientific information so he/she can take advantage of the various current sources of knowledge and can communicate by modern computing tools.
8. The internist should be an unselfish patient guide and guard in complex health care settings as prepaid medicine, private health insurance corporations, etc.

9. The internist should be a generalist above all, with special skills to respond and adapt to particular medical practice environment needs.

Central University of Venezuela Medicine Faculty through the Graduated Studies Board, and the Venezuelan Society for Internal Medicine through the Postgraduate Board have declared support for the above internist profile concepts in 1987 and 1991, respectively.

21<sup>st</sup> century generalist internists confront important obstacles in their way; on one hand, their academic training is more complex and onerous each day, and secondly, they confront countless unfavorable circumstances in their professional performance. That is why the internist flees towards subspecialties and there is a low internist recruitment rate. Various causes lead to the above-mentioned situation: The lower remuneration for internists compared with subspecialists and the lower amount of job sources available for internists. It is necessary to revert this trend and revitalize the specialty. In this sense, American College of Physicians (ACP) has been pioneer in supporting out campaigns to strengthen Internal Medicine identity, and promoting interest in Internal Medicine among pre-graduate students. This last purpose congregates us today before you, the potential future Internists.

In this sense, I would like to paraphrase, with some personal modifications, the current ACP President Dr. Munsey S Wheby, FACP recent comments:

"The Internist, thus conceived, must be an archetype, a "role-model", who - in sight of students - shows sincerely and spontaneously his/her interest, dedication, devotion, emotion and full satisfaction for the type of work he/she performs".

"To promote Internal Medicine among students, they need to have a first hand impression of how we, internists, proudly enjoy diagnostic and treatment intellectual challenges, the satisfaction implied in patient observation and judgment, and the call to compassion. Students should look at us as our own destiny agents, who fight to change those things and circumstances that hinder our job and darken our soul".

"Students should see how we strive to succeed in the hostile environment we work at by reducing and channeling bureaucratic or other restrains, and to improve general and economic internist situation. Not only should students see how we adapt to inevitable changes but also how we develop efficient and effective medical practice models, which at the same time are a personal gratification and satisfaction source".

"If, as educators, we teach the best we think and feel of internal medicine with passion and proud, we will have a good chance to inspire and guide a new internist generation that will revitalize our specialty".

I will conclude saying that 21<sup>st</sup> Century Internal Medicine continues being a discipline in perpetual development and adaptation to the different pressures that have always hounded it (social, economic, political, scientific, ethical, humanistic, etc.). However, Internal Medicine should remain a holistic discipline given the biophysical character of the human being.

**3. Internist Biographical Sketch: "Dr. Enrique Benaim Pinto Biographical Sketch" (Part II). Dr. Pedro Armas Nurse. (By Invitation)**

Dr. Benaim Pinto was a friendly, serene and receptive person, with an acute and critical reasoning. These characteristics, together with his vast culture, erudition and tireless capacity for studying and working, made him deserved the high positions he got. He was a distinguished professional, diligent researcher, outstanding teacher, exemplary citizen and consequent friend. Dr. Benaim Pinto constantly showed the way in medical advances, and knowledge acquisition and diffusion. Many deeds demonstrate his determination

to improve teaching, scientific knowledge, his job, his chair, research and patient care activities, and institutions. He founded Clinical Research Lab and Rheumatology Outpatient Clinic at Caracas University Hospital. Dr. Benaim Pinto also coordinated and gave prestige to the weekly Pathology-Clinical Meetings in Caracas University Hospital auditorium. His personal contributions played a role in the carrying out and maintenance of these meetings.

Dr. Benaim Pinto published an Editorial in Revista Acta Médica Venezolana in 1956: "Venezuelan Society for Internal Medicine: a need that cannot be postponed". This objective was met with the collaboration of numerous outstanding physicians. Venezuelan Society for Internal Medicine (SVMI) constitutive act was signed on April 8, 1956. Dr. Benaim was not only Founder-Titular Member but also hold the Vocal, General Secretary, and President posts. He was appointed National Medicine Academy Member in 1963 and promoted to Number Individual in 1976, when he sat in chair N° IX.

Dr. Benaim Pinto scientific task is backed by more than 126 published trials. His fecund production has unquestionable value and current interest. He made contributions on many topics: Amebiasis, anemia in Venezuela, sprue, connective-vascular tissue disorders, hyperthyroidism, hypertension, constipation, iatrogeny in medicine, tetanus, deep and superficial mycosis, ancylostomiasis,

trypanosomiasis, sexually transmitted diseases, bilharziasis, clinical pharmacology and doctrinaire aspects of Internal Medicine.

Dr. Benaim Pinto also successfully tackled the literature field. He published various eminent colleague biographies, which represented a historical contribution to the medical field: Maimonides life and work, José María Vargas, Santos Aníbal Dominici, Francisco Samaniego, Augusto Pi Suñer, Rolando Curiel, José Izquierdo, Félix Pifano, and Gustavo Machado.

Many of Dr. Benaim Pinto's works were honored: "*Ancylostomiasis Medical and Social Aspects in Venezuela*", "Luis Razetti" award (1947); doctoral thesis guided by Professor Antonio Sanabria. "*Internal Medicine Doctrine*", honored by National Medicine Academy (1967); he considers here the main practical and conceptual aspects of Internal Medicine. "*Anxiety and Obsessive Behavior as a Conditioning for Chronic Constipation*", Joel Valencia Parpacén Award (1966) at the Gastroenterology National Meeting. "*Complain meaning for the Doctor-Patient and Patient-Doctor Relationship*"; work done for incorporation to the National Academy of Medicine (1976); this writing represents an exposition derived from a thorough analysis of more than 20 years of professional experience. He published "*Analysis of the Medical Education Current Status in Venezuela*" in 1960; an up-to-date work that requires study.

Dr. Benaim Pinto received medals, with the most outstanding being: "Andrés Bello Order", first- and second-class (1967-1974). "Cúa Tercentenary Button" (1967). "Cecilio Acosta", first-class (1976). "José María Vargas". "José Izquierdo Order" (1977). "Francisco de Miranda" (1978). He also received Diplomas (5) and Awards (5) as result of his valuable contributions. Finally, Dr. Benaim left a valuable and scattered material (files, brochures, slides, recordings, manuscripts, journals, newspapers articles, etc.), which should be compiled and analyzed for future publication.

Convinced of the need to complement young doctor training through a better scientific, technologic and humanistic preparation, Dr. Benaim Pinto gave his support to the Internal Medicine Postgraduate Courses. When Dr. Benaim was Venezuelan Society for Internal Medicine president, he forwarded a letter to Dr. José Ignacio Baldó - by the time Department of Adult and Chronic Diseases chief (Health and Social Security Ministry) - setting out the Venezuelan Society for Internal Medicine interest in developing the above-mentioned courses. He also offered in that letter, dated May 8, 1959, his support to meet the objective. This move prospered in July 1959, when the course opening was ordered. Dr. Benaim Pinto promptly wrote the programs and functioning basis, which were published in a brochure. The first Internal Medicine Postgraduate Course was opened in October 6, 1959, and was located in Caracas University Hospital

and Caracas Vargas Hospital. Dr. Benaim Pinto shared the Postgraduate Course direction with Dr. Augusto León and Dr. Otto Lima Gómez, both outstanding professors. The Internal Medicine Postgraduate Course will celebrate its forty-fourth anniversary this current year.

Dr. Benaim Pinto retired from teaching on October 9, 1972, after 27 years of fruitful work. The Venezuelan Society for Internal Medicine organized a celebration to honor him in 1980. Dr. Juan Ernesto Montenegro - outstanding clinician and Dr. Benaim Pinto Chair member - expressed himself in this manner: "Enrique Benaim Pinto was an Internal Medicine giant, as will be demonstrated by his biographers. Enrique Benaim Pinto belongs to the Venezuela Central University School of Medicine history and he also belongs to the Medical Clinic history."

Dr. Benaim Pinto died on December 27, 1979, when he was 57 years old. He succumbed to a cruel and long lasting disease when we still could have expected many things from his exemplary personality. Peace and Honor to the distinguished master rests.

#### **4. College News:**

1. A new Program denominated "International Fellowship Exchange Program" will be opened this year 2004, supported by Pfizer S.A.

The program is similar to our Minifellowship program. Applications for the International Fellowship Exchange Program can be submitted to the International Administrator (Wendy Rivera) at the ACP International Office, Membership Division, American College of Physicians, 190 North Independence Mall West Philadelphia, P.A. 19106. U.S.A. Phone: 001-215-351-2520. Fax: 001-215-351-2759. Email: [wrivera@acponline.org](mailto:wrivera@acponline.org).

**5. Concept Article: Physician-Patient Relationship. Cornerstone in Clinical Medicine. Dr. Italo Marsiglia G. (FACP).**

Contemporaneous medicine strives to renovate and increase medical knowledge and related technological resources, in order to achieve the scientific medicine desideratum. This can be made evident in texts, journals, conferences and medical meetings, which are directed to this purpose achievement. However, an emphasis is exerted on patient somatic aspects in daily clinical practice, neglecting the psychological and patient suffering human aspects involved in the physician-patient relationship, the cornerstone of the medical act.

**The delicate equilibrium achieved when implementing "science" and "art" is the required support for the successful medical practice.**

The role of the constantly expanding science is unquestionable but it is evident that the only use of science does not guarantee the

good doctor role. **It is the "art" to comprehend and administer the human aspects, rather than the science, what allows the approach to the patient.**

In the ideal setting, it is possible to establish the physician-patient relationship by the **moral and ethical physician behavior** and by the physician qualities of **integrity, respect and compassion.** The relationship is based on physician patient understanding, mutual trust and capability for communication.

The adequate physician-patient relationship opens the window that allows physician to peep at the patient inner being. This permits to understand the meaning that disease has for the patient; how disease affects the patient; which the patient realities and fantasies on disease are; which the patient defenses to accept or reject disease are; how the patient will understand, favor or avoid physician action; and which our possibilities to achieve a close bond will be.

Doctors should take into account that disease faces the human being with two unique experiences, **loneliness** and **death**, which causes variable degrees of fear and anxiety. Patient emotional response depends on extent, severity and duration of disease; its repercussion on patient and household productivity; patient previous

experience with his/her own disease or other relative disease; patient cultural level; and patient emotional maturity.

Sacerdotal characteristic of medical practice is based on the sacred, personal and intimate physician-patient relationship, which should be guaranteed by medical confidence. The physician must protect patient confidentiality in the professional secret framework; even the reports provided to other colleges should only include relevant information for medical judgment.

Successful encounters of doctors with patients and their relatives need that knowledge and clinical judgment are complemented by a humane behavior. Patients may idealize their doctors, as they expect the most unselfish dedication from them. Physician-patient bond oblige physicians to guarantee patient fundamental rights and interests, respecting patient dignity and scale of values, and their freedom to act and choose. This does not mean that the physician should be subdued by all patient demands.

Patients should be approached with intelligence, gentleness, intrepidity, respect, critical judgment and tolerance, as approach to patient gets doctors involved in patient innermost feelings and vulnerable aspects - expectations, security, and prestige.

Every human being zealously keeps information related to his/her fantasies, longings, ambitions and frustrations. This explains why doctors may be surprised by patient intimate information content, which could not be guessed through patient appearance or superficial knowledge.

Knowledge of two psychological responses that arise from physician-patient relationship - transference and counter-transference - may make physician-patient relationship easier. **Transference** is an unconscious phenomenon by which feelings, attitudes and fantasies - originally linked to important figures (usually parents) during childhood life - are projected on persons in current life. Patients develop transference with their doctors during therapeutic relationship, where doctors substitute for one or more of those childhood figures. In turn, doctors develop **counter-transference** as an emotional response to patients, who represent someone in doctors' past.

The physician may know some patient needs and get identified with the patient. In the ideal setting, physicians reach an empathy level that allows them to put themselves in patient place, and understand patient desires, feelings and thoughts.

In their permanent training, clinicians should perfect knowledge and

skills to communicate with their patients. The way to reach this command may be tough and tedious, in the absence of sensitivity or humanitarianism, or the empathy to put oneself into someone else's position.

Fundamental factors for communication are doctor and patient degree of knowledge and intelligence, and patient attitude before the relationship, which can be wanted or rejected. Communication will also depend on both part emotional characteristics. Some patients may feel afraid of an intimate communication that they can see as an assault or violation, or as a potential stimuli for their homosexual fantasies; in contrast, some other patients, who need protection or affection, or who unconsciously use disease to get secondary gains, will adopt a dependency posture. These patients will tend to unnecessarily prolong physician-patient relationship, as disease has become a life style.

The right attitude is the intermediate posture. On one hand, the doctor can feel empathy for the patient emotional response to disease, but without getting involved to avoid unconscious manipulations on the patient side; on the other hand, the patient accepts his/her role without rejecting submission to the doctor but without pretending to accentuate the inherent grade of dependence on the relationship.

Doctors should also consider that their medical capacity might be affected by patient and relative demands, which could impose an emotional extra burden on doctors and make physician-patient relationship little objective or unviable. Internist capability to feel comfortable with this **"difficult cases"** will depend on how confident Internist feels on his/her professional role and how much Internist understands patient psychodynamic. Some Internists learn to deal with such cases, after many years of experience and by assay-error; unfortunately, some other Internists do not acquire the skills and they experiment anxiety when confronting difficult cases. In the above-mentioned circumstances, it might be necessary to consult other more experienced colleges.

However, the term "difficult" cannot be indiscriminately applied to every unsuccessful physician-patient relationship, as it might conceal or try to justify unskillfulness or bad case-handling. The scarce time provided for dialoguing with the patient is frequently responsible for errors and failures, as the elicited information is incomplete or wrong.

Undoubtedly, well applied medical science and technology favorably resolves a good part of diseases and human suffering; but nothing is more reassuring for the patient than observing the doctor truly interested in his/her disease, problems, and emotions, in strict

adherence to consideration, respect and discretion norms.

**6. Internal Medicine Clinical Pearls: "Clinical Manifestations Suggesting Cancer". (Part II) Dr. Trina Navas (ACP Member).**

Another frequent situation is symptom vagueness; for example cephalgia is a very important symptom for CNS tumors; however, it is one of the most frequent complaints for any specialty consultation. CNS tumors may manifest with peripheral neuropathy symptoms, which are due to direct infiltration, compression or metastasis; however, the same symptoms may occur with breast, lung cancer, colon cancer, lymphomas, sarcomas, and paraneoplastic syndromes.

Breast cancer has no specific symptoms. Three diagnostic probabilities are required for diagnosing breast cancer: accidental breast lump detection by the patient, breast lump detection during patient auto-examination, and breast lump detection by a doctor. Otherwise, symptoms would appear late and would include skin invasion, pain, and dyspnea due to metastasis. The only exception is breast inflammatory carcinoma that can manifest by swelling, heat, and redness around the areola.

Lung cancer symptoms (cough, expectoration, dyspnea, and weight loss) do not help to early detection. In the above-mentioned trial

with 170,000 patients, authors state that a small proportion of stage III (slight weight loss and good condition) tumors can be operated on, but when symptoms are obvious cure is not a treatment target. The National Lung Detection Trial proposes using thorax x-ray (PA) and CAT scan in heavy smokers. The PA chest x-ray may detect lung lesions greater than 20 mm in diameter. The helicoidal lung CAT scan is more specific for pulmonary lesions.

Mechanical causes account for 97% low-back pain cases; the remaining 3% is due to visceral causes (2%), generally no cancer related, and non-mechanical causes (1%). Low-back pain cancer causes (0,7%) include myeloma multiple, metastasis, lymphomas, leukemias, spine tumors, and vertebra primary cancer. A trial on low-back pain diagnostic methods states that the absence of improvement after 1-month rest is the only clinic parameter to have 90% diagnostic sensitivity. Another relatively useful clinical parameter is age older than 55 year. The sum of the two above-mentioned parameters plus inexplicable loss of weight, pharmacological treatment failure, and previous cancer history have 100% sensitivity but low specificity. This study outlines the importance of an adequate patient approach; there is no magic symptom, it is only the sum of the most transcendental symptoms what orientates diagnosis.

Thyroid cancer is usually asymptomatic. Only 3 - 5% of palpable

thyroid nodules are malignant. Anaplastic and, less frequently, metastatic thyroid tumors have obvious characteristics, but both circumstances are infrequent. Thyroid cancer overall mortality rate is 0.02% in USA.

Infrequent neoplasias include: (1) Heart neoplasias: They are usually located in pericardium (45%), myocardium (35%), or both (22%); signs are not specific, nor are symptoms such as dyspnea, chest pain, cough, orthopnea, palpitations, and asthenia; patients usually have a history of lung cancer (35%), breast cancer (25%), leukemias, lymphomas, melanomas, gastric cancer and sarcomas. (2) 39% rectovaginal fistulas have oncological origin; most of them result from cervical-uterine cancer, <1/3 from rectum or anal cancer, 34% are actinic, 11% are surgical complications, and 16% obstetrics.

Anemia in oncology should be carefully studied and the same as erythrocytosis deserves a complete review. Jaundice is associated with liver lymphoma or metastatic processes related hemolysis, especially those conditions that impair bile flow and have a relatively chronic evolution. Primary tumor related symptoms orientate diagnosis, although small tumors such as amelanotic melanomas with liver metastasis can go unnoticed.

Tumors that have a known genetic background include: Hereditary non-polypoid colon cancer, Peutz-Jeghers disease, familial juvenile polyposis, and breast and ovarian cancer. Those cancers should be thoroughly studied taking into account heritage, screening, symptoms and associated tumors for achieving diagnosis.

## **7. Chapter News:**

1. Venezuelan Chapter has been honored with the Chapter Excellence Award 2003, for the second consecutive year, in recognition of its activities.
2. XI Annual Meeting will be held on May 19-22, 2004. Outstanding national and international lecturers will be invited; among the latter, Drs. Kanu Chatterjee, Charles Francis (College Representative at the Meeting), Antonio Iglesias Gamarra, Antonio González Chávez (Solami Representative for the Meeting). Preliminary Program was published in our previous issue. You will receive the Program printed by the College opportunely.
3. Resident and Student Scientific Meetings have been successfully continued. Four Student Scientific Meetings have been performed. The last Student Meeting was held at Hospital Vargas de Caracas and was coordinated by Dr. Herman Wuani. The Resident Meeting Number 12, 13, 14 and 15 were held at Hospital los Magallanes de

Catia, Hospital Universitario de Caracas, Hospital Dr. Domingo Luciani, and Hospital Larralde de Valencia, respectively; they were coordinated by Drs. Eva Sekler, Francisco Fragachán, Marcos Troccoli and María Inés Marulanda, respectively. The 15<sup>th</sup> Scientific Resident Meeting, which was held at Valencia, is the first Chapter Resident Meeting held in the Venezuelan interior.

4. The Minifellowship competition is open for Chapter Members. The application reception period for this Merck Sharp & Dohm Laboratory supported program is January 15 to July 31, 2004. Competition rule information can be found in line at:

[www.homepage.mac.com/ppperdomo/acpvenezuela](http://www.homepage.mac.com/ppperdomo/acpvenezuela)

5. The Chapter Voluntary Program has been postponed for strategic and logistic problems, which will be solved very soon.
6. The current Best Published Scientific Trial Award will have a complement, as Schering Plough C.A. will pay for the winning trial first author subscription to the next Internal Medicine Congress (2005, Porlamar, Margarita) and for his/her expenses.

#### **8. HOW TO CONTACT US**

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The Chapter Governor will receive any contribution or "Letter to the Editor".