Bruce L. Rollman at al.

(New Eng J Med 1997;336:800-803)

The demands inherent in certain practice specialties are popularly believed to contribute to the risk of divorce among physicians. (...)

Female physicians had a higher risk of divorce than male physicians. Marrying before graduation from medical school was also associated with a higher risk of divorce. (...)

Specialty continued to be strongly associated with the risk of divorce, even after adjustment for other factors. With internists as the reference group, the adjusted relative risk of divorce was highest among psychiatrists (2.7 times as high as for internists), followed by "other" physicians and surgeons (relative risks, 2.2 and 1.7, respectively). Among pediatricians and pathologists, the risk of divorce remained similar to that among internists. (...)

The risk of divorce associated with certain specialties may also reflect personality characteristics associated with the choice of specialty, rather than the specialty's psychological or physical demands.

George W. Weintein

(Current Opinion in Ophtalmology 1997;8:8)

An old adage in general internal medicine can be paraphrased as "to know AIDS, is to know medicine". Indeed, managing patients with AIDS and its associated complications challenges just about every branch of medicine. As ophthalmologists, ocular complications and opportunistic infections in patients with AIDS provides an opportunity for us to work with our medical colleagues. Often, ophthalmologists are the first to diagnose an opportunistic ocular infection and the presence of this life-threatening illness.

David M. Minvis

(Arch Intern Med 1997;157:385)

The "MANAGED care" paradigm has challenged most aspects of conventional health systems.(...) To understand the issues that managed care presents to the health care endeavour it is important to understand what is managed. (...) In this essay we suggest that one object that is managed is uncertainty.

Uncertainty is a fact of life in medical practice. We, as physicians, usually do not know unequivocally the full extent of a patient's disease and even less often do we know the best single approach to diagnosis and treatment, if one were to exist even in theory.

This uncertainty is the result of several factors. First, uncertainty results from biological variability. The same pathologic condition may result in different outcomes in different patients due to genetic predispositions, concomitant disorders, or other undefined factors. (...)

Second, our knowledge of the basic pathophysiologic characteristics of disease and mechanisms of action of therapies is far from complete. Our diagnostic tests are imperfect yielding probabilities rather than certainties about the presence or absence of an abnormality. Many of the treatments we offer are based on what later may prove to be erroneous or, at least, incomplete premises. (...)

Similarly, much uncertainty results from lack of applied or empirical knowledge of what works and what does not work. (...)

For example, trials to assess the efficacy of digitalis therapy are currently being reported after decades of assuming therapeutic benefits in patients with congestive heart failure. Coronary artery bypass graft surgery became one of the most commonly performed operations before multicenter trials reported long-term efficacy data.