medically legitimate and potentially pensionable disorder.

The latter subject, I suspect, may point to the covert agenda in this exchange. Addiction medicine is a fledgling area of medical specialization that is actively striving for wider recognition. It does itself no service, however, by launching intemperate attacks on imaginary enemies.

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A fine piece of writing

I just read Dr. Maria Hugi's account of her experience with breast cancer ("Surviving breast cancer: an emergency physician faces the fight of her life," *Can Med Assoc J* 1997; 156:397-9). It may be the best piece of medical journalism I have ever read. Her complete candour about all of the effects cancer had on her life — professional, marital, sexual and parental — and, by implication, on her spirit, is utterly refreshing. Her terse, matter-of-fact style made the unspoken anguish all the more apparent, but only because of this candour.

Rare indeed must be the physician who can discuss the sexual side effects of hormonal therapy, attend a doctor-bashing support-group meeting and admit that her clinical skills had atrophied, and do so in a public forum. Rarer still must be physicians who can read this and not see their next patient with cancer, or even anxious about cancer, in a different light.

I suppose, ideally, that the fact that this story came from a fellow physician should not increase its relevance to us, but I believe that it does, immensely. Perhaps this is because so much of what I see as a neurologist is not what it seems, even regarding physical signs. I sometimes have difficulty believing something is the way it is until I find a physician, presumably as objective about medical matters as I am, who is experiencing it. I have thought, since my oncology rotation during internship, that the experiences of physicians with cancer could be a vast source of information about the human side of cancer. Time and again, while administering heroic chemotherapy in what was fairly obviously the last weeks of a person's life, I have asked myself, "Is this what a knowledgeable physician, a truly informed person, would want?" I still do not know the answer to that question, but I do know a whole lot more about humanity's gritty survival instincts, hinted at in Hugi's article. Thoughtful physicians who read it cannot help but improve or renew their appreciation for the experiences of patients with cancer, particularly women with breast cancer.

Keep up the good work, Dr. Hugi (and I love the name of your support group, "Treasure Chests").

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Residency-exchange programs

The resident-selection season is upon us again, and the process cannot help but provoke some thoughts on some of its apparent flaws. Canadian medical graduates are increasingly apprehensive about obstacles to returning to their home province if they choose to train elsewhere. As a result, they are often making choices that may have more to do with family and geography than with education.

One approach that may partly answer new graduates' worries would be to modify the current resident-training system to allow and encourage trainees to spend at least 1 or 2 years of training in another Canadian program. If this idea were widely accepted, an exchange between programs could develop so that there would be no alteration in the total number of residents in any program. For example, residents in anesthesia at the University of British Columbia could do their third year at the University of Toronto, with Toronto residents in anesthesia moving to Vancouver.

If the present resident-selection process and educational system are allowed to continue without change, there will likely be a great diminution in exposure to different ways of thinking and working as well as in opportunities to engage in special learning experiences. The increasing geographic narrowness of medical education in Canada should be examined not only for its impact on residents but also for its implications for the medical profession and the quality of health care in this country.

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Radical choices in mastectomy

I found the editorial "A surgical subculture: the use of mastectomy to treat breast cancer" (*Can Med Assoc J* 1997;156:43-5), by Dr. Adalei Starreveld, to be a bit patronizing.

Of course all surgeons are aware that partial mastectomy and irradiation is the treatment of choice in most cases of breast cancer, but not all of us practise in communities near radiation-therapy centres.

When confronted with the need for 6 weeks of treatment out of town away from dependent, often elderly, relatives — not to mention dependent