Editor's preface

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Humanism emerged as a coherent philosophy in the 14th and 15th centuries, when scholars and artists, rediscovering Greek and Roman classics, wrote about the dignity and worth of human beings. As our century comes to a close in a whirl of technology, humanism — or the lack of it — is re-emerging as an important concern for physicians and teachers. Claude Beaudoin and colleagues (page 765) report that only about half of medical students surveyed at 3 Quebec medical schools thought their teachers displayed humanistic characteristics; as many as 75% thought their teachers seemed uninterested in how patients adapt psychologically to their illnesses. The results were similar for survey respondents' perceptions of the teachers' humanistic characteristics in interactions with students. Victor Neufeld (page 787) comments on what we all know but seem to forget: "people [expect] better — to be treated as human beings, not just 'cases.' " Dr. Rob Patterson (page 823), using excerpts from journals he kept during his medical training, provides a glimpse of what humanism is — and isn't.

It is a universal truth that any study of health care utilization will show marked variation in the number of visits to physicians for a given condition. In addition to statistical variation, there are differences in patients' needs for care. But beyond this, there is controversy. Just as some patients don't see a physician when they should, it appears that others go too often. A physician's practice style may also influence the frequency of visits. Noralou Roos and colleagues (page 777) examined visit rates among patients with hypertension in Winnipeg and found that sicker patients made substantially more visits than those who were not so sick. Also, the frequency with which physicians saw their hypertensive patients one year predicted visit frequency the next year, but to a lesser extent. Barbara Starfield (page 795) views this result through the lens of the US health care system. She is impressed that such a high proportion of hypertensive patients made at least the recommended number of visits for hypertension. She reminds us that although physician practice style remains critical in determining visit frequency, patient need and socioeconomic status must not be neglected as policy-makers scramble to reduce health care costs.

Creutzfeldt–Jakob disease (CJD) is again in the news with the discovery of the prion for new variant CJD (nvCJD) in the appendix of a patient who was diagnosed with the disease 8 months after the appendectomy. Susan King and colleagues (page 771) report on the difficulties of notifying the parents of children who received blood or blood products subsequently found to be associated with CJD: there are no laboratory tests for the presence of prions, and there is no treatment. Should patients or their parents be told about this theoretical risk when there is not much they can do but worry? Bryce Larke (page 789) comments on the problem of recalling blood associated with CJD. He points out that as of a few weeks ago the US no longer withdraws plasma derivatives in situations where a donor is subsequently diagnosed with CJD or found to have a risk factor for the disease. In contrast, withdrawals of this type will continue in Canada.