professionals practising resuscitation. All medical students in Canada deserve sound instruction in resuscitation. We would appeal to each of the aforementioned authors to recognize that we are all working together toward this common goal.

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In their article Dr. Goldstein and Mr. Beckwith make a plea for more time and money to go to the teaching of resuscitation in Canadian medical schools. They list seven courses as essential to an undergraduate curriculum and conclude that "deans must support recommendations from ongoing curriculum review and allocate funds to a specific resuscitation program."

As the undergraduate deans responsible for the curricular content of the five Ontario medical schools we have reviewed this article with some care and have come to quite a different conclusion. We feel that except in the case of courses in first aid and basic cardiopulmonary resuscitation (CPR) all the learning of skills provided by these standardized courses may be included in the undergraduate program but should be clearly defined as a postgraduate objective. Our reasoning is as follows:

1. We can think of no instance in which an undergraduate student would or should be required to practise more than basic first aid and CPR in order to function optimally in clinical settings.

2. All curricula currently teach the principles underlying the appropriate use of resuscitation techniques but must leave the learning of more advanced skills to a time when they are actually required (i.e., during the intern and residency years).

3. Goldstein and Beckwith admit that for competence to be maintained in even basic CPR skills yearly recertification is necessary. This is also true in the case of advanced resuscitation skills, which supports the need to position these courses early in the postgraduate period.

4. As undergraduate deans we are constantly bombarded by groups that, with the best of intentions, feel it essential for their subject to be included in the undergraduate curriculum. An additional 136 hours of curricular content is an enormous increase. The dollar costs cannot be eliminated, although they may be directed through the use of our faculty resources. We ask Goldstein and Beckwith whether they view such technical training as optimal use of the undergraduate student's precious learning time.

All schools are reviewing their curricula and struggling to develop strategies to unburden them. Although the principles of resuscitation are essential components of all undergraduate curricula the teaching of the skills is best done early in the postgraduate training program.

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[The authors respond:]

We thank the undergraduate deans for their interest. We acknowledge that they are faced with the very difficult task of identifying the goals and objectives of an ever-evolving undergraduate medical program.

Let us clarify some misinterpretations of the article. We did not state, as was suggested, that the seven courses reviewed were essential parts of an undergraduate curriculum. These courses were a sample of the growing number of resuscitation courses now available. In appreciation of the limited "curriculum time and funding" we recommended that "consideration should be given to providing a comprehensive resuscitation curriculum rather than seven individual courses."

We also recommended that a conjoint committee be established to tailor a resuscitation curriculum that would consolidate the principles and methods necessary to teach resuscitation skills. It is unclear to us why the learning of resuscitation information and skills "may be included in the undergraduate program but should be clearly defined as a postgraduate objective." The undergraduate and postgraduate deans should meet to review which resuscitation skills can be expected at the various levels.

The four reasons given why advanced resuscitation skills should be part of the postgraduate curriculum represent an approach that produces interns who may be required to provide advanced life support without the proper training. We endorse the ongoing teaching of advanced cardiac life support (ACLS) to clerks at the middle or end of their clerkship, as is now being done in three of the five Ontario medical schools. This would allow clerks to observe and participate in resuscitation under supervision.

We also agree that advanced