the steering committee. However, 10 had to be chosen, and neither of these made the final list. Both are included among the topics that the steering committee has proposed for the (hoped-for) successor to these guidelines.

Like breast reconstruction and lymphedema, hormone replacement therapy could not be included in the first set of guidelines but is high on the list of topics for the next set. The policy statement of the SOGC will be valuable at that time, and I thank Dr. Reid for drawing it to our attention.

Probably neither Dr. Rieckenberg nor Dr. Ramsay disagrees with the general thrust of the paragraph in question, which can be summarized as follows: (1) The histopathological diagnosis of DCIS is often difficult — even the pathologists of a major clinical trial had difficulty. (2) Experience, in the form of a substantial DCIS caseload, presumably helps interpretation. (3) If there are any pathologists who lack such experience, they should not hesitate to refer specimens to a centre with special expertise. Naturally, it is the pathologist who must determine when expert consultation is needed.

I thank the co-participants of the Maritime Hereditary Cancer Programme for their excellent summary on genetic risk, but ask for their patience with us guidelines writers. We did not include hereditary risk factors among the first 10 topics, although we probably should have. I have little doubt that this topic will be tackled in the second round.

I am grateful for all of these helpful comments and those that were published in an earlier Letters section of *CMAJ*. I consider this correspondence a continuation of the Canada-wide consultation that was an intrinsic part of the development of the first 10 guidelines. All of these comments will be considered by the steering committee as it starts round 2, and they will all help to further mould a Canadian consensus.

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This list works. Use it

Dr. Brian F. Rudrick, in his letter "Familial abuse: a multifaceted problem" (*CMAJ* 1998;158[7]:866-7), presents good arguments but misses the point. Yes, women also abuse, and many items on "The eight types of abuse" list (*CMAJ* 1997; 157[11]:1557-8) can be applied to women who abuse. However, the list and the accompanying article, "More than meets the eye: recognizing and responding to spousal abuse" (*CMAJ* 1997;157[11]:1555-6), by Fern Martin and Dr. Catherine Younger-Lewis, address the abuse of women.

Why does this invariably happen? An article about the care of women is published, and someone objects that it appears to exclude men. If a medical journal published an article on a condition affecting children, say gastrointestinal disorders, would letters arrive asking "Why ignore adults? Don't we also suffer from GI disorders?"

The purpose of the article by Martin and Younger-Lewis and the exceptional list was to provide a tool for all physicians to help their patients discuss, and perhaps even address, abusive relationships. Remember the introductory paragraph: "This list is based on one made by *men* [italics mine] who were describing how they controlled or harmed their wives or girlfriends."

I speak as a woman who escaped 15 years ago from a long-term abusive relationship. The Lanark County Interval House list is the best thing I have ever read on abuse. As Martin and Younger-Lewis so eloquently state: "Many of the actions listed may be considered innocent when weighed in isolation. In combination and over a period of time, however, they may constitute a pattern of behaviour designed to break another person's spirit." The list validates the experience of a woman subjected to assaults on her spirit. If this list had been offered to me by my GP or my children's GP, it could have changed my life and given me the courage to leave years earlier.

Pay attention, physicians. This list works. Use it.

Jennifer Raiche
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Received by email

Getting prepared for rural practice

Dr. Allon Reddoch's article "A warm place to practice: meeting the challenges of medicine in the North" (*CMAJ* 1998;158[3]:337-8) voices the concerns of many future medical students. Our medical schools must recognize that the shortage of rural practitioners is partly associated with the lack of technical training for rural practice.

I hope to practise as a family physician in a rural or remote setting. I am familiar with the limitations of these practices because I was raised in Faro, YT. My concern is that medical school will not provide me with the technical skills and the knowledge needed to practise in resource-poor regions like the Yukon.

As Reddoch noted, some schools are providing rural rotations, but more universities must recognize the special technical needs of rural physicians. Acknowledging resource limitations and then training physicians