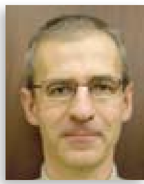

Editorial

Pride and prejudice

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Politics is nothing more than medicine on a grand scale.
Rudolph Virchow

Canadians are justifiably proud of their health care system, which values equity and fairness over privilege and the ability to pay. Similarly, Canadian family physicians can take pride in the fact that countless studies have shown that family physicians deliver the kind of health care that the public and policy makers want and people need—care that is centred on patients and committed to comprehensive continuing care.[1] The discipline of family medicine espouses the principles valued by health care systems around the world.[1]

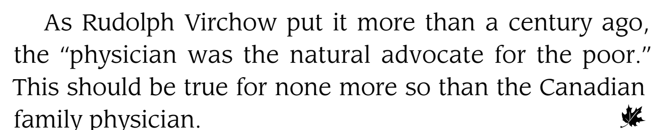
And yet 2 articles in this month's issue of *Canadian Family Physician* (*CFP*) reveal and discuss that there is much, much more to be done in order to make Canada's health care system one that is both truly equitable and truly effective, and one that we can really be proud of. In the commentary "Addressing health inequities. A case for implementing primary health care," (**page 1515**) Dr Carmel Martin and Terry Kaufman review the overwhelming evidence that the social and economic circumstances of individuals and groups have a far greater effect on their health than does health care.[2,3] Furthermore, it is also well known that while good medical care is important to the well-being of populations, improving health care is not enough to overcome health inequities.[3,4] Canadian family physicians are in the process of implementing family health teams and other changes in the way they practise, but much of the focus in this process has been on the "nuts and bolts" of the delivery of health care. Martin and Kaufman make a compelling case that family physicians can and should think beyond the "nuts and bolts" and provide leadership in addressing the social determinants of health and health inequities in their communities. They clearly outline 7 ways that family physicians can do this.

In a companion commentary entitled "Prejudice in medicine. Our role in creating health care disparities," (**page 1511**) Dr Len Kelly and his colleagues make the provocative case that among those who are already the most disadvantaged in our society—immigrants and aboriginal Canadians—and the most adversely affected by the socioeconomic gradient in health, the situation is made worse not only by language and cultural barriers but also by caregiver prejudice. Kelly et al argue that while it might be hard to define and measure prejudiced attitudes and behaviour, it is important to try to isolate and study these aspects of care, to understand their effects on the health of the disadvantaged, then to change them. A good place to start would be to examine our own potential biases or prejudices toward some of our patients.

November is also a time to remember another group of Canadians—a group whose medical problems are also neglected and little understood. I am the first member of my family in 4 generations not to do military service. My father is a veteran of the Suez Crisis and Cyprus peacekeeping missions by the British Army from 1955 to 1958, and his father served in the Royal Horse Artillery in World War I and won the Military Medal for bravery. As a physician, I also have military veterans among my patients.

This issue features an article from Veteran Health Files, a new quarterly series in *CFP* coordinated by Veterans Affairs Canada. The series explores situations experienced by family physicians caring for veterans of military service. This month's article by Dr James Thompson and colleagues, "Battlefield brain. Unexplained symptoms and blast-related mild traumatic brain injury," (**page 1549**) provides family physicians with a helpful review of a common, but little understood, problem that can afflict returning veterans of war. My grandfather lost a leg to a bomb while saving a fellow soldier and almost certainly had battlefield brain. I have the medal he won, the brass box it came in, and his discharge papers.

Like cold November weather itself, this month's issue of *CFP* might not make comfortable reading for many of us, but it should provide much upon which we should reflect and act.



As Rudolph Virchow put it more than a century ago, the "physician was the natural advocate for the poor." This should be true for none more so than the Canadian family physician.

Competing interests
None declared

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Cet article se trouve aussi en français à la **page 1509**.

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