become pregnant. Presumably, we are all talking about folic acid supplementation, smoking cessation, and avoidance of alcohol and drugs in this situation, so why not talk about HIV? The sooner we become more comfortable with discussing this topic, the better our prevention strategies will be.

Donna Keystone, MD
Bloor Medical Clinic
Toronto, Ont.

The fatigue of cancer

Dr. Jane Poulson, in her inspiring article on coping with the chemotherapy-related fatigue of cancer, "Dead tired" (*CMAJ* 1998;158 [13]:1748-50), offered a challenge to palliative care physicians to seek out the pathophysiology and treatment of this "pervasive and depressing symptom." As part of a larger study involving the Edmonton Symptom Assessment System (ESAS), we reviewed what literature was available on the measurement of fatigue.

Smets and associates[1] reviewed fatigue in cancer patients in 1993, noting that 70% of patients report a sense of fatigue during chemotherapy or radiotherapy and that, for certain diagnoses, 30% to 40% of patients continue to lack energy for years after the treatment is finished. In 1997 Vogelzang and colleagues[2] reported on a telephone survey of 419 cancer patients and their oncologists. Whereas 78% of the patients suffered fatigue and 32% reported significant disability because of it, only 27% of the oncologists recommended treatment for fatigue. Half of the patients did not discuss treatment of fatigue with their oncologists.

Poulson suggests that we physicians take this symptom too lightly, and I agree. In our recent, as-yet-unpublished study, we used the ESAS, which involves a series of 100-mm visual analogue scales for measuring 9 symptom domains, of which tiredness is one. For the tiredness subscale, we recorded the blinded perceptions of this symptom by the patient, the nurse and a close family member. The mean score (out of 100) of the patients was 34, of the nurses 40 and of the family members 38. Agreement, as measured by Cohen's kappa statistic, was significant between the patient and the family member (κ = 0.47) but not between the patient and the nurse (κ = 0.11). Although the nurses overestimated the patients' tiredness, there was poor agreement on the presence of this symptom.

We did not study physicians, but if the nurses' perceptions are anything to go by, we doctors are probably just as unskilled at recognizing this symptom (or, more likely, worse). To relieve suffering we must recognize the existence of the symptom and its effect on those afflicted. We must also accept that this recognition may be obscured by our paucity of knowledge, our presumptuous attitude or our restricted skills in this arena.

Bill Eaton, MD
St. John's, Nfld.
Graham Worrall, MD
Whitbourne, Nfld.

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Our experience in treating patients with metastatic disease resulting in spinal cord compression has been that attempts at rehabilitation are often stymied by the fatigue that Dr. Jane Poulson describes. People who are trying to develop a given set of muscles to compensate for weakness elsewhere in the body or to gain some measure of independence despite paralysis are often prevented from accomplishing their goals because of the fatigue associated with cancer. We now recognize that people with such fatigue can probably tolerate only 30 to 60 minutes of aggressive therapy and exercise a day. Instead of admitting these patients to a rehabilitation ward, where 4 hours or more of therapy is given daily, we are now more frequently admitting them to a palliative care ward, where 23 hours of each day can be devoted to quality of life and comfort and where the patient does not have to watch others improve dramatically while they are just too tired to participate fully in the rehabilitation program. This new approach appears to allow for a balance between quality of life and the limited amount of therapy that can be tolerated.

Patrick J. Potter, MD
Acting Chief
Physical Medicine and Rehabilitation
University of Western Ontario
London, Ont.

Our worst public health evil

The third sentence of the Editor's preface in the July 28 issue (*CMAJ* 1998;159[2]:125) is either wrong or written misleadingly. In it, Dr. John Hoey refers to the fairly well-established epidemiology of the health effects of tobacco and alcohol, going on to state that "[t]he health effects of illicit substances such as cocaine and heroin are even greater." Overall, they are not. Recent data show high rates of smoking in Canada, which reflect in particular a failure to deter young people from smoking. Alcohol use is also widespread. Because of the sheer numbers involved, these "legal" drugs cause more ill health than heroin or cocaine.

If what was meant was merely that the ill effects of cocaine or heroin use on the health of individual users are greater than the ill effects of tobacco

or alcohol, the statement may be accurate. However, the greatest overall harm to our nation comes from our "respectable" drugs.

William McCormick, MD
Professor Emeritus
Department of Psychiatry
Dalhousie University

[The author replies:]

Dr. McCormick has pointed out an important nuance, one with which I agree.

John Hoey, MD
Editor-in-Chief

A new approach to suicide

Doris Sommer-Rotenberg is to be congratulated on her campaign to establish a research chair in suicide studies at the University of Toronto, as described in her article "Suicide and language" (*CMAJ* 1998;159[3]:239-40). Her courage in speaking out against the stigma of suicide and mental illness is an example for all.

Sommer-Rotenberg asserts that the phrase "commit suicide" is part of the problem. It is. More damaging than the terminology, however, is the underlying implication: that suicide signifies a moral lapse by the patient or a failure by either physicians or relatives to prevent it.

The clinical reality is that up to 60% of people with schizophrenia will experience suicidal thoughts, and 10% will die as a direct result of the illness. The rates are similar for bipolar illness. In psychiatry we say that the patient committed suicide; in any other branch of medicine we say that the illness had a fatal outcome. Only when we stop seeing suicide as a moral lapse and recognize it as a possible outcome of a brain illness will we start to use standard medical means to address the problem.

In Victoria, deaths from suicide vastly outnumber those from motor vehicle crashes (Dianne Olson, Regional Coroner Victoria Region, BC Coroner's Service: personal communication, 1998). For example, last year 61 people died from suicide and 13 from motor vehicle mishaps. Those latter 13 people received extensive media coverage, but the 61 who died from suicide did not receive the same attention, nor will others who die the same way until more people like Sommer-Rotenberg are willing to stand up publicly and say, "My son had a psychiatric illness that was fatal, and something must be done."

Properly organized programs of care *can* make a difference. For example, a Swedish public health program in 1983/84 showed that primary care physicians, properly supported, can reduce the suicide rate.[1] Following an educational program concerning depression, given to all general practitioners, the suicide rate dropped significantly, especially among those with major depression. Admission to hospital for depression also decreased substantially. The prescription of antidepressants increased, whereas that of both tranquilizers and hypnotic agents declined. After the program was discontinued, however, the suicide rate reverted to the baseline level.

Mortality rates are reduced by establishing programs to deal with high-mortality illnesses. Some psychiatric illnesses fall into this category. We need to change our thinking about suicide so that we can change our approach to dealing with the problem.

A. Donald Milliken, MB, MHSA
Victoria, BC

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