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Ami Schattner

In reply: Wong writes eloquently, and seems utterly convinced of the merit of the "testing first" medicine that he preaches. Yet his arguments are flawed and his system, appalling.

Young physicians not wearing a white coat are a fairly common sight in hospitals these days. Without a coat, they no longer have a convenient means of carrying around essential tools such as a flashlight, reflex hammer or ophthalmoscope. Indeed, if all they have to do is automatically order computed tomography (CT) scans, they will not need such tools. It is exactly to oppose these negative trends in medicine that my article was written. What I was trying to say was not that history and examination should *replace* modern imaging, but rather, that the decision about whether and when to order a test, and what test to order, should more than ever be *based on* skilful verbal and physical contact with the patient. Careful interpretation of basic clinical data such as the proneness of the patient to develop certain conditions ("pre-test probability"), the behaviour of symptoms over time, and the results of very simple laboratory tests are also immensely valuable. Most of this information can only be gleaned from patient–physician communication.[1]

Would Wong's approach to acute abdominal pain (do a CT scan first and then let the diagnosis sort itself out later) hold water in cases of acute gastroenteritis, renal colic, peptic ulcer, acute hepatic congestion, incarcerated hernia or Henoch–Schönlein purpura? All these not uncommon causes of acute abdominal pain can be confidently identified by their typical history and findings and successfully treated with no resort to imaging, which may be not only redundant but also costly and hazardous.[2,3] An additional downside of imaging without forethought is that it is fraught with false negative findings (eg, early diverticulitis or pancreatitis) and false positive findings (eg, "incidentalomas") that often result in diagnostic confusion, lost time and more unnecessary testing.[4]

When the indirect benefits of patient–physician communication and examination are also taken into account, the integral value of the clinical paradigm is even more strongly reaffirmed. Medicine is a humanistic profession. Patients experiencing pain, distress or uncertainty look up to the physician who talks to them, touches them, comforts them and is sensitive to their plight.[5] Even the best, latest-generation CT scanner would never be able to do that.

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The essence of the art of medicine

C Ross Philpot

To the Editor: Your thoughtful editorial comment[1] in the 21 August issue laments that the essence of the art of our profession was potentially diminished recently by the report of a working party of the Royal college of Physicians of London.[2]

My medical dictionaries and textbooks are curiously silent on the notion of an "art of medicine", so I went to "the source" and discovered that "Life is short, and the Art long" comes from quotes of popular Latin authors as "Ars longa, vita brevis" — in turn from Hippocrates' original Greek,[3] **ὁ βίος βραχύς, ἡ δὲ τέχνη μακρή.**

A native Greek-speaking medical colleague of mine points out that the Greek word used in the quote implies "long through to the end" — presumably the end of one's career or the end of one's life. So we (and Hippocrates) are evidently referring to a rather grand concept of the art of medicine, not just a narrow view implied by the term "judgement", as proposed by the working party.

I see judgement as being but one of many essentials of the art of our profession, and agree with Van Der Weyden's assertion that the proposed use of the term "judgement" in place of "art" is indeed reductionist and should be rejected.

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Norman Shum

To the Editor: I agree with Van Der Weyden's quotation from Osler: "The practice of medicine is an art, based on science."[1] In my medical training in the 1960s, I was taught that medicine was both an art and a science — perhaps more the former than the latter, given that the technological age was not yet fully upon us. It saddens me that there is now an almost inexorable trend towards the use of advanced technology in medicine and away from human interaction between doctors and patients. I do not believe in reducing humans to mere numbers on a pathology results form or images on a computer-driven x-ray monitor. This is what helping patients "judge" which path to take "through the indeterminacies" back to health[1] suggests.

Gordon expressed similar sentiments in an earlier article:[2]

> The arts, humanities and social sciences act as a counterbalance to the relentless reductionism of the biomedical sciences . . . [M]edicine will attract students who are interested in the biomedical sciences, many of whom are particularly good at processing and memorising information. Unless they have adequate time for reflection, such students may ultimately adopt a dogmatic or overly technical approach to clinical practice . . .

As a "doctor" — in the sense of a modern version of an ancient healer — I accept that my role is "to cure sometimes, to relieve often, to comfort always".[3] There is cold comfort if we lose the "art" of medicine.

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