



cons of the test, find out what is important to the patient and — perhaps of more value in such a decision — what is *not* important to him, and then allow him to make the decision for himself.

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#### [Fred Tudiver and colleagues respond:]

Tom Vandor makes the interesting point that we frequently blame the user (the physician) when a clinical practice guideline is not “unanimously” followed, yet there is little research examining the deficiencies of guidelines. As outlined in our editorial, we believe that there are many other factors that affect the adoption of guidelines: physician and patient characteristics, social influences and practice characteristics.

James Goertzen addresses what we believe is an important factor in guideline adoption, the issue of conflicting guideline recommendations from different agencies. He drives this point home by directing our attention to the article on prostate cancer<sup>1</sup> that appears in the same issue as our editorial. It seems almost impossible not to step into the quagmire of conflicting guidelines when examining the recommendations for a common cancer, such as cancer of the prostate. We agree with Goertzen’s conclusions: that many clinicians face almost daily difficulties as they discuss with their patients which guidelines to follow.

It is for these reasons that our group is now working on a project, funded by the Medical Research Council of Canada, to determine how family

physicians make decisions about cancer screening when the guideline is uncertain or when the guidelines from different agencies conflict.

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### Which curriculum?

I share the concerns of Claude Beaudoin and colleagues<sup>1</sup> about medical education but must ask, “Are these results surprising?” Although we tend to assume that a curriculum is a singular entity, most introductory textbooks on curriculum studies<sup>2</sup> describe a framework in which 3 different curricula, each with its own historical roots and purpose, are always in operation.

The *explicit curriculum* is the dominant concept of curriculum stated in a curriculum document. It is a management tool, a standardization technique, rooted in a scientific and reductionist paradigm that has served researchers in the biological sciences well. It is this curriculum that undergoes reform in

response to criticism or societal change.

The *hidden or enacted curriculum* is that which actually takes place between teachers and learners, what happens in the “real world.” It differs significantly from that which is described in explicit documents. Faculties of medicine rarely look at what they enact.

The *experienced curriculum* is the curriculum that Beaudoin and colleagues have studied, the curriculum as experienced by the learners themselves. Not surprisingly, the outcome data for the experienced curriculum differ from the intended outcomes of the explicit curriculum.

Many curricular theorists argue that curricula are about cultural transmission and not about pedagogical techniques. In writing about medical education, Bloom asks “How can one explain this history of reform without change, of modifications of the medical school curriculum that alter only very slightly or not at all the experiences of the clinical participants, the students and the teachers?”<sup>3</sup> Beaudoin and colleagues have provided just the type of evidence that is needed to help us look at ourselves in the mirror.

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2. Marsh C, Willis G. *Curriculum: alternative approaches, ongoing issues*. Englewood Cliffs (NJ): Merrill; 1995.
3. Bloom SW. Structure and ideology in medical education: an analysis of resistance to change. *J Health Soc Behav* 1988;29(4):294-306.

### Antimotility agents and *E. coli* infection

To the objections you have already received<sup>1-3</sup> regarding your recommendation for the use of antibiotics in the treatment of *Escherichia coli* infec-