major national priority. However, we doubt that even the best palliative care would eliminate all requests for euthanasia or assisted suicide.

Kreyes' appeal to "common sense," no matter how attractive, is unlikely to provide a solution to the complex and pressing social problems of euthanasia and assisted suicide. This is an issue on which people of common sense disagree.

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## Gender sensitivity a sensitive issue

One of the excellent reviews concerning gender sensitivity, "Gender sensitivity in medical curricula" (*Can Med Assoc J* 1997;156: 1297-1300), by Barbara Zelek and associates, neglected very important terminology that has been used in the US but was not included in this article.

The term "seminar" should be reserved for teaching presentations involving male faculty members, with "ovular" being used for presentations by female faculty members.

**Jack H. Walters, MD**
St. Louis, Mo.
Received via email

I read the article by Zelek and colleagues with what I felt was genuine sensitivity. I have been educating young women and men to become physicians for the past 30 years and have been conscious for most of that time of the problems facing both sexes. I do not believe the problem to be as complex as the authors suggest. It is real but it is also simple: it is a matter of choosing the right words. In health care we are notorious for creating new words and giving old ones new meanings. A lot of our problems would be solved if instead of creating new words we made use of well-established ones. The article asks us to be sensitive to "genderizing" medical curricula. Gender is defined in this paper as "both the real relations between the sexes and the cultural renderings of those relations." I do not agree. The word gender refers to a grammatical classification of objects roughly corresponding to the two sexes and sexlessness (for example, masculine, feminine, neuter). Ships are a good example: for eons they have been of the feminine gender.

Gender has nothing to do with real relations between the sexes or their cultural renderings. Two simple words are enough to define this: respect and equality. And what this requires is the right attitude. The creation of new words and the misunderstandings of old ones are not the answer.

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I read this article with dismay, and I am concerned that there is a tendency for our prestigious journal to be involved in subject matter best reserved for newspapers. I am also concerned that the article was classified as educational. I hesitate to open a can of nonmedical worms but hasten to state that I am entirely sympathetic to the concerns of the authors, but not to their methodology. Simply stated, both genders should be treated equally, fairly and with respect in every way. However, promotion of the misuse of words and syntax destroys much of what is good by levelling everything in reaction to a history of gender inequality, which a decreasing minority of both sexes perceives to still exist.

If we need to alternate "men and women" with "women and men," we will need to do a count to ensure equal use. We will then be unable to concentrate on the merit of a medical article. What education! What syntax!

The principle of equality of the genders is unquestioned, and some suggestions in the article have merit. For example, if only the title Mr. is to be used for men, then Ms. should be used for women. Age and marital status are personal and irrelevant.

**Leslie (*Gender?*) S. Glass, MD**
North Vancouver, BC

I believe this is a timely and valuable article and particularly appreciate the advice for medical educators that will help us to avoid creating difficulties unwittingly. That one can easily be gender insensitive during a medical communication is exemplified in the last paragraph of the section on guidelines relating to language. The authors suggest changing "a 23-year-old woman who works as a medical secretary" to "a 23-year-old medical secretary." While this change might place equal emphasis on this person's occupation, compared with the previous example of a "40-year-old professional man," it has become totally insensitive to gender. The authors are presuming that all medical secretaries are women. If this was the only mention of the secretary's sex in this med-

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

**P. Gerard Cox, MB**
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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**
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**[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-