In examining the marital status of health care and medicine, the first step is to recognize that there are two things rather than a unity. Another essential step is to acknowledge that melding the two into one may have consequences — gains, losses or both — for either of the things so confused.

Dr. Patrick laments the loss of a culture based on the doctor-patient relationship. Drs. Lindsay and Herbert “have difficulty understanding Patrick’s dichotomy between health care and medicine.” Truly, they “know not Joseph” and, from méconnaissance, assume that he is talking not about culture but about the culturally bereft concepts of disease care and health care. The position they advocate is based not on culture but on the “new medicine,” which replaces medical culture with one governed by “utility” and “systems thinking.” However, I am unsure whether this new culture is really useful or systematic or whether it takes possession of these terms in a way more colonial than sensile.

Two historical analogies are useful in considering the two perspectives on medicine presented. The first is the relation between the classical Greek and Roman cultures. There is no dispute that there were two cultures and that the Roman one overpowered and replaced that of the Greeks. It is also accepted that classical Greek culture enriched that of the Romans.

The second analogy is to the indigenous North American peoples and the European “discoverers.” Here, too, one culture was overpowered and replaced by another. In this case it took several centuries for this fact to be commonly accepted. Throughout these centuries, North American indigenous culture almost disappeared: the languages, religions and values of the indigenous people were overlooked except when they obstructed the dominant mercantile culture.

With a bold move based on a lack of understanding of their adversary, Drs. Lindsay and Herbert made him “disappear.” They do present significant concerns about the difficulties inherent in the divorce proposed by Patrick, including the loss of efficacy of the very advice they decried as paternalistic. These difficulties are real, but to my mind they do not imply that there is no difference between medicine and health care, that nothing is being lost (for good or ill or both), or that we should boldly advance toward the best of all possible worlds without acknowledging these losses.

Patrick’s proposed solution is not the only possible one. Cultural revolutions can take many forms: physicians could be placed on reserves or otherwise rusticated, or the bones of medical culture could be ground into bread to feed more pragmatic vehicles such as campaigns for smoking cessation and other promotion of healthy living. The aim is not to reach an immediate solution but to start to address differences. This can only be done if the differences, and the nature and scope of the losses associated with change, are clearly conceived. Patrick, Lindsay and Herbert have taken valuable first steps toward clarifying these issues that we cannot afford to continue to ignore.

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[The authors respond:]

We understand full well the moral vision described by Dr. Williams in reference to Dr. Patrick’s position. We respect our colleagues’ view, but we reach a different conclusion from our experience as practitioners and medical educators. As we learn about and deal with the complexity of health and illness in individuals, families and multicultural communities, we conclude that a pluralistic, relativistic ethic is necessary.

We recognize that there are two concepts — health care and “disease care” — or medicine — but we see them as connected. Dr. Elliott’s historical analogies confuse us. We do not see physicians as caregivers disappearing or a new culture “overpowering” the existing one. Rather, we see in our recent well-rounded medical students, representative of the Canadian cultural mosaic, an evolution. They are learning communication skills that will enable them to provide care along a spectrum, from prevention to disease management. In today’s medical schools students are learning to work with other health care professionals and to respect the expertise of patients and health care workers who are not physicians.

We do not despair of the modern physician but see the “humaneness” of medicine as alive and well.

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Paging medical interns

Dr. Richard Harvey and associates should be congratulated on their research into the on-call aspect of internship (Can Med Assoc J 1994; 151: 307–311). More than a decade after my rotating internship, I still find myself talking about the experience in conversations with other professionals outside of the health care field. They listen in disbelief to my account of the hours worked and demands made.

In addition to documenting the demands on interns, the article proposes strategies. In a general practice in which house staff are not available I have noticed that preventive procedures of the type suggested, such as reviewing medications and ordering routine medications ahead, become commonplace in order to reduce the number of night calls. I have also heard anecdotally that in such a practice night calls are unlikely to go to a family physician or even a consultant; the nursing staff often deals