specific disinfectant solutions for *C difficile* spores and recommend specialized interventions only in outbreaks.[11] Several solutions have been identified as effective at reducing environmental contamination. An unbuffered hypochlorite solution (500 ppm chlorine) was used in one study to decrease contamination from 31.4% to 16.5% of sampled sites.[12] Another study used a 0.04% formaldehyde and 0.03% glutaraldehyde solution to reduce environmental contamination from 13% to 3%.[13] The American College of Gastroenterology Practice Guidelines for management of *C difficile* diarrhea recommend use of alkaline glutaraldehyde, sodium hypochlorite, or ethylene dioxide as effective disinfectants for vegetative and spore forms of *C difficile*.[14] The Centre for Disease Control and Healthcare Infection Control Practices Advisory Committee guidelines for environmental infection control in health care facilities recommend disinfection with hypochlorite-based germicides in addition to meticulous cleaning to counter environmental contamination with *C difficile* within hospitals.[15]

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Life cycle of family medicine doctors

On November 25 to 27, 2004, I, along with other Canadian family physicians, celebrated the 50th Anniversary of the College of Family Physicians of Canada.

In the past, I have reflected on the life cycle of the family as we care for our patients from birth to death. I deliver the newborn and support the grandparents as they deal with the "golden years."

As I was at the ceremony for our new Certificants, Fellows, and Life members, I thought about the life cycle of family medicine and of family doctors.

On this day, Dr W.D. (Doug) Armstrong (a past Family Physician of the Year) was receiving his life membership certificate. He had just retired from his family practice. He was my family physician and one of my mentors. I first spent time with him as a medical student, learning about family medicine in his office and at the Misericordia Hospital in Edmonton, Alta. Doug encouraged me to proceed with my career in family medicine.

On the day of the ceremony, as I received my Fellowship along with my classmates and colleagues, I pondered how we have taken over the role of our preceptors and mentors and how we are passing on the torch of family medicine as we teach and learn with medical students and family practice residents. This was just what our predecessors and mentors had wanted. They were the grandparents and we were the parents of the family medicine family.

On this same day, there were many new Certificants of our College. I had taught a number of them on their journey in family medicine, but for me, Dr Manickavasagam Sundaram's (Mani's) receiving his certification stood out. I had known him from his first days in medical school during his

"shadowing" experience all the way to the time he spent in my office during his family practice block in 2003. I hope I gave him "fatherly" support to continue with his career in family medicine, and I hope I will continue to do so in the future.

Now it is time for our new Certificants to take over the family medicine torch as the sons and daughters of our family medicine family. And may enthusiasm bubble in them as they start their new careers in family medicine. May they kindle in their medical students and family practice residents the same excitement and the quest for knowledge and the well-being of our patients that was passed on to us from our grandparents and mentors of family medicine not that long ago.

As we have just celebrated a special year for family medicine in Canada, reflect on your own family at home and our other family medicine family. May we support, encourage, and thank them both. And may the life cycle of family medicine doctors continue to prosper like the families of patients that we care for each day.

—Guy Robert Blais
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by mail

Introducing medical students to CAM: Response to Oppel et al

We appreciate the interest of Drs Oppel, Hoshizaki, Mathias, Sutter, and Beyerstien[1] in complementary and alternative medicine (CAM) content in undergraduate medical education. Since the Associate Deans' workshop in 2002, our national curriculum project has moved forward substantially beyond what was described in the editorial.[2] With the exception noted below, we generally agree with the content areas listed as part of the University of British Columbia curriculum. These topics have already been incorporated into our ongoing curriculum development project.

We do have three concerns. First, we are puzzled by the authors' reference to CAM "champions," as this word does not appear anywhere in our editorial. We intentionally avoided this term, knowing that, without definition, it would be prone to misinterpretation. We can only assume that the authors saw this term used in the workshop report (cited in our editorial) and used it out of context. The Associate Deans recommended identifying "leaders in CAM teaching within each medical school," which refers to individuals interested in exposing medical students to relevant CAM-related issues in Canada; reinforcing the importance of critical appraisal of all health care therapies; and providing students with the knowledge, skills, and attitudes to discuss CAM with patients in an informed and nonjudgmental manner. In order to introduce (and smoothly integrate) CAM content into existing curriculums, at least one faculty member needs to provide support to help move the process through bureaucratic and administrative channels. We advocate achieving these curriculum objectives without promoting the uncritical acceptance of any specific CAM practices or products.

Second, the authors identify two primary sources, which they claim that we cited in our editorial (references 3 and 5 in the authors' response). In fact, these sources were neither cited nor mentioned in our editorial. The authors' suggestion that we cited programs that promote CAM appears to have been taken out of context. We referred to the University of Arizona's Integrative Medicine Program merely as an obvious example of the increase of CAM curriculums over the past 5 years in the United States; our intent was not to analyze the degree of objectivity of program content or teaching methods.

Third, the authors propose that CAM curriculums address "why the evidence for CAM is not accepted by the scientific community." The wording of this statement is heavily loaded and, in our opinion, does