We should show compassion and avoid letting any of our patients suffer unnecessarily because of these old myths.

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Male circumcision

The response by Drs. Eike-Henner Kluge and Mary E. Lynch to my letter on circumcision (*Can Med Assoc J* 1994; 150: 1541–1544) is a study in cultural myopia and denial. An increasing number of recent studies show significant prophylactic benefits of male circumcision.

Lynch cites results of a study by Schoen and colleagues[1] showing that penile cancer occurs in only seven to nine men per million population. More recently Schoen pointed out that penile cancer occurs in 1 out of every 600 uncircumcised men compared with a rate of virtually zero among circumcised men.[2] Those who claim that the incidence of penile cancer in countries without routine circumcision (e.g., the Scandinavian countries) is similar to that in the United States, where circumcision is often routine, fail to note that virtually all US cases of penile cancer oc-

cur in the uncircumcised minority.[3]

Lynch criticizes the nine recent studies showing that uncircumcised male infants are 12 times more likely to have a urinary tract infection (UTI) for being retrospective. However, three of the studies were prospective.[4]

She also states that the rate of complications from circumcision is up to 35% and lists several complications notable for their extreme rarity. The American Academy of Pediatrics (AAP) found a rate of complications from neonatal circumcision of 0.6%; these complications consisted mainly of easily treated local infection and bleeding.[1] This complication rate may be contrasted with the 5% to 10% of uncircumcised males who undergo therapeutic circumcision for phimosis, paraphimosis or balanoposthitis, the 1000 cases of penile cancer diagnosed annually in the United States alone, the thousands of dangerous UTIs diagnosed annually and the devastating toll of HIV transmission.[5,6]

Lynch also cites a study by Ganiats and associates[7] purporting to show that neonatal circumcision is not cost-effective; however, the study did not consider phimosis, balanoposthitis, long-term sequelae of UTIs, noninfant UTIs or transmission of HIV and other sexually transmitted diseases. Lynch refers to a 1989 report by an AAP Task Force on Circumcision, headed by Shoen, that reached a neutral conclusion on the issue of neonatal circumcision.[1] Since then many studies have been published, and today Schoen endorses newborn circumcision as "a preventive health measure analogous to immunization."[8] I hope that Lynch conveys this information to the parents of newborn boys.

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Evidence-based care writings: gobbledegook

Seldom have I read such a surfeit of jargon from McMaster University, Hamilton, as that contained in the article "Evidence-based care: 2. Setting guidelines: How should we manage this problem?" (*Can Med Assoc J* 1994; 150: 1417–1423), by the Evidence-Based Care Resource Group. Unintelligibility and gobbledegook used to be the prerogative of the behavioural scientists but are now rampant among the medical pedagogues. Although these latter-day educators might be pitied in their glorification of the arcane it seems that their condition is self-inflicted in the hope that they will be able to maintain a monopoly on their unsharable "expertise."

According to the disciples of evidence-based care, "[t]here are four steps in determining how to manage a clinical problem. The first is to formulate questions that are answerable . . ." Does any physician, or anybody else in their right mind, start by posing unanswerable questions? The second step is "to locate and synthesize the evidence needed to answer the questions . . ." This suggests that the physician should leave the patient, who may be in diabetic coma, rush out and request a MEDLARS search, and then conduct a critical appraisal of the articles found. The third step is "to estimate the expected benefits, harms and costs of each option . . ." These should be known to the physician before he or she sees the patient. The fourth step is "to judge the relative value of the expected outcomes to conclude whether the benefits are worth the harms and costs." The advocates of evidence-based care revel in obfuscation and platitudes.

In the same issue of *CMAJ*, in Jill Rafuse's article "Evidence-based medicine means MDs must develop new skills, attitudes, CMA conference told" (150: 1479–1481), Dr. Gordon Guyatt is reported as having told attendees at the CMA's 6th annual Leadership Conference that evidence-based care places less value on clinical experience and the study of physiologic principles. Has Guyatt ever given any thought to how Harvey discovered the circulation of the blood if not by meticulous observation and the application of sound physiologic principles? Guyatt also mentions that emphasis should be shifted from traditional medical training to "systematic observation." How did Osler, Hunter, Koch and the other great names throughout the ages make their contributions if not by systematic observation. Does evidence-based medicine offer something that these giants lacked? I doubt it.

Philosophers, historians and scientists from Molière to Medawar have passed on their message by using everyday English, French, German and Latin. This applies to Newton, Lavoisier, the Curies, Virchow and Villemin. They eschewed pompous and pedantic language that rendered the speaker speechless, if not dumb. They subscribed to the pithy apothegm, as did that great Harvard philosopher and satiric songwriter, Tom Lehrer, who maintained, "If you can't communicate, shut up." It used to be said, "He who can, does; he who cannot, teaches."