cons of the test, find out what is important to the patient and — perhaps of more value in such a decision — what is *not* important to him, and then allow him to make the decision for himself.

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[Fred Tudiver and colleagues respond:]

Tom Vandor makes the interesting point that we frequently blame the user (the physician) when a clinical practice guideline is not "unanimously" followed, yet there is little research examining the deficiencies of guidelines. As outlined in our editorial, we believe that there are many other factors that affect the adoption of guidelines: physician and patient characteristics, social influences and practice characteristics.

James Goertzen addresses what we believe is an important factor in guideline adoption, the issue of conflicting guideline recommendations from different agencies. He drives this point home by directing our attention to the article on prostate cancer[1] that appears in the same issue as our editorial. It seems almost impossible not to step into the quagmire of conflicting guidelines when examining the recommendations for a common cancer, such as cancer of the prostate. We agree with Goertzen's conclusions: that many clinicians face almost daily difficulties as they discuss with their patients which guidelines to follow.

It is for these reasons that our group is now working on a project, funded by the Medical Research Council of Canada, to determine how family physicians make decisions about cancer screening when the guideline is uncertain or when the guidelines from different agencies conflict.

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Which curriculum?

I share the concerns of Claude Beaudoin and colleagues[1] about medical education but must ask, "Are these results surprising?" Although we tend to assume that a curriculum is a singular entity, most introductory textbooks on curriculum studies[2] describe a framework in which 3 different curricula, each with its own historical roots and purpose, are always in operation.

The *explicit curriculum* is the dominant concept of curriculum stated in a curriculum document. It is a management tool, a standardization technique, rooted in a scientific and reductionist paradigm that has served researchers in the biological sciences well. It is this curriculum that undergoes reform in response to criticism or societal change.

The *hidden or enacted curriculum* is that which actually takes place between teachers and learners, what happens in the "real world." It differs significantly from that which is described in explicit documents. Faculties of medicine rarely look at what they enact.

The *experienced curriculum* is the curriculum that Beaudoin and colleagues have studied, the curriculum as experienced by the learners themselves. Not surprisingly, the outcome data for the experienced curriculum differ from the intended outcomes of the explicit curriculum.

Many curricular theorists argue that curricula are about cultural transmission and not about pedagogical techniques. In writing about medical education, Bloom asks "How can one explain this history of reform without change, of modifications of the medical school curriculum that alter only very slightly or not at all the experiences of the clinical participants, the students and the teachers?"[3] Beaudoin and colleagues have provided just the type of evidence that is needed to help us look at ourselves in the mirror.

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Antimotility agents and *E. coli* infection

To the objections you have already received[1–3] regarding your recommendation for the use of antibiotics in the treatment of *Escherichia coli* infec-

tions,[4] we would like to add our concern about the use of antimotility agents in children infected with *E. coli* O157:H7. Three North American studies[5–7] have suggested that drugs that slow intestinal peristalsis are associated with an increased risk of hemolytic uremic syndrome, or of more severe complications, when given to children infected with this pathogen. We strongly discourage their use in acute childhood diarrhea.

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The language of suicide

I agree with Mrs. Sommer-Rotenberg[1] that all must be done to promote a more compassionate attitude toward those who are affected by suicide. Abolishing the phrase "commit suicide" from the English language would be a step in the right direction.

Two opposing forces invade us as soon as we learn of the death by suicide of a loved one. There is a feeling of love and one of despair. Love leads us to believe that the suicide was not willingly done, whereas our despair warns us that this thought may just be a buffer against guilt. Our religious beliefs make us associate guilt and shame with the wilful realization of a suicide.

After Michel, our 27-year-old son, had taken his life, we sat around the living room table discussing the aspect of choice in his suicide. I argued that he had not really chosen his suicide, while his younger brother argued to the contrary. With time, I came to accept my younger son's view that the suicidal act is in fact a choice — but then, we have to define the quality of that choice.

In medieval times the inquisitors would torture a heretic and invariably would obtain a confession (false, of course). Under intense suffering the accused one "chose" the path that led him or her to be burned at the stake. To me, the decision of the suicidal person is comparable: his or her choice is made to escape intense suffering. We cannot describe this choice as "free."

I believe that understanding the fact that one does not freely choose to end one's life helps us to deal with suicide with a more open and humanitarian attitude. To better understand suicide we have to realize that the cause is unbearable suffering, possibly in the presence of a mental illness.

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Urology: An unfairly neglected discipline of medical training

I would like to draw attention to the differential emphasis and importance given to examination and management of male and female genitourinary problems in medical school curricula. I studied medicine at Queen's University, where medical students are required to do a 3-week rotation in gynecology. In contrast, urology is not a mandatory rotation. Is gynecology more important than urology? Approximately equal numbers of gynecologic and urologic patients visit outpatient clinics, and I imagine that most men would argue that medical conditions affecting their intimate anatomy and its function are as important as those affecting women. I would suggest that the discrepancy reflects the historical perspective that construed many of women's medical conditions as resulting from their dysfunctional "hysterical" wombs. Thus acquisition of gynecological examination skills became fundamental. But times have changed and so should the gender differences that exist in the way we teach and learn medicine.

During medical school, I was one of 2 women in my class who chose urology as a component of the surgical specialty training requirement. I wanted to confront my discomfort and lack of experience with examination of the male genitalia, and, as a future psychiatrist, I thought the rotation would prepare me for discussions about sexual dysfunction with my future patients.

In an informal poll of a number of my female colleagues, my suspicion that we could leave medical school without ever examining male genitalia was confirmed. Some of my classmates had never inserted a Foley catheter in a man. As residents, we will be called upon to do so by nursing staff, should they have difficulty placing the catheter. How are we to diagnose epididymitis without experience in examining the normal epididymis? During my family medicine rotation, supervised by a male physician, I was always asked by the patient to leave the room when there was a concern necessitating an examination of the genitals. Although I recognize that it is every patient's right to refuse to allow a student to be involved, I suspect that it was my gender, and not my status as a student, that precipitated these requests.

Historically, women have had no choice but to consult a male specialist about their genitourinary conditions, whereas men have been referred to a specialist of their own gender. Why are so few women encouraged to pursue a career in urology and why are so few accepted into urology specialty training programs in Canada? It may be that the predominantly male urologists wish to protect men from the anxiety provoked by talking with a woman about their most intimate medical conditions. With