

[The author responds:]

H.M. Finestone draws attention to the potential need in diagnosis to account for multiple factors and expresses the view that “it is not simply an ‘art’ that leads one down this line”: “rigorous scientific principles can still be used to achieve this goal,” and “in a unified fashion.” The implication appears to be that any given mode of thought or action in the practice of medicine either is art and thereby subject to being rhapsodic and individualistic, or is guided by rigorous scientific principles and thereby is more-or-less predictable and uniform across individual practitioners — even in the context of complex challenges. Insofar as this indeed was Finestone’s idea, it needs to be juxtaposed to my corresponding presentation.

As I said, I used the term “art” in the Aristotelian meaning of “productive arts,” subsequently referred to as “mechanical arts” or “servile arts” (in contradistinction

to “fine arts”).¹ Nothing in the history of these arts, medicine among them, is inconsistent with the ideal of normative algorithms for setting gnostic probabilities in medicine; and in accord with this, I advocated the development and deployment of them. In these terms, gnostic probability-setting would be uniform across individual practitioners, in complex situations just as in simple ones. And what makes scientific gnosis essentially uniform even in the absence of normative algorithms is a shared commitment both to a theoretical framework that is singular by being rational and to the deployment of scientific knowledge, equally singular, in this framework. Principles are the foundation of scientific gnosis, but they are principles of the *art* of the practice of scientific medicine, not principles of medical science. I therefore do not think of them as scientific principles of practice but as principles of scientific practice.

Should Finestone use the term “art” in the same meaning as I do, inclusive of

the context of scientific art, he likely would not make the point quoted above.

Sylvia and Richard Cruess raise some questions about the most important topic in my series of essays. Given their expertise in modern education in medicine, I appreciate their bringing up what they see as “issues of concern.”

Physicians are to meet, they say, society’s expectations that they have “a fairly broad pool of knowledge, no matter how specialized they may be.” The Cruesses therefore ask how this would be accomplished in the early-specialization framework I advocate. Even in this framework, one specialty would be general medicine, with triage for referral to narrower specialties a core function in it. Once the public would come to know that other specialists are more narrowly educated, it scarcely would expect any fairly broad pool of knowledge — nor lament its absence — on the part of the physician practising only cataract diagnosis and surgery.

McNeil

Motrin

2 x 1/2 page. 4 c;r

Feb. 19, 2002

Related to this, the Cruesses ask how the medical common that I advocate² differs from the core curricula in use at present. The latter are preparatory to the uniform licensure that now is “required of all physicians entering medical practice in Canada.”³ Its underlying philosophy is that whereas “the human body appears to react to ... insults in a finite number of ways,” the examination is to cover “all of these ways” and, thereby, the “domain of medicine” in a comprehensive way.⁴ Thus the aim still is to educate, and to license, only all-purpose — complete — physicians. By contrast, the medical common I advocate encompasses only that which truly is of common concern across all of the differentiated types of modern practitioner. This obviously involves only a very small fraction of all of the ways in which the human body reacts to insults. The concept is profoundly different, and so consequently are the curricular implications.

As for “what process might be utilized to actually identify ‘the common,’” I’ll just comment on pruning “the full clinical presentation list” of current concern in the licensing-oriented curricula.⁵ One option is to convene representatives of the various types of specialized practice of modern medicine and to have them go down that list, each identifying the topics that truly would be relevant for professional self-cloning. I would expect that none of the 127 main types of clinical presentation on that list would turn out to be relevant to all types of practice.

Olli S. Miettinen

Department of Epidemiology and
Biostatistics
Faculty of Medicine
McGill University
Montreal, Que.

References

- Miettinen OS. The modern scientific physician: 1. Can practice be science? [editorial] *CMAJ* 2001;165(4):441-2.
- Miettinen OS. The modern scientific physician: 8. Educational preparation [editorial]. *CMAJ* 2001;165(11):1501-3.
- Medical Council of Canada. *Objectives for the qualifying examination*. 2nd ed. Ottawa: The Council; 1999. p. ii.
- Medical Council of Canada. *Objectives for the qualifying examination*. 2nd ed. Ottawa: The Council; 1999. p. iv.
- Medical Council of Canada. *Objectives for the qualifying examination*. 2nd ed. Ottawa: The Council; 1999. p. 1-5.

Correction

In a recent *CMAJ* article on measles,¹ in the second column under the Prevention heading, the sentence that begins “The second dose should be given at least 3 months after the first” should instead begin “The second dose should be given at least 1 month (minimum 28 days) after the first.”

Reference

- Shapiro H, Weir E. Measles in your office. *CMAJ* 2001;164(11):1614.

McNeil

Motrin

2 x 1/2 page. 4 c;r

Feb. 19, 2002