Chapter 3
A Personal Reflection on the Core of Medical Practice

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> An empirical science deprived of reflection as well as a purely speculative philosophy is insufficient. Consciousness without science and science without consciousness is radically mutilated and mutilating (Edgar Morin, French philosopher and sociologist, 1921–)

3.1 Introduction

> No one is equal to anyone. Every human being is a unique stranger (Carlos Drummond de Andrade, Brazilian poet, 1902–1987)

We live in a time when the virtues of science are idolised almost as if it were a new religion. Science is believed to be based exclusively on technology, and technology is based only on mathematics. We theorise that all humankind's enigmas and problems can be expressed through numbers and equations, and the qualification of something can boil down to its mere quantification. Therefore, distinguishing the virtual from reality is increasingly more difficult. More and more, people tend to go through life alone, surrounded by many other humans who share the same loneliness. The hyper-information of contemporary society often makes it difficult for anyone to have an informed opinion and make a conscious and autonomous decision. Fruitful introspections and dialogue are increasingly rare. In a society where everyone runs, often by inertia, uncritically mimicking what they see in others or at the behest of some sinister 'Big Brother' because they are no longer able to stop, to appreciate silence, stillness, be enchanted by the simplest things or sympathise with the fragility of Man. For the remaining minority, time has become a secret luxury

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J. McFarland et al. (eds.), *Humanism in Surgery*, New Paradigms in Healthcare,
https://doi.org/10.1007/978-3-031-86018-8_3

that cannot be dispensed to maintain the indispensable emotional and psychological balance and thus face daily life better. Life, at present, has all of this and, therefore, there are clear and substantive implications for the practice of clinical medicine.

As far as medicine is concerned and regarding the exercise of clinical activity, which I consider to be its core, present times are characterised by the progressive devaluation of clinical semiology and anamnesis as a structuring element of the medical act, by the artificial refuge in solutions that predominantly refer to the use of technological means, by the unconscious escape from scenarios in which the suffering of others—as well as one's own—by the subconscious denial of the inevitable finitude of life, as well as the conscious, unconditional, and sometimes even unbridled search for pleasure, infallibility, and fame at any price. Unfortunately, the practice of medicine is increasingly submerged in a complex, inoperative, and absurd bureaucracy, implemented with the official seal of a hierarchy that has led the policy of this complicated sector, with the unacknowledged and apparent purpose of making the time spent by its professionals profitable when what is essentially intended is to have obsessive control over all countable indices; even though, in reality, this is not even adequately achieved, in many circumstances, due to the blatant inoperability of the computerised means made available!

It is a scenario where the excessive and indiscriminate overvaluation of the results of auxiliary diagnosis means prevails, not rarely as a means of promoting them, as if it were a mere business, to the detriment of humanisation in the attitudes and empathy in the decisions between those who are supposed to be the 'only' and 'true' interlocutors in this particular relationship: the Doctor and the Patient.

3.2 The Mission of the Physician

> The thought of death deceives us; for it causes us to neglect to live (Luc de Clapiers Vauvenargues, French philosopher and writer, 1715–1747)

There is a notorious and growing gap within the community of medical graduates: those who are physicians and those who, by not being so and working in the execution of additional diagnostic tests or techniques or the planning and analysis of the determinants in health or Politics, never lose sight of the notion that their work is equally fundamental to compose, with the necessary adequacy and intelligibility, the indispensable puzzle to arrive at a correct diagnosis (clinical, psychological, and social). So, for the best possible treatment of the patient (and the citizens), and when seeing an image of a fragment of the body of an anonymous human being (on the computer or under the microscope), when handling any of its biological products, when performing an instrumental procedure, more or less invasive, when writing or analysing reports, or when legislating on the regulation of this complicated sector, never forget that all actions have repercussions, directly and indirectly, on someone who is suffering and needs their decisive contribution… and the others! Those who only see figures and financial returns, often for their profit and of speculative origin, look at the patient as a mere means of survival. Or equally reprehensible, those who only care about their fame and appearing in columns at the expense of disproportionate propaganda of their successes. Those who sit comfortably at a desk across multiple departments (governmental or private), exercising their power in a detached, despotic manner, constantly using linguistic euphemisms to hide their repugnant hypocrisy and their profound indifference to those who suffer and to whom the first and last mission is to alleviate physical and psychological pain, contributing decisively to restoring possible autonomy (those of the first group).

Being a physician and practicing medicine is not to have a profession like any other. Health and disease, life and death, suffering and physical and emotional well-being, are anything but irrelevant and what we should cherish the most. Because our more precious collective civilisational heritage is the uncompromising defence of these principles, since we are invested in the honourable and timeless role of being our patients' most interested and competent advocates. With competence, empathy, compassion, humanism, and common sense, we should try everything to avoid or minimise the patient's suffering because making them suffer without a reason will never be part of our mission. This job will be all the more successful if a physician knows how to be more than 'just' a doctor, adapting to each particular case and transforming this point of view into something special that becomes an integral and inextricable part of his being. We should always bear in mind that clinical activity lives from its context. Feelings and antagonistic realities such as successes and defeats, hopes and frustrations, suffering and joy necessarily abound because man's journey on Earth is composed of a mixture of life, health, sickness and death, pleasure and suffering, and in all of these stages, a doctor may be called upon to intervene and help.

Given what has been said, if anyone thinks the mission of a physician is only the proper diagnosis and treatment of the diseases, he his entirely mistaken. I could not agree more if we add the vital respect for the norms of medical ethics and deontology, but I still find it largely insufficient. By adding empathy, compassion, and concern for the psychological and social conditions of the patient and their family and professional environment, we will be much closer to the ideal. However, even then, it will be insufficient. Isn't renouncing to agree with the patent exiguity of the minimum conditions for treating patients with adequate dignity and humanisation the last mission a doctor can resist investing in, when everyone collapses in front of him? Because to do so, when dealing with the problem of health and disease, particularly in the context of a real catastrophe, is really to be a doctor. Furthermore, either we are that way, or our mission is inescapably lacking and incomplete.

3.3 The Medical Act

> We are completely immersed in this world belonging to our sufferings, our happiness, and our loves. Not to feel is to avoid suffering, but also rejoicing. The more qualified we are for happiness, the more qualified we are for unhappiness. (Edgar Morin, French philosopher and sociologist, 1921–)

Figuratively speaking, the medical act is a meeting between two persons of sound body and mind, resulting in the correct diagnosis and effective treatment of the patient's disease, even when palliation is the only option.

The Hippocratic Oath, so often repeated, only because it seems wrong not to do so, 'to cure sometimes, to relieve often, and to comfort always' is what best defines the physician's mission. A timeless imperative of professional conscience, it also contains something of such transcendent importance that it can only be accomplished, step by step, in a path of solidarity and unreserved partnership, in which the idiosyncrasies of both physician and patient enhance in favour of spiritual communion, imbued with solidarity, compassion, trust, and empathy. This allows, where applicable, an acceptance, with the least possible suffering, of disability, when not, of death itself, however, without ever removing the last spark of hope. It is necessary to recognise that the indispensable dialogue continues beyond simple words, and a therapeutic result is not restricted to the adequate use of drugs or surgical instruments. Therefore, the actual dimension of this unforgettable act, from beginning to end, should only bear these two committed protagonists: The Patient and the Doctor.

I often whisper to myself, 'How do I do it?' when addressing unique issues, for example, impending death, with patients or their relatives. I always conclude that one should never try to anticipate the natural development of events, show as much calm and availability as possible, make others feel our presence in a supportive and professional way, not rationalise or overdramatise our speech, and know how to use body language appropriately and spontaneously. To know how to listen attentively to the family members' venting, look each other in the eye, not be afraid to get emotional and provide a space for others to do so naturally, are ways of transmitting the necessary messages of serenity and complicity that allow us to mitigate the suffering of others.

It is also relevant to mention, besides the physician never abandoning a patient, even if the pathology has no cure or specific pharmacological or surgical treatment available, he must always know how to comfort, give hope, and help to accept and understand the nature of the disease and, if necessary, death itself. Whenever, when I have this kind of conversation with patients with a reserved prognosis because they suffer from evolutive diseases that spare consciousness and lucidity, I always end up concluding that we have to do it without any reservation or previously established clichés, letting the speech flow spontaneously with a serene tone and in an environment as calm as possible.

It is crucial not to stray from the point, not treating the patient as if they were an 'ignoramus' or a 'poor thing'. Knowing how to convey the truth, which means to know his personality and making yourself known as a person, is fundamental, as is having the courage to openly acknowledge what you do not know and be willing to ask for advice from more knowledgeable and experienced colleagues. Respecting their wills and values and being firm and cautious in dismantling the web of ideas devoid of any scientific basis, without ever withdrawing the last shred of hope, completes the list of requirements. This is learnt through experience, dialogue with our mentors and patients, their families, and friends, as well as vital constant reflection on our professional practice and its fundamentals—writing, reading, analysing, and discussing. True medicine is precisely this—everything that the venerable tradition going back to Hippocrates has handed down to us over the centuries and nothing else.

Knowing how to support those accompanying the last moments of someone's life, showing gestures as simple as looking into the other's eyes with tenderness, gently holding hands, and silently listening to their loved one's breathing is, in fact, the most humanising way for a person to say goodbye to this world, being the most human of all available treatments. As long as the gesture is spontaneous, it can be immediately felt by the patient as a form of warm bodily, tactile, and auditory language that carries a message of professional competence, availability, solidarity, and relational affection. It can trigger a subliminal expression that must be correctly interpreted and contextualised by the physician, materialised in the exteriorisation of a whole important set of feelings often reflected fleetingly, although quite significantly, in the patient's face.

Suffering is a part of human life. The search to avoid it is one of the physicians' inalienably noblest missions, as much as speaking the language of truth and knowing how to transmit the prognosis inherent to the formulated diagnosis properly. However bad it may be, it is necessary to find the means, the time, and the place best suited to the specific circumstance and with respect for the patient's autonomy and personality in an atmosphere with indispensable affectionate complicity. This is one of the pillars upon which the ethics of interpersonal relationships must be based, especially in the context of the physician's relationship with the patient and even more so in the context of diseases with a reserved vital or functional prognosis.

3.4 Technology in Medical Practice

> We cannot stop in time… for the first time, an invisible and unknown being has paralysed the entire civilisation of technique. Until yesterday, we could consider ourselves omnipotent amid the rubble, the first and only ones also in our primacy of destruction. We had forgotten that to exist is to breathe (Donatella Di Cesare, Italian thinker and essayist, 1956–)

Technological development will always continue to improve. It has brought and continues to bring new and substantial benefits to humanity. So, it is not desirable, nor possible, to claim that it should be merely suspended, just as it is also undesirable to deny the clear evidence of its recognised virtues, which imposes the recognition that the resulting scientific advances have brought about a notable increase in survival and quality of life for patients and populations.

However, it is equally valid that clinical activity is increasingly being (unduly) subordinated to the blind and crushing advances of technology and the absurd demands of the bureaucracy imposed by the most diverse institutional hierarchies. As referred before, semiology and anamnesis have progressively been devalued and no longer occupy their rightful top position. In fact, they are the first indispensable pieces to guide the judicious requisition of auxiliary means of diagnosis and to the formulation of a prior assertive differential diagnosis. However, they are nowadays unfortunately neglected as a privileged way of emotional closeness between doctor and patient.

Acknowledging that using technological means, in the context of the medical act and the doctor-patient relationship, should come first and foremost in the course of a path mapped out by these two persons and with the necessary logic and coherence, but never at the beginning or end of it, or even as the result of a solitary decision removed from the respect due to the expressed and informed will of the patient, even if well-intentioned.

For example, remote work and telemedicine are not to be thought of as anything more than a possible, albeit merely transitory, means in particular contexts, such as that of the pandemic or when accessibility is an insurmountable obstacle or one that is notoriously difficult to overcome because they will never be able to resolve, in the long run, most of the dysfunctionalities concerning the mission of health-related professions that provide direct clinical care, since human contact is something irreplaceable because it is only through this that the medical act performs with all its full humanisation.

In the doctor-patient or mentor-student relationship, replacing face-to-face consultations with a computer or a telephone conversation and a live class with a computer might be the most acceptable transitional measure as an alternative to its endless postponement. Alas, that it is, and will never be the same, must be pedagogically recognised. Just like in the relationship between two lovers or friends, the touch, the variations in physiognomy and tone, the spontaneous smiles and cries, in short, the availability of healthy face-to-face interaction, transmits semiotic and affective signs that duly contextualised allow each of the actors to leave, saying that it was worthwhile, that it was for this that they went there, or that time was well spent.

I believe that 'voluntary' limits should be set to scientific and technological development so that they do not give us the intoxicating prospect of becoming immortal or turning us into mere bionic beings. Because that would make Man a predator of his fellow Man, as well of himself and all Humanity. Because that would be equivalent to becoming equal to divinities and therefore ceasing to be fully-fledged Human Beings. Because that would mean pretending to materialise the spirit in total opposition to its essence. Because that would represent something that would contradict the timeless logic of the universe, in which everything is constantly recycled and transformed. Because life must originate from another life and never be an obstacle to continue so ad eternum. Because nature's resources are finite, we cannot lose this vital notion of survival and healthy coexistence. Thus, we must contribute that those to come will also have the conditions to carry out their projects with the same freedom and responsibility, as well as with identical social rules and imbued with identical values of previous generations. We have to accept that the iron molecule of haemoglobin that is in the blood of any one of us, nobody knows where it came from or where it will go after we die, but that it should continue eternally to circulate in the same way throughout the cosmos, just as it did before. This is an absolute condition for maintaining the existence of our collective home, called Earth, which we have no right to mortgage for excessive ambitions and empty of any real sense of civilisation.

Thus, we can consider that technology should be used as a mean, but not as an end in itself, since, as the venerable colleague Mário Moura says in a certain text full of provocative interpellations, ‘eye to eye’ and ‘skin to skin’, (to which I would add ‘mind to mind’) is something simultaneously so simple, so intuitive, and so transcendent, that it is capable of carrying an irreplaceable intrinsic therapeutic and civilisational value, whether from a strictly medical or psychological point of view or an anthropological and even philosophical one. Something that the cold contact between man and machine can never provide.

3.5 The Doctor-Patient Relationship

> No human life, not even the life of the hermit in nature’s wilderness, is possible without a world which directly or indirectly testifies to the presence of other human beings (Hannah Arendt, German American philosopher, 1906–1975)

The doctor-patient relationship is that special *meeting* between two people, where respect for the right to confidentiality and free choice, without prejudice to others, must never be absent, just as the timeless values of professional ethics and deontology can never be alienated. Attitudes are best born from the genuine feeling of solidarity and compassion of the doctor involved, where physical and affective closeness between the doctor and the patient is determinant because indifference and distance between these characters should never be part of the essence of the medical act.

One of the practitioner’s noblest attributes is to decode, through clinical observation, the moods of their patients. In their facial expressions. In their eyes. In their gestures. In their voice. Taking a humanised and individualised clinical approach by reading between the lines of the patient’s speech, in the sense that the patient will accept the decisions as they feel well-founded. This allows for the necessary internalisation after they have had the opportunity to express their fears, their doubts clarified, and their idiosyncrasies and wishes respected. If deciding and acting is an intrinsic part of the essence of the medical act, we must also bear in mind that, however much medical science we may know or clinical experience we may have, its consequences are unpredictable. We must strive to find the right balance between our convictions and intentions and the will that emanates from the values of the patient and/or their family, however unexpected the events may be.

This relationship implies being available to know how to overcome, if appropriate, the traditional conventionalisms imposed by society, from the time, place, or fees, to the use of the typical instruments, exchanging the stethoscope and the sphygmomanometer for the use of the word, the look and the gesture, promoting the creation of an environment in which the exchange of emotions is much greater than the faultless compliance with the dosage of any medicine. It will be, therefore, caring for our fellow man, where elements such as music, for example, can work true ‘miracles’. This is inferred from what Plato, the great philosopher of ancient Greece, wanted to express when he said, '[music] gives soul to the universe, wings to the mind, flight to the imagination, and charm and gaiety to life and everything'.

As I am trying to demonstrate, being a doctor is knowing how to go beyond the strict role of a mere 'physician'. In a broader sense, it may even mean not having the mission to prescribe additional diagnostic tests or pharmacological therapy. It can be materialised 'only' in an encounter capable, more than anything, to provide the possible pleasure in each circumstance to someone concrete, to whom we help, understandably full of uncertainty about his future, that find the way to free himself from the interminable labyrinth that the incessant search for knowing how to answer the questions relative to the causes of the cataclysm that has suddenly and inexplicably fallen upon him. Why me? Why now? Why this one and not another disease with a not-so-inexorable path to almost complete dependence? Why is this disease still untreatable? Why does this pathology spare the mind but leave the body completely inert?

Every time I left Fernando's house (a pre-terminal ALS patient I regularly followed for several months), I wondered what the real impact of my visits would have to him. Perhaps the comfort provided by friendship and empathy, the only possible 'medicine' in these circumstances, would be much more effective than the remote possibility of having had access to any pharmacological innovation, the usefulness of which, at that exact moment, would have been highly doubtful, as he lucidly recognised, given that the reversibility of the clinical picture would not be within reach of any reasonably expected scientific advance. Moreover, the true purpose of medical art was fulfilled, even in an unconventional way: that of making the patient accept, with the most extraordinary possible tranquillity, the prognosis of his illness, without ever resorting to the trick of shirking this responsibility by giving false hopes.

However, as I experienced during the pandemic, there are circumstances in which words are of little help. What they express needs to include the effective translation of the reality internalised by the emotions we share with the patients. Pertinent information and, at the same time, knowing how to convey hope is one of the doctor's noblest missions, even in clinical situations of recognised poor prognosis, above all in the case of major natural catastrophes. Besides having to try to respect (if possible) everything that is required in the most common clinical situations, it has the particularity of taking place among people who are subject to overwhelming emotional stress, in which the feeling of vulnerability of the Human Being is terrifying, the lack of resources is extremely limiting, the time available for each medical act is extremely short, the pressure of the circumstances and surroundings is overwhelming, interpersonal, verbal communication is difficult or even almost impossible, in short, the prevailing feeling will often be that the end of life, and perhaps of the world itself, may be imminent.

Although all this may undoubtedly be a reality at any given moment, it does not imply that the spark of humanism and goodness, capable of transforming that moment into an unforgettable one for both protagonists, is missing. There are times when what in other circumstances might have been trivial and devoid of any noteworthy meaning can become something so precious that no words can describe it.

Only the heart can understand, and the participants' memory makes the correct registration. Forever.

In other words, as long as Man is the Being that we know today, with the ability to feel emotion, to feel compassion, to feel indignation, to carry a remarkable set of civilisational values accumulated over countless generations, to be able to make choices and ethical judgments based on them and to possess body and spirit, he should always be treated by someone with identical attributes. When one of these days, in a more or less distant future, comes to be a bionic Being composed of a set of electronic circuits and pieces of disposable inert material, it will then make all the sense that it is treated as a mere 'robot' and not as someone originated and created with love by fellow beings; perishable, fallible, endowed with emotional intelligence, and a rough amalgam of hair, skin, muscles, bones, nerves, blood and soul made, because that is the biological magma sprinkled with feelings where the beautiful and imperfect structure of the Human condition is based.

3.6 Conclusions

> In the depths of love there is the desire for eternity (Friar Bento Domingues, Portuguese theologian, 1934–)

The 'idolised' quality of life does not necessarily translate into a long one. Functional aspects and the capacity for self-sufficiency are fundamental for each person to feel true happiness. Not to be in pain. To have a restful sleep. To take pleasure in relating to others, be it family or at work, when eating, when drinking, when smelling a perfume, a delicacy, or your lover. When contemplating your partner, children, parents, grandchildren, siblings, colleagues, neighbours, landscapes, poems, or canvas. On holiday or in the hustle and bustle of daily life. When hearing the first cry of your first child, the moan of sexual pleasure from one's partner, or a favourite tune. When feeling the energetic handshake of a long-standing friend or the caress of someone with significant emotional ties to us. All this is fundamental to the fulfilment of each of us, although each one is free to have their natural preferences in how, when and with whom. Or with no one else!

To safeguard an eminently humanistic posture in the medical practice it is necessary to invest in the training of new students and interns in Humanities (Ethics, Philosophy, Sociology, Anthropology, History, Literature, Painting, Music, Theatre and Cinema), together with the study of the medical field itself, instead of always deifying the omnipotent, omniscient and omnipresent capacities of cold technology, which seems to make everything credible in the eyes of men and represents the infallible answer to all their doubts and problems—addressing that there are not just one, but two equally valid meanings for 'Personalised Medicine'. The traditional version that should never be abandoned, according to which its exercise should always assume respect for ethics and the set of characteristics (psychological, philosophical, anthropological, sociological and religious) of each individual in pursuit of the principle that says 'an identical disease in a different person is a distinct disease', and, the most recent, but equally valid and promising, in which what is valued above all is the singularity of the genetic heritage of each being, and, in this way, one can better understand why a particular physiological phenomenon, in different patients, produces different effects, or why, for the same disease, different people react differently to the same pharmacological treatment.

To obtain the maximum benefit for the patient, it is necessary to improve knowledge in clinical semiology to make better use of technological means and not by its mindless generalisation as if it were a panacea or an obsession taken to the extreme. We should be concerned with promoting the return of a particular tradition of respect for hierarchy based on professional experience, solid scientific knowledge, the capacity for intergenerational transmission of knowledge and the establishment of empathetic inter-human relations, and mutual trust and respect, solidly based both on professional ethics and deontology, and also on the venerable collection of values inherited from our timeless mentors, instead of, counterproductively, relegating it to second place before the whirlwind of required assistance goals, calculated according to mere quantitative indices, but increasingly separated from the fundamental needs felt by both professionals and the patients themselves, and also because this is very important for the training of new generations of doctors and the practice of humanised, holistic, personalised and quality medicine.

For these reasons stated above, the medical practice of this unforgettable craft and its teaching must be founded to avoid being overwhelmed by anguishing and lacerating doubts accompanying us in our professional life. In reality, we have not been formatted to peacefully accept the error, even if inherent to all professional activity and involuntary, and of not having managed to avoid the unexpected death of our patient or to arrive at the exact diagnosis in time. As much as we do not want it to be, this is like an accusation before the court of our mind and soul. We assume it, subconsciously, as a defeat that is difficult to accept naturally. Where did I fail? Where I was not assertive enough in the timing of the clinical process? What alternative therapy should I have prescribed? What diagnoses have I not thought of?

My opinion regarding the eternal and never conclusive debate about the nature of medicine in which it is discussed if it is an Art or a Science is that it could, and should, be both! It is an 'Art' that aspires to use scientific methodology and adopts the so-called basic sciences to construct its principles and values without being a pure science itself, nor even claiming or having to restrict itself to this condition. Therefore, it is Art in the way of the relationship between the Doctor and his patient. It remains Art in the appreciation and context of the subjectivities of anamnesis and emotions in the clinical decision. It is also Art in the intellectual and aesthetic conception of the architecture of differential diagnosis. In everything else, it is Science.

We must assume without subterfuge that to diagnose, treat, cure, care for, accompany, or share in solidarity the joy, anguish, and suffering of others is to understand the essence of Man and Humanity, dictates to which no one should remain indifferent, especially not a doctor, nor a good governor, being unaware of the singular core of human nature or being indifferent to the consequences of suffering and disability. Understanding someone's illness goes far beyond diagnosing and treating it with competence and professionalism. It must also aim to seek knowledge of the multidimensionality of the person suffering from it. Medicine should always be practiced from Man for Man, or it will never be able to use this millenary epithet.

In an admittedly provocative conclusion, the physician should never contribute, within the scope of their correctly understood mission, directly or indirectly, implicitly or explicitly, to any member of our species taking possession of what should remain the exclusive and distinctive property of divinities that is, access to eternity, as I think is symbolically underpinned by the 'almost touching of the fingers between God and Man' in the timeless painting by the brilliant Michelangelo, called The Creation of Adam, on the ceiling of the Sistine Chapel. Death is the last chapter of life and an indissoluble part of it, and also an indispensable condition for the dignity and maintenance of our collective existence in this 'house called planet Earth' that we inhabit and must continue to healthily inhabit so that future generations may feel the pleasure of living there, a condition to which all Human Beings legitimately aspire to.

In short, not everything that is technically and scientifically possible to implement is ethically licit since the eventual implementation of that hypothetical scenario would be like a new Holocaust, in which the victims would not now, as in the past, be only the believers of a particular religious faith or ethnic group, but rather all of Humanity. Signalling the end of medicine, the Medical Act, and the Doctor-Patient relationship as I think it should be understood.

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