The God particle

Dr Pimlott makes an astute observation that family practice possesses intrinsic uncertainty and subsequent existentialism. Scientific existentialism promises to climax in the coming year as eager physicists at the European Centre for Nuclear Research seek the famed Higgs boson, or "God particle." Why should we care? Because the energy and happiness generated in this pursuit has a long history within our very own field of medicine.

Nicolaus Copernicus, a practising generalist physician, reframed our perspective on the heavens by suggesting that the universe did not revolve around our tiny blue planet. This revolution in science is not unlike the patient-centred themes of Hippocrates, to whom we have all sworn an oath.

Family medicine boasts a long and proud history of bright minds and remarkable, practical talent. If we worry that medical students might shun the uncertainty of a generalist career, we need not be troubled. Just as string theorists revel in their mathematical eroticism, so too can primary care physicians thrive on the challenge posed by the intrinsic amorphism of the human condition.

—Faizal Bawa MD
Bracebridge, Ont
by e-mail

Soft to know?

In response to Dr J.L. Reynolds' excellent article "Hard to know. What is hard knowledge?" (*Can Fam Physician* 2007;53:385 [Eng], 389 [Fr]), I am given to believe that it is not just end-point medical knowledge itself that is dichotomously labeled (and overtly so) as "hard" or "soft." It is also the process employed resulting in discovery of a given quantum of enlightenment that draws the inference of "hard" (nowadays the complimentary term) versus "soft" (a term of disparagement). Dr Reynolds thoughtfully refers to facts (today called hard but by the passage of time not infrequently discovered to be changeable, erroneous, or impermanent—therefore in reality soft) versus the "touchy-feely stuff," currently denigrated as soft material but which, being rooted in "human being-ness," is often shown to be nature's hardest, most lasting knowledge.

The rigidities of the scientific method being what they are, it is the exemplariness of the randomized placebo-controlled crossover trial, and, of course, only when encompassing a statistically-blessed large *n*, that merits the badge of "fact" or "hard." Biological observations derived from merely human circumstances (such as occur daily over a practitioner's lifetime) could not possibly, by today's orthodoxy, merit such acclaim. You mean ... What? ... Such observations are not deemed worthy of being called evidence?

And therein lies, as Reynolds writes, the sadness—a profound sadness. But therein also lies, as his words imply, the very reason that we teach (read "demonstrate") our trainees the behaviours (read "processes") of inquisitiveness, imagination, and compassion, together with their inherent mores and values. Our careful recording of, and our learning from, such types of observation also constitute a science, in my opinion. Indeed, parts of this new science are beginning to adopt names, such as "narrative medicine." A bright future can, in all possibility, hold as goals for the family physician an expansion of the accepted meaning of evidence and especially a rehabilitation of the meaning of "soft" (as in "knowledge"). Who better than we, given the kinds of persons we strive to be and to train, and given the situations we encounter daily, to reflect so?

—Gordon D. Hardacre MD CCFP FCFP
North York, Ont
by mail

The meaning of "is"

I was delighted to read some of the commentaries in the March issue of *Canadian Family Physician* concerning quantum physics and its relationship to modern medicine. I was particularly interested in the article by Dr Reynolds, "Hard to know. What is hard knowledge?" (*Can Fam Physician* 2007;53:385 [Eng], 389 [Fr]). His linguistic ambiguities were particularly amusing and insightful, and it occurred to me that this hard/soft, *exclusive, either/or* world in which we find ourselves is very similar to the particle/wave duality of quantum physics. Perhaps we can learn something from this paradox that is useful to us in medicine.

It is seemingly impossible to resolve the particle/wave duality, unless we simply accept that perhaps both exist or that neither exist (making the universe *inclusive* and *both/and*). Perhaps we can also solve the hard/soft duality by accepting that not only both exist, but that sometimes the one is more useful that the other; and that sometimes the other is more useful that the one; but *never that either is useless*—making the universe inclusive as well. To do that we would have to

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recognize that disease no more exists than does the human spirit, or Reynolds' "human being-ness." That would require a perceptual shift in medical thinking that is no less than tectonic! However, when one considers that Schrodinger's cat, depicted on the front cover of the same issue, seriously brings into question whether any experiment or research in medicine can be unbiased (because it will always be observer influenced), it seems to me a perceptual shift well worth making, although considered unlikely by Bawa in his commentary, "A quantum leap in medicine" (*Can Fam Physician* 2007;53:386 [Eng], 390 [Fr]).

I could be labeled a heretic for suggesting that disease does not exist or that perhaps disease and the human spirit are even somehow 2 sides of the same coin. A part of the reaction or resistance to any perceptual shift occurs because of the limitations of the language we use to describe the experience. Human spirit is surely more easily recognized as a process, a work in progress so to speak; whereas we tend to see disease as being fixed and immutable. Perhaps Reynolds and I would disagree on this. Seeing disease as fixed causes us to define the cure as one for all—the same for everyone. But disease is a process, too, and we need to remember that it changes not just with time and from one human "being" to another, but also with our perceptual angle. Uncertain? Yes. But uncertainty embraced breeds humility and understanding.

—Edward Leyton MD FCFP CGPP
Kingston, Ont
by fax

Feminine fraternity

Dr Reynolds' commentary (*Can Fam Physician* 2007;53:385 [Eng], 389 [Fr]) was very much appreciated. The abuse of power and the development of the MDeity syndrome is still too prevalent in the medical fraternity. Physicians with this type of attitude create substantial time difficulties for those who choose compassion, empathy, and good social skills when dealing with patients. There is a small subgroup of physicians who are "social-intelligence challenged." They might be tired and overworked, as most of us are, but the human touch and compassion, or soft knowledge, are critical to compliance and patient satisfaction. Physicians can learn to say no, agreeing to disagree in an agreeable way. By dividing patients' human value from behaviour, one can always address behaviour, making certain that the patients know that they are cared for and that their complaints are important. Practitioners with MDeity syndrome create grief in the referral process, and much explanation is required when advising patients as to why these doctors have this cold and seemingly unlistening attitude. Such issues as this one need to be addressed in particular in the surgical residency programs. The increasing percentage of women physicians has been refreshing in this respect, as the feminine touch (even when administered by male physicians) is generally nurturing, yet direct and authoritative. We must keep encouraging each other to aggressively embrace hard knowledge intertwined with the feminine, compassionate, imaginative touch. We need more creative and compassionate medical students.

—Brian A. Shamess BAMD
Sault Ste Marie, Ont
by fax

Response

I am pleased that there has been so much positive comment on the March issue of *Canadian Family Physician* and on my paper "Hard to know. What is hard knowledge?" The thoughtful letters of Pimlott, Hardacre, Leyton, and others add much to the discussion of the essence of family medicine.

Pimlott rightly points out that the ability to manage uncertainty is an essential attribute of a good family physician. I agree that teaching this to our residents is vital. Hardacre makes a further addition: the importance of the narrative in distinction to the obvious weakness of medicine that is based only on facts,