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.

Samuel E.D. Shortt, MD, PhD
Adjunct Associate Professor
Department of Family Medicine
Queen's University
Kingston, Ont.

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").

John C. Hostetler, MD
Kingston, Ont.
Received via e-mail

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.

William L. Maurice, MD
Associate Professor
Department of Psychiatry
University of British Columbia
Vancouver, BC
Received via e-mail

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

pets — many older women choose the "quick fix" — modified radical mastectomy — and an overnight stay in hospital.

Would academic surgeons please descend from Mount Olympus and view the world through the eyes of the humble community surgeon?

David E. Leask, MD
Kitchener, Ont.

[The author responds:]

Dr. Leask's letter illustrates part of the problem described in the article "Patterns of initial management of node-negative breast cancer in two Canadian provinces" (*Can Med Assoc J* 1997;156:25-35), by Dr. Vivek Goel and associates. Mastectomy rates vary among Canadian provinces, and travel time to a radiation-therapy facility is inversely associated with the use of breast-conserving surgery in both provinces (although it is not statistically significant in Ontario). However, travel time and other variables were insufficient to explain the large difference in mastectomy rates between British Columbia and Ontario.

Everyone who sees many women with breast cancer knows that some women prefer definitive treatment by surgery if it will shorten the time they have to spend away from home. As well, we all know surgeons (and not exclusively surgeons in rural communities) who tend to perform mastectomies in older women as well as those who tend to perform mastectomies because they privately still hold the opinion that mastectomy is the better treatment. More than once a patient has told me that her surgeon gave her both options but concluded, "If you were my wife . . ."

There also is the distressing fact that some women still need radiation therapy after a mastectomy, when the risk of local or regional recurrence is high. The combination of these treatments exposes these women to a considerable risk of lymphedema.

I did not wish to patronize, and Leask's statement that all surgeons are aware that partial mastectomy and irradiation are the treatment of choice in most cases of breast cancer brings me some reassurance.

Adalei Starreveld, MD
Radiation Oncologist
Cross Cancer Institute
Professor
Department of Oncology
University of Alberta
Edmonton, Alta.

India's hungry mosquitoes

My husband, Dr. Curtis A. Steele, and I have just returned from India. We learned all we could about malaria before the trip and followed advice, and I hope we will not acquire the disease. We would like to add some information to the article "Malaria in Canada" (*Can Med Assoc J* 1997;156:57), based on our experience.

Arriving in the Bombay airport at 2 a.m. — most flights from abroad arrive in the middle of the night — hundreds of travellers stand in line in a space where mosquitoes abound. To prevent being bitten, visitors must apply an insect repellent before landing. We did not do this and were each bitten dozens of times before arriving at the immigration desk.

Window screens are seldom used in India. During our travels we saw only one screened window, and a few more with lace serving a partial screening function. Even in our air-conditioned hotel the bathroom window had a grille, not a screen, between us and the outdoors. Screen doors do not exist — outdoors and indoors are one.

There was nothing from which to hang a bed net in any of the places we stayed, expensive hotels or otherwise. We find it impossible to imagine being in India and not being bitten by mosquitoes, unless one stays covered in a completely effective mosquito repellent.

Nancy Porter-Steele, PhD
Halifax, NS
Received via e-mail

Cumulative patient profiles

Dr. Richard Tytus and I read with great interest the article "Physicians who keep lax records put careers in danger, college course warns" (*Can Med Assoc J* 1996;155:1469-72), by Dee Kramer. Because we are involved with the Practice Management Committee of the Hamilton Academy of Medicine, we responded to members' requests by developing a series of patient-record-management sheets, the cornerstone of which is the cumulative patient profile. As is evident from the cumulative patient profile form presented with Kramer's article, the most recent update of this form was by the University of Toronto in 1977. We designed our sheets to reflect current concerns and provide versatility for individual physicians. Physicians who would like to receive a sample copy can contact me. Multiple copies can be obtained from Colwell Systems, tel. 800 265-3375.

Michael J. Pray, MD
Harbour Commissioners Building
102–605 James St. N
Hamilton ON
L8L 1J9

No barriers in Manitoba

CMAJ's Pulse column ("Financial and geographic barriers to fee-for-service practice," *Can Med Assoc J* 1997;156:616) summarized the financial and geographic barriers to fee-for-service practice across Canada, but the information with respect to Manitoba is out of date.