cial change. Unfortunately, this has not been my experience, nor that of other women I know who work for social change.

I disagree with Sutherland's analysis of my logic; I believe she is confusing nature and culture, and this leads to a flaw in her reasoning. Certain things are societal constructs and others are biologic facts. Women's bodies are biologic — one can do very little about one's genes. In contrast, women's social circumstances are, to a large extent, due to societal constructs. Poverty or abuse are problems that all of society can rectify.

We all want a better world. We are not trying to deprive ourselves of any wisdom by excluding the sources of such wisdom. Our struggle would be so much easier if the patriarchal system would, in fact, act to alleviate the suffering of so many women throughout the world. I cannot think of a single woman who would not welcome such changes.

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Treatment of cancer pain

Dr. Neil Hagen and associates state that "cancer pain is prevalent in Canada and elsewhere and is frequently undertreated" and that "practising physicians must play a pivotal role . . . [by] acting as patient advocates" ("Diffusion of standards of care for cancer pain," *Can Med Assoc J* 1995; 152: 1205–1209). These statements, the alpha and omega of this epistle, clearly delineate a problem. However, the body of the article, rather than pointing to solutions, merely underscores the heart of the problem — undertreatment of pain.

Why does this article miss the mark?

When a caregiver with a patient in pressing pain considers the implication of "regulatory agencies," "simple, validated algorithms for the management of pain," "multidisciplinary cancer-pain assessment and management" and "demographic data on patients with cancer pain," he or she could throw up his or her hands in confusion and consternation, to the patient's detriment.

One puzzling statement seems to put the cart before the horse: "Feedback to health care providers by regulatory agencies is helpful in showing that the implementation of the innovation results in improved patient outcome." Is it not the prerogative of health care providers, rather than regulatory agencies, to consider treatment options and to record results? Would regulating agencies not formulate protocols after appraisal or assessment of many such initiatives?

Perhaps the suggested diffusion model should be replaced by incorporating patient advocacy into an acceptable mission statement, such as: "Although the physician should be mindful of his or her role in maintaining reasonable standards set out by licensing and accreditation bodies, nevertheless, his or her primary responsibility and concern is to act as the patient's advocate." Thus, a patient would more likely be reassured that his or her pain would be adequately addressed.

This polished paradigm could well replace the distorted perceptions promulgated as part of the "war on drugs" with reassurances such as those from paid pundit Ron Melzack[1] that "morphine given for pain is nonaddictive."

Unfortunately, physicians are often torn between the desire to attend to the pain-relief needs of patients and the fear of constraints imposed by the bureaucratic "Big Brother," which counts and controls the number of prescriptions (through triplicate prescription-pad programs) but is far removed from the needs of a particular patient.

If we could replace the present view — "hang your clothes on a hickory stick, but don't go near the water" — with "damn the torpedoes; full speed ahead," perhaps undertreatment of pain would cause little concern.

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References

1. Melzack R: The tragedy of needless pain. *Sci Am* 1990; 262 (2): 27–33

How important is length of stay?

I believe two points need to be made about the article "Variation in length of stay as a measure of efficiency in Manitoba hospitals" (*Can Med Assoc J* 1995; 152: 675–682), by Drs. Marni D. Brownell and Noralou P. Roos.

To a physician, health is a more appropriate outcome measure than length of hospital stay. To determine cost-effectiveness, it is essential to know whether the cost is justified by the benefit to the patient. Brownell and Roos assume that length of stay has no relation to patient outcome; therefore, cost-effectiveness equals short stay. They base this assumption on the findings of Cleary and associates[1] that there was little difference in patient outcomes despite variation in length of stay. However, these authors specifically stated that "these results cannot be generalized to other types of hospitals or more heterogeneous groups of patients." Brownell and Roos studied eight hospitals and 11 diagnostic categories, including only three of the six medical conditions studied by Cleary and associates. In fact, although Cleary and associates tried to control for "degree of sickness," their data on cholecystectomies suggest that patients with a longer stay had more predischarge problems, which were