Medical records: reflex of physician-patient relationships

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Abstract

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The article presents a discussion on the physician-patient relationship, using records for this purpose, taken as an instrument of medical work capable of measuring the quality of the professional relationship. By being a document that logs information related to assistance, research and teaching, it is a communication element between services sectors, the institution, and patients. Based on research in five hospitals in Recife/PE, which shows the existence of medical records with low-quality in their completion, the study points as possible cause the maintenance of individual and organizational postures that establish distortions in filling up medical records. Based in the hypothesis that such situations may reflect an excluding autonomy relationship, as well as ethical fragility in physician-patient relationship. This article discusses, under the light of the contemporary theories, the possible intervenient factors in these relationships, and it concludes pointing to the importance of researches and new studies that would solve the repercussions in filling up the data contained in medical records

Key words: Medical ethics. Medical records. Physician-patient relationship. Professional autonomy.

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Correct medical practice should adopt as basic principles trust and respect relationships between physician and patient. Patient trust physician convinced that he disposes of needed knowledge to solve patient's problem, and physician's respect to patient bases in ethics principles of beneficence and non-maleficence [1]. However, in the 14th Century already, the crises in medical practice and education was reason for Petrarca's concern (1304-1374), who called the Pope's attention for lack of ethics of many physicians, and the risk of medicine imposition that killed without punishment rich and poor people.

Since then, medical formation followed different postulates up to the first decade in the 20th Century when significant changes brought in repercussions in professional practice, consolidating a new paradigm based in hospital internship and specialization. According to Mendes, the paradigm

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of scientific medicine, which consolidates with Flexner's report in 1910, becomes institutionalized through organic connection between the big capital, medical corporation, and universities, and starts to direct medical practice[2]. In the last decades, biology, specialization and technology were overvalued, with most visible consequence medicalization and physician's dehumanization, changing him increasingly into a technician, an expert, but in many cases, ignorant of the human aspect of the patient that he is caring, not knowing *the other* as the essence of his work .

Although at first sight, it may constitute a paradox of difficult visualization for many professionals, the belief on scientific truth has nothing scientific in it, acting as any belief in determining behaviors. Introjection of this standard tends to lead physician to adopt an asymmetric posture and hierarchically superior in the power relation that, inevitably, he establishes with patient. This is even more decisive and noticeable when caring occurs in health public services, whose patients are low-income families, social, cultural, and politically excluded within urban universe. As they present strong cultural and social different in relation to physician, they feel compelled into believing that they are not worthy of respect for their autonomy [3].

In this asymmetric context, physician tends to feel the herald of truth, either because he is effectively who has the knowledge to determine treatment that may provide healing or relief of symptoms presented by user or because cultural and social inequality marking the relationship makes those demanding his services to give him hierarchic primacy. Thus, both due to his own beliefs and by sharing it with user, who often reinforces it, makes him to feel invested with power to act in behalf of scientific truth, providing himself a superior hierarchic position.

Such power inequality manifests itself even in cases that, eventually, the resulting of his acting is more negative than benefic. Such power, often and inclusively, becomes an instrument to get profit, which derives from devotion to belief by both actors in the relationship: direct and indirect financial gain (by means of gifts, souvenirs, and travels) or simply by reinforcement of projection of a social image with differentiated status[3]. This circumstance ends by consolidating a practice that is not always benefic for a better physician-patient relationship (RMP).

Opposing this perspective centered in physician's power, a suitable RMP implies in quality, a decisive and essential factor for medical practice success. Improvement of RMP does not positive effects just in the treatment of disease and user's satisfaction, but it influences decisively in the quality of service. Health service user, in a good RMP, should be looked at with an autonomous being, with frailness, expectations, beliefs, and subjectivities, which should be respected by whom establishes the relationship – which should be of exchange, listening, and affectivity. Absence of such attributes in the relationship between professionals and patients may associate itself to part of discredit and distancing that one observes increasingly in patients. This situation is remitted to insufficiency in professional formation that does not valuate suitably interpersonal communication in professional exercise.

Medical record is the health instrument, susceptible to measure directly the type of quality between professionals and patients' relationship.

Article 1 of Federal Council of Medicine (CFM) Resolution no. 1,638 defines medical records, classified as: *document constituted of a set of information, sings, and images recorded, generated from facts, events, and situations about patient's health and the care given to him, of legal, secrecy, and scientific character*. From such definition, one obtains a document that pervades care, research, teaching, administrative, and legal control actions, in addition of communication element between internal sectors and between the institution and patient.

The importance of medical records as ethical element guiding physician-patient relationship is shown in Article 69 of the Medical Ethics Code (CEM, 1988): *It is prohibited to physician to not prepare medical records for each patient* [5]. This text is present again in the CEM that came into force in 2010, this time in Article 87 of Chapter X, referring to medical documents[6]. Medical records is a citizen's right, therefore, its undue use should derive in penalties. Article 39 of 1988 CEM, as well as Article 11 of current code, determines medical responsibility susceptible to penalties: *to prescribe or to attest in secret or illegible manner, as well as to sign blank sheet of prescriptions, reports, certificate, or any other medical document* [5,6].

Incorrect and/or illegible fill up of medical records has been one of the problems found in many Brazilian hospitals. In past years much has been questioned about scarcity and scarce legibility of data stated on them.

The *"Jornal do Commercio" (Commerce Journal)*, published in Recife, in this regard, gives its opinion: *physician's handwriting, here is the popular expression to characterize word writing that no one understands, often not even he who wrote it. This is due to the fact that physicians, generally, are foes to calligraphy. This deserves a research* [7]. This documental routine should nor or may not be faced with carelessness, as simple compliance to bureaucracy. The little importance given to it by public and private services should be of concern to those who desire a dignified care[8,9].

The quality in filling up medical records may suffer influence from multiple factors. Labor relations, in the organizational plan, may or may not allow for adequate conditions of attendance. Concerning work relations, maintaining agencies – public, and private – present significant differences of quality in handling their medical records. New technological methods, such as electronic records, may influence positively producing significant improvement in their completion and comprehension. Additionally to these specific factors, partially concerning implementation of computers technology, adequate professionalization, adoption of ethics principles, as well as knowledge and respect for the Health Single System (SUS) are decisive factors for a fair and respectful RMP, which may influence directly in the quality of medical records.

Low valuation of the medical ethics code also contributes for the current problems experienced in the RMP, leading, in some cases – to exclusion of the *other* in a relationship that should be full of exchange and dialogue. This practice of excluding autonomy denies the role of the main subject in the relationship, the user, as well as his inherent rights, mostly concerning the exercise of his autonomy. As counterpart, medical autonomy is conditioned by a professional formation whose predominant paradigm is the sheltering of biomedical,, who does not valuate biopsychosocial aspects inherent to citizens.

One may presuppose, therefore, that precariousness of RMP generates and be generated by a tension between autonomies. In one hand, the physician, in a context of dependence in continued technological innovations, not always supported by consistent clinical trials, surrounded by mythical, cultural, and organizational aspects, and in the other hand, patients with their fears, beliefs, frustrations, desires, and cultural traditions. One must highlight that this *other*, the user, needs to be cared and, as Ayres stated [10], to care someone is to intervene over him, is sustaining a certain relationship throughout time between matter and spirit, the body and the mind.

A medical record filled with insufficient or illegible data may represent a inadequate RMP that when undertaken in haste and/or superficially omits information, disrespect user's rights, and denies his freedom to have his clinical history preserved and documented. Medical records filled up correctly and legibly does not translate necessarily a good RMP for two reasons, a) data may be translating a merely biomedical sheltering, not including the biopsychosocial component; and b) may

have data that do not translate clinically user's status or do not represent a correct therapeutical project(anamnesis ill guided, incorrect auscultation, inaccurate diagnosis, inadequate therapeutics, etc.).

This article, originated in PhD thesis, gathers theories about the topic made available in literature, in an attempt to unveil intervening factors in the quality of medical records that, in our point of view, reflect the quality of RMPs

The right to health

Health characterizes as been non-dissociable right to life, locating, for the reason, among human being's most precious intangible goods, worthy to get state protecting tutorship. In Brazil, health care is any citizen's right and duty of the State[11], and it must be totally integrated to public policies, according to Ordagcy [12].

During last century, in 1948, in the post-war period and with the international commotion in view of atrocities undertaken, human rights got its most modern and important definition in the United Nations Organization (UNO),*Universal Declaration of Human Rights.* In consequence, each country's legal ordainment would tend to ensure domestically the fundamental rights (without losing sight of the necessity of joint internationalization), under the generalization perspective (extension of entitlement of these rights to all citizens). The Article 25, paragraph 1 of the Declaration sets forth: *every Man has the right to standard of living capable to ensure to himself and his family health and well-being, inclusively food, clothing, housing, medical care* (...) [13].

Two major documents for their universal and democratic character, in the health sector, were produce in two different moments: the *Declaration of Alma Ata* [14] and the *Letter from Ottawa for Health promotion* [15]. The first produced by the World Health Organization (WHO), in September 1978, recognizes health as fundamental social objective, and provides a new direction to policies of the sector, emphasizing community participation and basic health care as conceptual fundaments. The *Letter from Ottawa*, of November 1986, recognizes as fundamental prerequisites for health: peace, education, housing, purchasing power, stable environment, preservation of natural resources, and equity.

Health public policies history keeps close correlation with economic and political conjunctures. In case of Brazil, until arising of SUS, all attempts to implement health policies were tied to circumstances of the productive process, and they presented comprehensively excluding features. This historical process may be, for Acurcio [16], transforming in such way that the new one manifests in search of strategies to form including public policies, targeted to a more equal and less unequal society,

and without subordination to conjuncture trends.

Comprehensive health definition, consecrated since 1988 Constitution, conditioned current health policy. It implies in social obligations like: accessibility by every citizen, independently of his financial capacity or form (or possibility) of insertion in the labor market, capability to respond to requirement set by changes in the demographic frame, and of the epidemiological profile, assuring adequacy of actions to demands generated by the different sanitary framework, in the many regions of the country; construction and preservation of health, and not just healing diseases; working in articulated manner, making available the integrality of health care and supply of good quality services that require compatible human care, with sheltering – this later meaning dialogue, respect, and listening.

Medicine and medical formation

William Osler (1849-1919), in the United States in the beginning of 20th Century, considered as one of the most important worldwide figures of internal medicine, Master in semiology, and professor at the *Johns Hopkins University*, outstood himself in teaching medicine, calling attention for the importance of clinical history and of semiology in clinical rationale, warning students to listen to patients.

However, since 1910, with the arising of *Flexner Report* [17], curricula structure of medicine courses underwent fragmentation of specialization, making it difficult integral care and comprehension of patients. Criticism after the report, published in 1910 by the Carnegie Foundation, warned that it contributed to institutionalize the following elements in medical teaching: mechanicism, biologism, individualism, specialization, technificiation, and curism.

Technological progress introduced new elements to the diagnosis act, interfering in anamnesis. Fachini, Piccini, and Santos, regarding this aspect, state: *the semiological content is not structured from a careful anamnesis undertaken with time and clinical mastership*. And they add: *when the clinical exercise changes physician into a technician, two risks may be seen before hand: for patients, the iatrogenesis, and for physicians, his incapacity to understand patient's and sickness singularity* [18]. Feuerwerker[19] analysis the consequences of technological incorporation over formation and physician-patient relationship, pointing that technology acting as essential element in the diagnosis phase, reduced the importance of clinical history, and of the physical examination and, therefore, physicians contact with patient, and interest in his speech. Study undertaken by Grosseman and Patrício also shows several types of limitations in professional formation, highlighting that *o learning centered in diseases diagnosis and treatment, mainly in classroom and hospital context, generates insufficient opportunities to interact with community to understand its culture, and its health-disease determinants* [20].

Much has been discussed in the last years about curricula in medical schools in Brazil. The University of Pernambuco (UPE) undertook a long process (tem years) attempting to reformulate the curriculum of Medical Sciences School. Sampaio states in his Master's degree dissertation, about this: *it has not been possible to discuss with necessary and desirable comprehensiveness, the changes in pedagogic posture. There is the risk of implementing bureaucratic changes that little influence may have in the desirable changes in professionals' posture in view of their future patients* [21]. After five years, evidences persist that discussed changes in this statement need to be reevaluated. The topic *medical records* are discussed just in the first two teaching units. The adopted basic text presents the topic in just 10 paragraphs, and throughout the course, it is retaken only during internship.

As discussed, with arising of the 1988 Constitution brought new and comprehensive definition of health concept, transcending much the hegemonic conception existing until then. Law no. 8,080/90, the so-called Health Organic Law, consolidated constitutional postulates, and restated health as a set of actions with political, social, and economic character. This conceptual re-meaning brought in direct implications in physician's professional formation, requiring from them experience on universal access, quality and humanization of health care, with social control, which means effective and permanent integration between medical formation and medical services.

In view of the necessity to promote changes to achieve these objectives, Oliveira [22] evaluated the results gotten between 2006 and 2007 in the Incentive for Curricula Changes Project for Medicine courses (Promed), instituted by the Ministries of Education and Culture, highlighting the following difficulties, among others, faced in the formation change process: little sensitivity for professors (managers and consultants), little progress in school-services integration, with school managers stating that " service physician is not in condition to teach". One adds the severe ethical problem of school change be seen as possible to be done isolate from the health service (Promed consultant). This picture , full of obstacles and limitations, led the Federal government through the Ministry of Education, of the Higher Education Chamber (CES), and of the National Education Council (CNE) to institute Resolution CNE/CES 4 [23].

This resolution established the *National Guidelines of Medical Graduation Curricula*. In its Article 3, it establishes a series of recommendations, among which we highlight the profile of the graduated: *physician, with general practice, humanitarian, critical, and reflexive formation, capable to act, guided by ethics principle, in the health-sickness process in its different levels of care*[23]. Article 4, item I, recommends ethics and responsibility principles in professional practice: *-professionals shall carry out their services within the highest quality standards and ethics/bioethics principles, taking into account that responsibility of health care does*

not cease with the technical act, but with the solution for the health problem[23].

Medical formation requires effective application of these curricula guidelines, and the expansion of the approach to medical records exercise and of physician-patient relationship in all pedagogical units. Health organizations managers cannot omit themselves ethically from charging more appropriate postures regarding citizen's rights, and medical professionals cannot – or should – disregard his primary function: to protect and respect *the other*, dialoguing, listening, and incorporating his truths.

The meaning of ethics in the exercise of medicine

The adoption of ethical posture constitutes the essence of physician's work. In recent article, Oliveira Júnior [24] sets himself in regard to ethics as: *ethics is healthy for every citizen. It is, by saying, the thermometer that regulates human relationship, conferring satisfactory conditions to it for the development of each one's potentiality, seeking the concept of 'Well living', claimed by Aristotle. Medical ethics is coupled to a differentiated plus. In addition to philosophical finality, which shelters humanity with same blanket, the medical is targeted to those who develop care with health.*

In this perspective, to look the other seems inherent or mandatory for the exercise of a professional that does not exist without a relationship of two, at least. Relationship that must guided by the ethical principles of beneficence and non-maleficence. Morin understands that ethics is a re-connection with community and with the *other*, in such manner as: *every look about ethics should perceive that the moral act is an individual act of re-connection with the other, re-connection with community, re-connection with a society and, at limit, with the human species* [25].

In the current context of successive crises – of relationships, economic, of values -, education in medical ethics assumes significant importance. Dantas and Souza state: *the arising of bioethics, in 1971, awakened the attention toward the necessity of a transdisciplinary and holistic approach about the ethical aspects in health, expanding the scope of deontology and medical ethics disciplines to consider other issues that go beyond simple practical application of ethical concepts in professional realm* [26].

Survey carried out in 2004 [20] gathered information about physician's relationship with the other while still in the formation process. Students' discourse, when initiated in medical course, accounts for reasons as the desire to help others; to work with human demands; to save lives, and to shelter and mitigate people's suffering. In addition to yearnings of help, those of personal achievement coexist, such as social and financial recognition, and good quality of life.

The existence of multiple probabilities, often disconnected from sector and organizational reality, may generate, consequently, multiple frustrations in expectations, desires, and dreams when achieving the imaginary may contribute to

change ethical postures in relation to society, either as accommodation or as unfavorable reaction toward user, setting him as responsible. Coelho Filho considers, about this aspect: *the set of frustration of expectations, desires, and dreams ends by conforming a skeptical professional regarding the possibility (and necessity) of a humanized medical practice* [27].

Society, as we know it nowadays, is complex, comprising several world conceptions and views, which implies in flexibility and randomness. According to Mariotti, to understand and interact with current society it is necessary a new world view, which accepts and seeks to understand the constant changes of the real, and does not intend to deny multiplicity, randomness, and uncertainty, but rather to live with them [28]. Thus, in the context of complex societies, individual and collective limits, indispensable to ethical and solidarian social companionship, they acquire differentiated character. Morin states, about this: *the more complex is a society, the less rigid or coercitive are the limits that weigh over individuals and groups* [29].

To meet societies' needs, increasingly more complex, States organize themselves in sectors, and the health sector is one of the most illustrating of the multifaceted relations, either for overlaying existence of multiple interests or by the non-structured characteristic of problems that arise from social relations, as exemplified by the RMP.

Medical autonomy and practice

To adapt health services to different realities requires, among other aspects, to know the main actors participating in them. Actors playing in different realms of knowledge, in a complex multi-disciplinary companionship and generator of many conflicts and contradictions. Medicine, among other professional categories of the sector, presents technological, political, historical, and cultural particularities that set it in a hegemonic position in relation to the others.

It is important, in case of medicine, to dimension specificities and autonomy levels to understand the ethical aspects involving the profession. Under such vision, Machado places fundamental points that need to be considered: *medicine holds some social characteristics that make it paradigmatic: it has autonomy accrues power and decision about its actions, it has monopolist prerogatives, it has authority not only professional but cultural as well over its clientele, and it is self-regulated*[30].

Physicians work in a highly specialized market with knowledge considered as scientific, which can be acquired only in professional schools, accredited, and licensed by the State, which makes a differentiated professional since this instrument is self-regulated. There are not bureaucratic and managerial mechanisms that are able to control effectively physicians' professional activities [31].

medical practice, in capitalist production framework, and the hegemonic health model in force, it centers in liberal professional-client relationship and/or in a health service-user relationship. These relationships may produce inclusion or exclusion attitudes of attended subject in the medical act. This subject (the other), fundamental part in attendance, must be included necessarily in order to get sheltering, the dialogue.

The *other* is, or still, should and must be, the focal point of the medical act that based in Hippocratic principles, form the philosophical standpoint, and in the precepts of medical ethics code, under legal rule, is been treated in will suited way, with scarce dialogue, and incipient inclusion in the construction of the therapeutical process. Morin states, about this: *the exclusion principle is the source of selfishness, capable to require sacrifice form everything, of honor, of family, of homeland. But the subject comprises as well, in antagonic and complementary way, an inclusion principle that allows to include in his Self into a We (couple, family, homeland, party)* [32].

The otherness and acceptance of the other are fundamental in the emotion of love and in the establishment process of a language, a conversation. For Maturana, quoted by Tarride, *the social phenomenon, as well as the human, is founded in a emotion without which there would not be: love, understood as acceptance of the other in companionship* [33]. Wagner considers that clinical work needs to change its object and objective, seeking the social dimension of the subject in order to deal with people, with their social and subjective dimension, and not just biological; this is a challenge for health in *general, inclusively for clinic undertaken in hospitals*[34].

Autonomy, in determined historical moment, is described as the exercise of *good will, as* it is endowed with reason, whose fundament for such choices is morality. *Morality is, then, the relation of actions with autonomy of will, that is, the possible universal legislation through its maxims* [35]. According to Soares [36], to expand individuals' opportunities means to promote autonomy, as well to understand how power is distributed socially among groups to re-dimension its flow. Autonomy must incorporate the social, to consider existence of *the other*, mainly the object of action: which is the individual and the collective. For Morin, quoted by Tarride, this thinking and this complex praxis require a new way of acting that organizes, not command, that not manipulates, rather communicate, that does not lead, but cheers [32].

Even if set in cause while possible exercise of a free will, autonomy – along with justice – remained as guider in constructing citizenship in the last century, in the context of contemporary laic and plural societies. The concept of autonomy remits to discussions about its paradoxes, the relation between autonomy understood as freedom and collective's needs that relate themselves to balance between autonomy and justice[35]. Similarly, in the inter-subjective relations the exercise of autonomy is built by elaboration of the *other's* discourse, and not by its elimination, and the conception of subject is an instance not just of the *I think*.

One may classify it as active discourse established in relation to the *other* and to the world.

The concept of autonomy in Maturana and Varela, also quoted by Tarride, bases in the formation of the *autopoiesis* concept, used to characterize of living being capability to self-organize, to be able to constantly *produce* themselves [32]. In human beings case, the development of language would demarcate not just the development of a way of communication, but the development of linguistic behavior and, with these, the reflection and conscience, and in consequence, the human[30].

Medical autonomy, for the Federal Council of Medicine [6], is explicit in the new Medical Ethics Code in two moments: a) *in the initial considerations, when it states: the search for a better relationship with patient, and the assurance of greater autonomy to its will; and b) item 7 of the Fundamental Principles by making explicit: Physician will exert his profession with autonomy, not been obliged to render services that oppose to his conscience or to whom he does not desire, except situations of lack of another physician, in urgency or emergency case, or when his denial may bring damage to patient's health*.

In all conceptions worked herein, one finds the search for explanation of ways through which one builds autonomy, its effective possibility in the being and in being in the world, and its necessity and legitimacy, from survival in biological meaning until consecution of companionship, justice, and equity objectives within the scope of societies.

We prioritize the approach centered in the subject, not just by the initial approach character of this text, but as well for considering that, according to Morin, it is the major forgotten in the realm of knowledge production [25].

Thus, in addition to referring to cognitive processes, we seek to reflect about the issue in which the measure autonomy of *subject* that *knows* is important, and in which way it can contribute to necessary changes[37]. This new praxis bases itself in the recognition that user (the other), in addition to feeling himself vulnerable in relation to service and team for many reasons (emotional, cultural, economic, cognitive) he lives with difficulties of accessibility of several type (geographic, organizational, of work process). These factors aggravate themselves because an egocentric posture present in good portion of the companionships between teams and patients.

The relation between organizations and their member have been studied exhaustively, highlighting always the difficulty that managers experience when attempting to change an individual posture in attitude targeted to the collective. Dussault [38] states, in this regard, that a management problem is the adhesion of professionals to the organizational objectives, and that too much controlling and depriving autonomy prevents rendering of good quality services.

Egocentrism represents selfishness stimulator in individuals, and society lives with rivalries, competitions, and fights between selfishness, in such a way that even selfish interests may take over

governments. Bureaucracy and compartmentalization of knowledge generates exclusions and inadequate attendance: *the development of specialization tends to close individuals in a domain of partial and closed competence, from which derives fragmentation and dilution of responsibilities and solidarity* [39].

Health organizations, mainly the public ones, present pyramidal structures, segmented and fragmented. The administrative philosophy adopted is bonded more to the principles of patrimonial management, without flexibility, and strategic view. The relations of services and teams with patients have not been guided by the precepts of integrality and accountability with their territories. These behaviors tend to generate, in daily routine of relations, excluding and inadequate attendance.

RMP – autonomies under tension

Excluding attitudes and/or inadequate behavior may have origin in medical formation process, and it is externalized in services. Sanitarians and basic health clinic physicians answered a survey remitting to subjectivity treatment in the professional formation: *during academic formation, professionals learned to seek the object "disease" in people, and they missed the lack of approaches that stimulate their potential of relating with the other* [20].

Medical formation externalizes embodies in health services. Within the scope of formation or of professional exercise, inherent values to medical institution, often secular, pervade and conduct professional conducts. Clavreul, quoted by Fernandes, refers as this: *this institution has its predefined laws and statutes, as well as its control and inspection mechanisms, RMP becomes, actually, a relationship between the medical institution and the disease, not existing space for subjective presence, that is, for the subject of the physician and the subject of patient*[40].

This relationship institution-disease has generated dissatisfaction due to the impersonal and little affective character. Criticisms from society have echoed frequently and, according to Dunning, quoted by Grosseman: *one of the factors that have contributed to this is that, today, a more well informed population requires more consideration and transparency from medical professionals, in addition of safe professional models* [20].

A differentiated view, which takes as reference the social class situation, it is presented to us by Fernandes, evidencing the diversity of interests and political postures in the RMP: *there is not space, thus, for emergence of political counter-hegemonic contents in the medical consultation, that is, subjective aspects that comprise citizenship and, in behalf of a scientific neutrality, physician acts politically, conforming patient to the governing social order. RMP may be understood, in this sense, as a domination relationship by medical order over the society, and state domination over non-hegemonic classes* [41].

For Entralgo, quoted by Grosseman [20], physician-user relationship is a singular form of friendship human being/human being, that should encompass benevolence (to wish well for the *other*), *benedicence* (speak well of the other in as much as that one can do it without lying), beneficence (loyally accept what the other is, kindly helping him to be what he should be), and benefidicence, which a effusion – expansion of affect – toward the other, to share with him something that intimately belongs to him, in which happens confidence.

However, the most varied factors interfere in the RMPs, making it difficult to understand the other, glossing affect, blocking dialogue. The influence of external causes to the relationship are commented by Fernandes: *the anatomy-clinical rationale is often insufficient to care the suffering presented to physician, whose predominant causalities, in majority of cases, are found in other realms of life, that is, in social, emotional, environmental, etc.* [41] Concerning historical, organizational, legal, ethical, and clinical process of following up RMPs, physician does not have other documental tool than the medical records.

Survey carried out in Recife confirms the recording of this fact in area literature, and corroborates previous impressions, pointing to worrying picture related to completion of medical records. In the chapter referring to the discussion, Sampaio and Barros state: *considering the summation of all items, of all clinics, in a total of 25, it was evidenced that in the first visit in all three levels of complexity presented completion level predominantly very bad*[42]. From this, one concludes that the main instrument to certify the ethical and technical quality of the RMP still lags behind. Thus, it is important to foment ethical education of the professional to provide him with capacity building to respond effectively patients' yearnings and needs of his services.

Final considerations

One of the products from RMP, the medical records, should change in live report of user's life history instead a mere bureaucratic-accounting instrument, as many hospital units treats. The findings in clinical exams, diagnostic hypothesis, conducts, and recommendations must be documented, recorded for the future of the relationship. A future that implies responsibilities, continuity, teams' involvement with citizens within their territories of action. One understands that the more fruitful and respectful is the relationship with the other, more information shall be documented in the health services.

Physician is the *other's* clinical biographer. As biographer, he must take responsibility of the historical truth of the essence of his professional *praxis*. In order to medical records correct completion be valuated and solution are sought to re-mean it, it is indispensable to undertake studies and survey focused over this important professional practice element. The simple adoption of new technologies, like electronic medical records may be innocuous if we do not re-qualify the meetings between professionals

and patients. The change of physicians into effective and responsible caretakers must be consubstantial for the obsessive search for quality of professional formation by educators and managers, as well as regarding medical records that, should be seen, as key-element of recording and communication in a RMP.

The reality experienced in services, and in the practice of teaching medicine has stimulated and reinforced the need of theoretical deepening in professional formation, as well as the undertaking of surveys about the medical records problematic. Either from the individual point of view or from the organizational dimension, is noticeable the necessity to identify the reasons for found reality, to generate inputs for new surveys and didactic material for discussions within undergraduate and graduate scope. Thus, one may strengthen learning and institute new caring postures regarding patients' autonomy, in a relationship that is guided by listening, dialogue, and by a preponderantly biopsychosocial sheltering .

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Resumen

Prontuarios médicos: reflejos de las relaciones médico-paciente

Este artículo presenta un análisis de la relación médico-paciente, utilizando el registro médico, tomado como instrumento médico capaz de medir la calidad de la relación profesional. Debido a que el documento que registra información sobre la asistencia, la investigación y la enseñanza, es un elemento de comunicación entre los sectores de servicios, la institución y los usuarios. Basado en la investigación en cinco hospitales de Recife, lo que indica la existencia de registros con relleno de baja calidad, el estudio sugiere una posible causa de mantener posiciones individuales y de organización, que proporcionan una distorsión completa de las listas de éxitos. Partiendo del supuesto de que tales situaciones pueden reflejar una relación de autonomía de exclusión y de debilidad ética en el médico y el paciente, este artículo describe las teorías contemporáneas a la luz de los posibles factores implicados en estas relaciones y concluye resaltando la importancia de nuevos estudios de investigación que den a conocer las implicaciones para la terminación de los datos contenidos en registros médicos.

Palabras-clave: Ética médica. Historia clínica. Relaciones médico-paciente. Autonomia professional.

Resumo

Prontuários médicos: reflexo das relações médico-paciente

O artigo apresenta discussão sobre a relação médico-paciente, utilizando para tanto o prontuário, tomado como instrumento do trabalho médico capaz de mensurar a qualidade da relação profissional. Por ser documento que cadastra informações a respeito da assistência, pesquisa e ensino, é elemento de comunicação entre os setores dos serviços, a instituição e os pacientes. Pautado em pesquisa em cinco hospitais em Recife/PE, que evidencia a existência de prontuários com baixa qualidade de preenchimento, o estudo aponta como possível causa a manutenção de posturas individuais e organizacionais que estabelecem distorções no preenchimento. Baseando-se na hipótese de que tais situações podem estar refletindo uma relação de autonomia excludente, bem como fragilidade ética na relação médico-paciente, este artigo discute à luz das teorias contemporâneas os possíveis fatores intervenientes nessas relações e conclui apontando a importância de pesquisas e novos estudos que desvendem as repercussões no preenchimento dos dados contidos nos prontuários médicos.

Palavras-chave: Ética médica. Registros médicos. Relações médico-paciente. Autonomia profissional

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