ical communication, such a change in text would be inappropriate.

P. Gerard Cox, MB
Firestone Regional Chest & Allergy Unit
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Hamilton, Ont.

I am disappointed that you would publish such a paranoid, meaningless article. In this era of fiscal restraint it is hard to believe that there is money available to fund committees such as the one mentioned in this article.

Kenneth L. Maudie, MD
Cranbrook, BC

[One of the authors responds:]

I was unprepared for the level of hostility that a discussion of the subtle biases inherent in the language, content and process of medical education seems to have provoked among *CMAJ* readers. Although these readers agree in principle that equality must be upheld, equitable practice is either ridiculed or denounced as a slight to our language or our profession. I am left wondering what a professed belief in equity actually means.

In a tongue-in-cheek manner Dr. Walters seems to be asking whether we really must launder the English language to eradicate all traces of sexism. The aim of the guidelines is not to delete words from the language, but rather to have educators and their students use the meanings behind the words to explore hidden stereotypes and biases. For example, the word hysteria has as its root the Greek word *hyster*, meaning uterus. Rather than eliminating the word from use, students might have an interesting and useful discussion of whether the term implies that being female is the cause of this psychiatric disorder.

Dr. Cox's point is well taken and illustrates how stereotypes can be subtly embedded and deeply held. Although at least 10 people read the manuscript before publication, none of us noted the error he spotted. The parallel terminology should read "a 40-year-old man who works as a professional" and "a 23-year-old woman who works as a medical secretary." All of us hold cultural and social stereotypes that can limit our views and expectations of, and our communication with, others. I hope the concepts outlined in the article have helped some physicians recognize these stereotypes and either minimize them, or at least acknowledge them and their effect on teaching and practice.

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Brave new world of gender-inclusive language

The articles "Attitudes toward the use of gender-inclusive language among residency trainees" (*Can Med Assoc J* 1997;156:1289-93), by Dr. Gordon H. Guyatt and associates, "Medical curricula for the next millennium: responding to diversity" (*Can Med Assoc J* 1997;156:1295-6), by Dr. Christiane Kuntz, and "Gender sensitivity in medical curricula" (*Can Med Assoc J* 1997;156:1297-1300), by Barbara Zelek and associates, contain a megadose of Orwellian newspeak. Gender-inclusive language and sensitivity are the mantras of the '90s. We have reached the stage where an inanimate object replaces a human (oh, sorry — living) being, as when chair replaces chairman. This mongrelization of the English language is all but complete, all in the name of political correctness — a new form of totalitarian suppression of free speech.

Emile Berger, MD
Montreal, Que.

[Dr. Guyatt and associates respond:]

Many people, like Dr. Berger, find it oppressive when they encounter negative reactions to language that has been used habitually throughout their lives. Indeed, an overzealous insistence on using or avoiding particular forms of expression can be irritating, burdensome and unnecessarily inhibiting.

A problem arises, however, when people find particular expressions disturbing or offensive. Most people agree that pejorative terms that refer to a person's race have no place in the language, yet people who use them are liable to find objections oppressive and will consider them an excessively rigid application of political correctness.

Berger may find the comparison of this example and the use of language that women find disrespectful hyperbolic or even ludicrous. Berger, however, is not a woman and has not been subjected to the systematic discrimination and barriers against advancement that women continue to face.

We should seek an appropriate balance between 2 potential problems. On the one hand, we should encourage gender-inclusive language and discourage language that people find patronizing or disrespectful. On the other hand, excessively rigid application of language formulas can create an oppressive environment.

Data we cited in our article indicate that women avoid surgical specialties, and part of the reason is that they feel alienated in the surgical environment. Our use of language reflects attitudes and contributes to their creation. The greater acceptability of gender-exclusive language in surgical environments is no coincidence.

We do not know exactly where the right balance lies between creating a climate in which women feel fully re-

spected and valued, and dealing with the negative reactions of critics.

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Paradigms found

The comments by Dr. Graham Worrall and associates ("The effects of clinical practice guidelines on patient outcomes in primary care: a systematic review," *Can Med Assoc J* 1997;156:1705-12) and Dr. Robert S.A. Hayward ("Clinical practice guidelines on trial," *Can Med Assoc J* 1997;156:1725-7) about clinical practice guidelines (CPGs) are excellent and timely.

We agree with Hayward that CPG initiatives should continue, with a focus on validating methods and assessing effectiveness, as suggested by the data in Hayward and associates' article "Canadian physicians' attitudes about and preferences regarding clinical practice guidelines" (*Can Med Assoc J* 1997;156:1715-23). These authors document that physicians may not use CPGs to any great degree in practice decisions and that they make decisions largely on other grounds. Have physicians appropriately valued existing CPGs, or have they undervalued them? Will more and better CPGs change that valuation?

Worrall and associates state that evidence-based CPGs "are the main tool for introducing evidence-based medical care." In contrast, many believe that clinical epidemiology is one of several core basic sciences that every physician must now have.[1] A health care professional educated in this area is best able to accommodate evidence and CPGs, when possible, while acknowledging their real limitations. Educating physicians about the principles of epidemiology and developing a professional culture of open discussion about our values and how we make decisions may be a better way to ensure that evidence-based medical care is introduced successfully, yet without uncritical acceptance.

We believe that making even better decisions requires a more complete theory of medical choice. Traditional medicine, as one such theory, does not accommodate advances in measurement, statistics and clinical epidemiology. Evidence-based medicine, as another, captures these. Our profession urgently needs a debate over the relative importance or value of causal and prognostic evidence (clinical epidemiology) in making medical decisions. Evidence-based medicine is now nearing dominance within research, journals, academic practice and political discussions about Canadian medicare (e.g., the National Forum on Health). However, medical decisions take into account many factors apart from epidemiologic evidence, including preferences, ethics and patterns of resource allocation. A new theory should try to incorporate the best parts of traditional medicine, evidence-based medicine and some of these other considerations. From such a perspective, the efforts and debates concerning CPGs will seem but one small step toward far wiser decisions.[2]

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2. Jones GW, Sagar S. Rationing health care. *World & I* 1996;11:18-9.

Éducation en éthique : expérience et réflexion éthique

Dans son article «Medical education must make room for student-specific ethical dilemmas» (*Can Med Assoc J* 1997;156:1175-7), M^me^ Joye St. Onge a su traduire le gouffre qui sépare l'expérience des étudiants en médecine et l'enseignement éthique qu'ils reçoivent. À titre d'étudiant, j'ai en fait pu constater ce vide qui prévaut dans notre formation en éthique. Le discours éthique qui nous est proposé est à mille lieues d'un quelconque ancrage expérientiel.

Aujourd'hui, les approches principielle et casuistique dominent l'enseignement de l'éthique — pédagogie qui demeure au niveau proprement théorique. Les étudiants perdent, selon mon expérience, le contact avec la réflexion éthique. Ils qualifient les cours d'inutiles. La dimension humaniste est éradiquée des discussions. Que faut-il faire pour donner une approche éthique à la médecine?

Il ne s'agit pas uniquement d'introduire une dimension particulière dans la pratique médicale. Les changements importants dans nos réseaux de santé nécessitent une définition novatrice de la compétence professionnelle du médecin.

Parler de compétence professionnelle ne suppose plus uniquement une compétence technique et scientifique permettant de poser un diagnostic en conformité avec la science médicale. Les compétences communicationnelle et éthique doivent tenir une place prépondérante dans la compétence professionnelle du médecin.