"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
Edmonton, Alta
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

not do justice to the many peer-reviewed studies of certain CAM therapies that have appeared in leading scientific journals, or to the variety of current scientific opinion regarding the evidence for certain CAM therapies.[3]

We believe there is a need to build a comprehensive CAM curriculum that interweaves critical appraisal of the evidence, historical and current health care trends, and communication skills in such a way that the curriculum can be adapted and shaped by individual schools to suit their own medical programs. Leadership within the medical schools should be characterized by the principles of balance, diversity, impartiality, and open-mindedness. Our intent is best illustrated by echoing the words of Dr Yasuhiro Suzuki, Executive Director of the World Health Organization, who recently observed that "traditional or complementary medicine is victim of both uncritical enthusiasts and uninformed skeptics."[4] We hope that, with appropriate leadership in the introduction of CAM into medical education, it will eventually be victim of neither. Members of the national CAM in undergraduate medical education project are working together to achieve this goal.

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Calgary, Alta
—Michael Epstein, PHD
Saskatoon, Sask
—Rebecca Brundin-Mather, MASC
Calgary, Alta
—Heather Boon, PHD
Toronto, Ont
—Allan Jones, MD
Calgary, Alta
by e-mail

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Correction

In the November issue of *Canadian Family Physician*, an error was introduced in the CME article on *Clostridium difficile*–associated colitis [*Can Fam Physician* 2004;50:1536-45]. On page 1536, the end of the "Principal Message" in the French abstract should have read "Le métronidazole est utilisé seul comme traitement initial, avec la vancomycin comme second recours."

Canadian Family Physician apologizes for this error and for any embarrassment it might have caused the authors.

Correction

Dans le numéro de novembre du *Médecin de famille canadien*, une erreur s'est glissée dans l'article de FMC sur la colite associée au *Clostridium difficile* [*Can Fam Physician* 2004;50:1536-45]. À la page 1536, la fin du message principal dans le résumé en français aurait dû se lire comme suit «Le métronidazole est utilisé seul comme traitement initial, avec la vancomycine comme second recours».

Le Médecin de famille canadien présente ses excuses pour cette erreur et tout embarras qu'elle aurait pu causer aux auteurs.

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