

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 associates⁷ 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: gobbledygook

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 gobbledygook 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.”

Today, those who cannot become medical educators speak in mandarin and, in their effort to remain elite, have painted themselves into a corner. Unfortunately, these days people are not taught Latin, but had they had the good fortune to learn that noble language they might subscribe to Seneca's aphorism "What cannot be said simply is not worth saying."

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[Dr. Guyatt responds:]

I congratulate Dr. Morgan on his vivid and entertaining use of language and particularly on his effective use of alliteration. It is unfortunate these are used in an extravagant denunciation of not only medical pedagogues but also behavioural scientists.

I am surprised that he found Ms. Rafuse's article loaded with jargon. The author, a journalist rather than an advocate of evidence-based medicine, did a good job of minimizing the use of jargon.

Not only do physicians regularly ask unanswerable questions, they often mistakenly believe they have the answers. Dr. Morgan's characterization of the use of evidence-based medicine in the emergency room is obviously a parody. He is right that physicians should know the expected benefits, harms and costs before intervening; however, they often do not.

In his final paragraph Dr. Morgan suggests that his main complaint is that advocates of evidence-based medicine have difficulty communicating simply and clearly. The enthusiastic response to the first article describing the evidence-based approach¹ and to our series of users' guides to reading the medical literature,^{2,3} the international attendance at our yearly workshop on how to teach evidence-based medicine, and the expanding interest in this approach at international scientific meetings and among medical educators all over

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