Lee Goldman
– Ann Intern Med 1997; 127: 836

The term *internal medicine* originated from the *German Inneren Medizin*, came into common usage in the 1880s. Internal medicine in Germany was distinguished from "clinical medicine" because of its new emphasis on experimental physiology and chemistry rather than the progression of disease manifestations.

Unlike most specialists, who are clearly identified by technique (for example, surgery), body part (for example ophthalmology), or target population (for example, pedriatries) Internists are commonly confused with interns and are frequently asked by patients and friends, "Exactly what does internal medicine means". Although everyone understands the meaning of the word family and ascribes value to it, the word internal suggests something mysterious, unseen and quite possibily unpleasant.

In recognition of this problem, the American College of Physicians has developed a brochure entitled "Internal medicine. Doctors for adults. Where we fit in today's primary care picture" and a campaign to educate the public on the role and function of the internist. An analogous but far less ambitious campaign was undertaken more than a decade ago, when the upsurge in primary care internal medicine was just beginning and the distinction between the diagnostic consultant and the primary care internist needed to be clarified. At that time, Kurtz and Goodman argued that internist, including both generalists and subspecialists, should be called adult medicine specialists.

Many years later, it still seems that an unhelpful or poorly descriptive name should be changed, not clarified with subtitles. My suggestion is that we change the name from *internal medicine* to *adult medicine.*

Duncan P. Thomas
– J Royal Soc Med 1997; 90: 50

To claim that today's medicine is free from empiricism would be rash indeed, but the stringent requirements for licensing of new drugs and the rise of evidence-based medicine do ensure that therapeutic measures are judged increasingly on the scientific evidence and decreasingly on the force of personality, standing in the profession, or fervour of the protagonists. The best tool for providing this evidence is usually the prospective randomized control trial.

Looking at the history of drug evaluation Green subdivided the agents into three groups: those used as a result of observation and empiricism; those used on the basis of authority; and those used on the basis of experiment.

Little can be said in favour of authority alone as a criterion of values in therapeutics. The undue longevity of many useless and even harmful drugs or modes of therapy can be laid at the door of authority. A good example of this type of approach was the use of copious bleeding and purging by Benjamin Rush during the yellow fever epidemic in Philadelphia in 1793. Rush, a signer of the Declaration of Independence, was one of the most famous men in America, and he "knew" that bleeding and purging was beneficial for his patients. Rush's approach to treatment was full of misguided fervour, but he was essentially unchallenged because of his distiguished position.

While treatment based on scientific experiment in the form of randomized trials has nowadays come to dominate our approach to disease, this has not always been the case and it is instructive to review the beginnings of the development that led ultimately to the modern controlled clinical trial.

Peter A. Ubel
– Arch Intern Med. 1996; 156: 1263

One of the great achivements of medical ethics may be how it has influenced our understanding of informed consent. Informed consent began largely as a legal construct. It developed from comon law notions of battery, whereby people were understood to have a right to refuse invasion of their bodily integrity—people are not suppose to stick knives into other people without their permission. Legal doctrines of informed consent continued to evolve, so that now it is common for informed consent cases to be tried on the grounds of negligence. Thus, for example, a physician would be negligent merely to accept a patient's refusal of a Pap smear, unless the physician informed the patient about the risks and benefits of refusing the test.