Thoughts on the importance of being different

It is with great pleasure that we read Dr Ian McWhinney's recent editorials on "The importance of being different"[1,2] that appeared in the February and March issues of *Canadian Family Physician*. In this day and age, it is a rare event indeed to have the privilege to read a reflective article that discusses and synthesizes the major issues confronting the discipline of family medicine. We felt challenged by many of the ideas developed in the articles, and we have comments we would like to share.

The first difference refers to the precedence of relationships over content in family practice. Although we easily recognize ourselves in this description, we would like to suggest that it is more the characteristics of the relationship than the precedence of the relationship that distinguish family physicians from their colleagues in other specialties. Specifically, we are referring to a continuum at the extremities—on the one hand, we have very specific topics and few encounters, and, on the other hand, we have many diverse topics and repeated encounters. This is not an issue of the foreground or background of relationships because, when a doctor meets a patient, he or she necessarily engages in some form of relationship.

The second difference pertains to the use of knowledge in context. Family physicians, like other clinicians, tend to see themselves at the centre of individualistic, "nuclear" doctor-patient relationships. This increases the burden on the doctor's shoulders unnecessarily as he or she "walks through the territory with the patient." Doctors fail to view themselves as part of a complex web of relationships that patients maintain throughout their lives. Family physicians are more eager than most other specialists to consider family context and life circumstances, but they often still do not integrate a patient's network of "significant others" in their diagnostic or therapeutic processes.

The third difference refers to organismic versus mechanistic thinking in medicine. This very interesting section shows how, through advances in cognitive science, neuroscience, and neuroimmunology, we have come to think of living organisms in terms of complex, multilevel systems with information-processing capabilities. In such a perspective, mind-body dualism becomes obsolete. Although this is powerful material, Dr McWhinney's perspective questions the necessity of abandoning the mechanistic way of thinking (which is very neat and convenient) in favour of the organismic one (which is extremely seductive on theoretical grounds). In fact, depending on the type of question one asks, both types of thinking can be useful in general practice. Mechanistic explanations are well suited to straightforward situations, like explaining a common cold to a patient, while organismic explanations are better suited to complex situations like somatoform disorders. In daily general practice, it simplifies the doctor's life to have linear causal models to explain things to patients. When dealing with complex issues with our patients, it is difficult for us to translate organismic thinking into clinical action or decision making. Although we completely agree with the theory here, the problem is one of applicability in everyday practice.

The fourth difference is that general practice is the only field that transcends the division between mind and body. We suspect that weaving back and forth between physical and psychological dimensions (during the same encounter or during different encounters) is what clinicians in action do most of the time. True integration of both dimensions (which would better reflect the transcending nature of this difference) is a much rarer event.

Dr McWhinney also develops the idea of the healing aspects of doctor-patient relationships. If physicians want to be able to attend to their patients' emotions, it is suggested that they must attend to their own. Most of the problems that family physicians encounter in their day-to-day practices are relatively straightforward and require the use of basic interpersonal skills. Still, complex situations that require higher-order counseling or psychotherapy skills (eg, palliative care, chronic degenerative diseases) do arise in daily practice. We are convinced that the mastery of basic interpersonal skills is more than enough for most doctors to respond appropriately to expressions of suffering. Learning these skills should be an integral part of medical education. However, we do not share Dr McWhinney's view that medical education should include "education of the emotions."

Although personal awareness, or being in touch with your own emotions, can be seen as a valuable personal goal, we do not agree that it is a prerequisite for helping others. We would like to propose two types of arguments to support our point of view. First, we learn from ethologic studies that most animals express and respond to emotions without, as far as we know, any "consciousness." Second, anthropologic studies on the role of the shamans teach us about their healing powers. These indicate that attentive listening does not seem to be an important part of the healing process. Third, a quick look around us reveals that there is much helping and healing going on in the world outside physicians' offices: within families (between spouses and between parents and children), within the complex network of relationships people are involved in, and within communities. We suspect that most of this occurs without special training and does not involve attentive listening. Do we deny that healing occurs or claim that the type of healing that occurs is of a different nature or of a lesser value than that which occurs through professional relationships? Physicians often

witness the failure of their patients' "natural network" to support them adequately through difficult times. Family physicians are in better positions than specialists to assist their patients by helping them reconnect to their significant others who can, and do, contribute to their healing.

We would like to emphasize the importance of Dr McWhinney's contribution to the development of family medicine; nevertheless, we believe that some of his perspectives put undue burden on family physicians' shoulders.

— Marie-Thérèse Lussier, MD, MSC and Claude Richard, MA
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References

1. McWhinney IR. The importance of being different. Part 1: The marginal status of family medicine [editorial]. *Can Fam Physician* 1997;43:193-5 (Eng), 203-5 (Fr).
2. McWhinney IR. The importance of being different. Part 2: Transcending the mind-body fault line [editorial]. *Can Fam Physician* 1997;43:404-6 (Eng), 414-7 (Fr).

Drugs and herbal preparations: how safe are they?

I appreciate the concern expressed about the safety of herbal products.[1] However, very few hospitalizations were reported to be caused by herbal preparations. Ms Kozyrskyj discussed a large number of herbs, but the list of adverse effects is quite short, and most of the effects were not severe.

On the other hand, surveys have estimated the proportion of hospitalizations caused by prescriptions to be approximately 25% of the total number of hospitalizations. Any casual reader of the *Compendium of Pharmaceuticals and Specialties* (*CPS*) will be familiar with the large number of adverse effects associated with most drugs listed there, and many of the effects could be severe.

If we hold the drugs we prescribe to the same standards to which we would like to hold herbal products, we might well revise our assessment of them. Articles that depict herbs as dangerous should also acknowledge the dangers of drugs.

— Michael Vesselago, MD
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Reference

1. Kozyrskyj A. Herbal products in Canada. How safe are they? *Can Fam Physician* 1997;43:697-702.

Rebuttal

I would like to thank Dr Vesselago for his comments on my article.

Most health professionals are aware of potential side effects associated with use of drugs and their contribution to morbidity and mortality.[1] As Dr Vesselago noted in his letter, one only needs to consult the *CPS* to be acquainted with all possible side effects of a drug. But that is precisely the point I was trying to make in my overview of herbal product regulation in Canada. Data in the *CPS* on the side effects of drugs is accumulated from premarket and postmarket drug surveillance studies.[2] No such medium exists for herbal products, and they are not registered with the Health Protection Branch. Moreover, the *CPS* also lists inactive ingredients found in drugs, ingredients that pose risks to some patients. Again, this kind of data is not available for most herbal products. If health professionals are going to practise evidence-based medicine, then herbal products should be subjected to the same scrutiny as conventional drugs, with respect to efficacy and safety. Registration of herbal products will promote the availability of data on herbal product efficacy and safety.

The objective of the overview was to familiarize family physicians with these issues, provide guidance regarding available references on herbal products, and include suggestions on their use in the absence of existing data. I also pointed out the purported benefits of alternative therapies. In this respect, I believe I presented a balanced view of herbal product use. Only when health professionals are familiar with the issues surrounding herbal therapies can they help their patients make informed choices and correct misconceptions about herbal products, which are often promoted as harmless.

— Anita Kozyrskyj, BSCPHM, MSC
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1. Johnson JA, Bootman JL. Drug-related morbidity and mortality: a cost-of-illness model. *Arch Intern Med* 1995;155:1949-56.
2. Somers E, Carmen-Kasparek M, Pound J. Drug regulation—the Canadian approach. *Regul Toxicol Pharmacol* 1990;12:214-23.

Accessing primary care services

In the article "Distribution of physicians in Ontario,"[1] Dr Coyte and associates draw attention to the real difficulties faced by many Ontario residents in accessing needed primary care services. His paper uses an approach that avoids many of the shortcomings of the "head count" method favoured by the government and used recently to determine areas in the province in which newly entered physicians should be subjected to medical fee discounts.

The findings by Coyte and coworkers show that many residents in southern Ontario are comparatively undersupplied with primary care services provided by general practitioners and family physicians. Unfortunately, too much attention was paid to the inability of the methodology to attach statistical significance to difficulties in accessing primary care services in some northern regions. This is a function, in large measure, of relying on a county-level analysis. The findings of Coyte and colleagues are