with the effects of cancer. Programs are needed to strengthen muscles that may be weakened as a result of peripheral neuropathy, loss of muscle bulk from chemotherapy or the tiredness that can accompany cancer.

The weakness seen in many cancer patients is different from that in patients with other diseases and it requires different techniques. Attention should also be given to problems such as lymphedema following radiation and the pain that accompanies many tumours.

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Reference

[One of the authors replies:]

On the basis of the traditional medical model, I understand how the label “oncology rehabilitation” would be considered very specific. However, rehabilitation can encompass more than the physical aspects associated with cancer care. It is a process by which a person is restored not only to an optimal physiological but also to a psychological, social and vocational level of functioning. Perhaps “A Comprehensive Rehabilitation Program for Patients Living with Cancer” would be acceptable.

Before this program was launched patients’ needs were evaluated, and our initial efforts were in direct response to the views expressed. Previous research showed us that interventions such as a structured physical activity program could influence not only patients’ physical needs but also their psychological, social and emotional ones.

Remember when patients were told to rest following a myocardial infarction? With time and research, we have learned otherwise. Similarly, patients living with cancer are unsure of what to do. How much activity or exercise is possible or safe? What can or should they do or not do? In addition, cytotoxic therapy is well known for the metabolic and hematological problems it causes, and this forces both physician and patient to be wary.

Because of this, recommendations for exercise programs are rarely if ever prescribed for fear of overexertion. To make matters worse, patients are told to rest and this can potentially lead to further decline in both physical functioning and psychological well-being.

We recognize that our program is incomplete in its current form, in part owing to resource limitations. With ongoing research and further funding, we hope to be able to develop guidelines in all domains of oncology rehabilitation.

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The teaching contributions of residents

In an editor’s preface regarding the recent 10-fold increase in resident tuition fees (from $190 to $1950) at the University of Toronto,1 you referred to an article on the teaching activities of attending staff2 and stated that you were “unaware of any published attempts to create a similar accounting of residents’ contributions to teaching.”

Numerous reports on the extent, quality and impact of the teaching performed by residents have been published. The time residents spend in teaching activities, which includes supervising, instructing and evaluating students and junior residents, has been estimated to be as high as 25% of all resident activities3,4 and is likely to exceed the teaching time of attending staff. Medical students have rated teaching by residents to be an important source of learning; they have estimated that one third of their knowledge is derived from teaching by residents.5 Resident and faculty teaching behaviours are different and complementary.6 Students have responded that residents contribute more to their learning in the clinical setting than do faculty members.7 Investigators are exploring means by which resident teaching may be improved8,9 as well as evaluating the relationship between teaching and learning in residency.10 Although no study has fully documented the number of hours residents spend teaching by year or discipline, and no study has ever evaluated the monetary value of residents’ contributions to teaching, there is little doubt that residents are expected to perform a great deal and are recognized by medical students as an important source of learning.

The fact that residents perform a great deal of teaching is a separate issue from that of resident tuition fees. There is a lack of acknowledgement and remuneration for clinical teaching activities performed by both attending staff and residents. The decrease in government revenue for medical schools is also an important issue that needs to be addressed. However, to increase resident tuition fees, especially as dramatically as has been attempted, is not an appropriate, effective or fair response. As noted in your editor’s preface, teaching must remain a privilege and a duty for both faculty and residents; a concentrated effort to evaluate, promote, improve and increase teaching performed by residents and staff would better support this goal.

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References
7. Barrow MV. Medical student opinions of the
Methadone treatment

A nn Mullens’ account of the initiative by the College of Physicians and Surgeons of British Columbia to expand its methadone program clearly illustrates the need for better facilities for opioid addicts.1 However, the wider debate about methadone should also incorporate the fact that methadone is a tried and tested drug for the treatment of chronic pain and for pain in terminal illness. It is cheap, long lasting and well absorbed when taken orally. However, many pain and palliative care specialists hesitate to prescribe this useful drug because, without a permit, the referring physician is usually unable to continue therapy.

No one would argue against making sure that those who care for people addicted to opioids have the necessary training and experience. Restricting physicians’ ability to prescribe methadone may achieve this, but it places an extra administrative burden on those who care for those with intractable pain or who are near death.

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Reference

J e voudrais attirer votre attention sur le point suivant tiré d’un article récent : «All patients start with daily witnessed doses of methadone, usually at about 80 mg daily»1. La dose de 80 mg par jour est, à mon avis, une dose d’entretien usuelle et non une dose initiale souhaitable. La dose initiale devrait plutôt être dans la zone de 15-30 mg par jour. De plus, l’on rapporte des mortalités chez les patients recevant des doses initiales de 70 mg ou plus2.

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Références

Correction
A copyediting error was made in a recent article by Michael Bliss.1 The reference to “sisterhood of nuns” on page 833 should have read “sisterhood of nurses.”

Reference