ity rate for 1994 does not necessarily imply a deterioration in perinatal or infant health; it could be the result of random variation. However, the concomitant increase in the proportion of live births of infants weighing 500 g to 2500 g in 1994 adds to the seriousness of the increase in infant mortality. We are examining regional patterns in the change observed in 1994 and attempting to exclude possible errors in the data. Future trends in low birth weight and infant death require close attention.

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Beware the curriculum-reform troops

The CMA needs to rethink its endorsement of a gay curriculum for medical schools, as described in the article "Gay, lesbian and bisexual health care issues and medical curricula" (*Can Med Assoc J* 1996;155:709-11), by Drs. Gregory Robinson and May Cohen.

This program looks like a design not to influence competency but to mandate a prescribed moral belief about homosexuality. Human sexuality is inherently a moral discussion. Will this proposal give full expression to differing views and model the tolerance it purports to teach? Without penalty? Moral convictions at odds with this curriculum could be risky for student or faculty. A closet might be a safe place.

Then again, maybe the authors have in mind the original idea of the university — unimpeded inquiry, free expression of ideas, search for truth — and I just missed it. We have here a curriculum enthusiastically promoted but without evidence. AIDS aside, questions of prevalence, genesis, dynamics, associated morbidities and medical justice relating to homosexuality are largely unstudied but are typically decided in the well-rehearsed court of febrile opinion.

This proposal appears to offer no departure. Surely medical research is not satisfied by reference to a few surveys of the gay population. The sad irony is that because the answers are "known" before the questions are posed and because acceptance of homosexual behaviour is sacrosanct, it is unlikely that tough issues will be faced, that rigorous research will be conducted and, ultimately, that anything will be learned.

Finally, and most offensively, is what the authors propose the good physician to be. Rather than simply showing compassion, integrity and respect for all, it is conformity that matters. Acquiescence to a particular moral view becomes the proper aspiration of all physicians. Dr. Michael Myers urges people in medicine who belong to quite conservative religions that consider homosexuality a sin to refer their gay patients to other physicians (*Can Med Assoc J* 1996; 155:770). In this brave new curriculum, when we cannot change people's beliefs, they keep them to themselves,

Table 2: Rates of live births by weight category*

	Year; rate per 1000 live births†								1987 to 1993		1987 to 1994	
Birth weight, g	1987	1988	1989	1990	1991	1992	1993	1994	χ^2‡	*p* value	χ^2‡	*p* value
< 500	4.7	4.2	3.9	5.8	8.2	5.1	8.5	5.8	71.26	< 0.01	47.65	< 0.01
500–749	1.4	1.3	1.6	1.3	1.4	1.4	1.6	1.5	3.34	0.07	5.73	0.02
750–999	1.7	1.8	1.8	1.7	1.7	1.7	1.8	2.0	0.00	0.96	5.32	0.02
1000–1249	2.2	2.1	2.0	2.2	2.2	2.2	2.3	2.2	2.12	0.15	1.44	0.23
1250–1499	2.8	2.7	2.6	2.8	2.8	2.6	2.9	2.8	0.18	0.67	0.57	0.45
1500–1749	4.1	4.3	4.1	4.1	4.1	4.1	4.0	4.2	0.98	0.32	0.15	0.70
1750–1999	6.6	6.6	6.5	6.3	6.4	6.5	6.8	7.5	0.04	0.84	16.13	< 0.01
2000–2249	12.2	12.9	12.1	12.4	12.3	12.3	12.0	12.0	3.19§	0.07	5.11§	0.02
2250–2499	23.8	24.6	24.5	24.0	24.2	23.6	25.5	27.1	4.49	0.03	59.81	< 0.01
Not stated	2.0	3.7	3.7	2.9	8.7	3.6	3.0	1.6	208.18	< 0.01	0.12	0.73
500–2499	54.9	56.1	55.2	54.8	55.1	54.4	56.8	59.3	1.14	0.28	44.74	< 0.01

*Data from Newfoundland not included.
†In the category of birth weight < 500 g, the rate is per 10 000 live births.
‡1 degree of freedom.
§A decreasing trend.

and we mandate referral. Whether this advice applies to other types of behaviour that people find sinful, such as adultery, child abuse and lying, is not stated. Perhaps we need a list of referrable sins and colleagues who agree with them. Drs. Robinson and Cohen opine that physicians with good understanding cannot provide optimal care to gay patients if they do not support their orientation. This belies an indifference to our calling to serve the patient's best interests first.

This curriculum is not about understanding, ethics or the good of the patient — the noble traditional pursuits of medicine — but about something foreign and foreboding. The curriculum-reform troops are at the school gates, but educators would do well to pause before admitting them with this self-interested agenda, threat to freedom of conscience and impoverished idea of what a good physician is.

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Calgary curriculum on gay and lesbian issues

The article "Gay, lesbian and bisexual health care issues and medical curricula" (*Can Med Assoc J* 1996;155:709–711), by Drs. Gregory Robinson and May Cohen, was welcome. As the authors note, gay and lesbian health concerns have all too often been absent or minimal in medical education. I am glad to see that these concerns are now being addressed at a national level.

I was dismayed, however, that the University of Calgary Faculty of Medicine was not discussed. Gay and lesbian issues have been on the curriculum here for 25 years. These issues currently constitute at least 4 hours of core curriculum, half of which involves large-group presentation, including gay and lesbian patients discussing their experiences with the health care system in Calgary. The other half of the time is devoted to small-group, preceptor-led sessions at which gay and lesbian issues in general and gay and lesbian health care in particular are discussed in a problem-based-learning context. Volunteer patients are available to the small groups to discuss their health care experience as well as issues concerning gay and lesbian experience and their effects on health.

These sessions are highly valued by the medical students and are often touted as one of the most meaningful of the learning opportunities in the entire core curriculum. I have been approached by students, residents and staff who acknowledge the importance of this area not only in health care delivery but in gay and lesbian physicians' place in the health care system.

We are now expanding the curriculum to include gay and lesbian youth issues, particularly cultural oppression and suicide, in the curriculum dealing with child, adolescent and family development.

I would be happy to share our curriculum with any interested readers.

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Curing and killing

As time passes, the wisdom of Hippocrates is more widely recognized. However, one aspect of the "Alberta Euthanasia Survey: 3-year follow-up" (*Can Med Assoc J* 1996; 155:885-90), by Drs. Marja J. Verhoef and T. Douglas Kinsella, is deeply disturbing; namely, the physician's view of who should do the killing, be it merciful or merely contractual.

Canadian physicians who have practised medicine in parts of the world where pre-Hippocratic ethics survive need to share that experience with our colleagues at home. Long meditation on these realities undoubtedly inspired the Hippocratic Oath in the first place.

Animistic, natural or traditional healers, sometimes called "witch doctors," practise both killing and healing. They know about poisons. Thus, when you go to visit such a physician you must always wonder whether someone else has paid more for your death than you have paid for your life. Trust is very much reduced under such circumstances. Anthropologist Margaret Mead understood the radical implications of the Hippocratic Oath.

> For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with power to kill had power to cure, including specially the undoing of his own killing activities. . . . With the Greeks, the distinction was made clear. One profession, the followers of Asclepius, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect — the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child. . . . This is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer — to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. . . . It is the duty of society to protect the physician from such requests.[1]

We believe that this argument should convince most physicians that we should have nothing to do with mercy killing. Taking on this