

**W**e are a risk averse society. Ironically, Canadians are more protected from random acts of nature, trauma, infectious disease, and other life-shortening events more so than perhaps any other society in history. Median life expectancy in Canada is at an all time high, and continues to increase. In spite of this apparent reality, many people are fearful. Fear: of loss of biodiversity, of global warming, of nuclear Armageddon, of a giant meteor striking the planet, of the effect of microwaves on cellular function, of genetically altered crops. This aversion has many consequences, some of which result in an increase in overall risk. In most cases the degree of fear has little or no relationship to the strength of the actual risk or the underlying science. The prevalence of scientific illiteracy contributes mightily to this phenomenon. A parent may think nothing of driving with their child without a seatbelt, incurring real and quantifiable risk, and yet be adamantly opposed to the introduction of genetically altered canola oil for fear of a non-existent threat to the child's health.

Much of the challenge in patient communication in medicine derives from the difficulties in educating patients about risk assessment.

The review article by Karen Psooy from the Winnipeg Children's Hospital represents a step forward in advising patients with a solitary kidney about restrictions in their activity based on the risk of renal trauma. It is plausible that many risk-averse parents of a child with a solitary kidney, for example, would restrict their child's involvement in contact and team sports. The article presents an evidence-based approach, and the evidence is reassuring. Children should be encouraged to engage in physical activity without restriction, modified by common sense. As recommendation 5 states, 'If your child having only one brain doesn't mean that an activity is too risky, neither should the child having only one kidney'. Sound and practical advice.

The CUA guidelines on the management of urinary incontinence is an outstanding summary of a complex field, and should be useful to practicing urologists. Importantly, the article summarizes the new taxonomy of voiding dysfunction. Symptom classification should be related to storage, voiding, and post micturition, rather than to the hodge podge of older terms (irritative versus obstructive, for example). Urologists should make an effort to adopt these new terms, since they reflect a modern understanding of voiding dysfunction, and better communication between colleagues will result.

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