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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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

not detected in the medical-record review. The authors also pointed out the need to define the reasons for differences in length of stay before concluding that reduced stays do not compromise health and safety. These factors cast serious doubt on the validity of the assumption on which Brownell and Roos' analysis is based.

The second issue is the total costs of care, including the postdischarge costs. Was there a significant difference in usage of home care between the hospitals or patients that had short stays and those that had long stays? Was there a significant difference in the time lost from work, or in the time and effort spent by unpaid volunteers such as spouses, siblings, parents or children for home care, for patients discharged early versus those discharged late? Brownell and Roos pay no attention to these issues.

Brownell and Roos have shown only that some hospitals routinely discharge patients after shorter stays than other hospitals. They have shown nothing about the total costs to the medicare system or to other members of society, the reasons for the variation or the equality of outcome. Without these elements, their article is interesting and nothing more.

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[The authors respond:]

We agree with Dr. Winkelaar's statement that "health is a more appropriate outcome measure than length of hospital stay." In fact, we have conducted a separate study of health outcomes.[1] Like Cleary and associates,[2] we were particularly interested in whether hospitals that had shorter lengths of stay also had more adverse outcomes. We looked at both readmission rates (an outcome measure commonly used as an indicator of quality of care in hospitals[3–8]) and visits to emergency departments and physicians' offices to determine whether patients with shorter stays experienced complications. We found no relation between length of stay and adverse outcomes, which is reassuring. Other researchers have also shown that shorter stays are not necessarily related to adverse outcomes.[9–13]

We are certainly aware that there are limits to decreasing length of stay without affecting patient health adversely. However, system inefficiencies likely contributed to the differences in length of stay we observed, and there is no evidence that elimination of these inefficiencies will have any effect on patient outcomes. We took great care to ensure that we compared homogeneous groups of patients by controlling for factors that influence length of stay, such as severity of illness, age, socioeconomic status and ethnic background. Despite this, we still found differences in length of stay among the hospitals.

Dr. Winkelaar raises some interesting questions concerning the total cost of care. We do not have access to data on home care in Manitoba; therefore, we could not determine whether patients with shorter stays actually required more home care. However, since the hospitals examined in our study had equal access to the same home-care services, this seems unlikely. Furthermore, we found no difference in the number of physician contacts between patients with short stays and those with long stays, which suggests that there is no difference in the need for additional health care services. As for the costs to patients and their families, we believe that it is not necessarily beneficial (in terms of physical and psychologic health) to spend additional days in hospital.

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