Letters
Correspondance

Reaching a consensus on irritable bowel syndrome

It is surprising that in spite of a repeatedly stated effort to be patient centered no patients were included as participants in the consensus conference on irritable bowel syndrome[1] for what is so obviously a primary care issue. An oversight?

Russell Springate, MD
Toronto, Ont.

Reference

1. Paterson WG, Thompson WG, Vanner SJ, Faloon TR, Rosser WW, Birtwhistle RW, et al. Recommendations for the management of irritable bowel syndrome in family practice. *CMAJ* 1999;161(2):154-60.

I am surprised that a report from an expert consensus conference on irritable bowel syndrome[1] failed to mention the use of peppermint oil. A MEDLINE search using the key words "peppermint oil and irritable bowel" retrieved 33 817 documents. One particularly interesting study was conducted by Pittler and Ernst in 1998.[2] I agree that there is no level 1 evidence here, or anywhere else. However, as the authors of the consensus conference report mentioned almost everything else that can be used to treat irritable bowel syndrome, they should have included peppermint oil.

Paul Lépine, MD
Ste-Foy, Que.

Competing interests: None declared.

References

1. Paterson WG, Thompson WG, Vanner SJ, Faloon TR, Rosser WW, Birtwhistle RW, et al. Recommendations for the management of irritable bowel syndrome in family practice. *CMAJ* 1999;161(2):154-60.
2. Pittler MH, Ernst E. Peppermint oil for irritable bowel syndrome: a critical review and meta-analysis. *Am J Gastroenterol* 1998;93:1131-5.

[The authors respond:]

We agree with Russell Springate that input from patients suffering from irritable bowel syndrome is very important. However, the purpose of our meeting was to critically examine the current medical literature on the management of irritable bowel syndrome to develop evidence-based guidelines for use by family physicians. A small subgroup of the participants in the consensus conference convened a focus group meeting with a number of patients with irritable bowel syndrome in advance of the conference. The ideas and concerns expressed by these patients were discussed in the small group sessions and taken into consideration as we developed our recommendations.

Paul Lépine points out that we did not mention peppermint oil as one of the antispasmodic agents with potential benefit in the treatment of irritable bowel syndrome. To provide a concise review for family practitioners, we made no attempt to be all inclusive in our discussion of drug therapy, and in fact we did not mention over a dozen other antispasmodic agents that have been subjected to clinical trials in irritable bowel syndrome. It is interesting that although Lépine's MEDLINE search uncovered 33 817 documents on irritable bowel syndrome and peppermint oil, Pittler and Ernst[1] included only 5 double-blind, placebo-controlled, randomized controlled trials in their metaanalysis and they concluded that "in view of the methodological flaws associated with most studies, no definitive judgement about efficacy can be given." This underscores the need, as stated in our paper, for proper prospective randomized controlled trials in irritable bowel syndrome that include well-validated outcome measures.

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William G. Paterson, MD
Queen's University
Kingston, Ont.
W. Grant Thompson, MD
University of Ottawa
Ottawa, Ont.
Stephen J. Vanner, MD
Queen's University
Kingston, Ont.
Thomas R. Faloon, MD
University of Ottawa
Ottawa, Ont.
Walter W. Rosser, MD
University of Toronto
Toronto, Ont.
Richard W. Birtwhistle, MD
Queen's University
Kingston, Ont.
Janet L. Morse, MD
Thornhill, Ont.
Thomas A. Touzel, MD
Napanee, Ont.

Reference

1. Pittler MH, Ernst E. Peppermint oil for irritable bowel syndrome: a critical review and meta-analysis. *Am J Gastroenterol* 1998;93:1131-5.

To test or not to test

The authors of the clinical practice guideline for management and referral to nephrologists of patients with elevated levels of serum creatinine[1] have a laudable goal of improving the care of people with renal disease. However, I was left a little uncertain as to just what it was they were recommending as the justification for and frequency of serum creatinine tests. Were they recommending this test as part of a periodic health examination or as part of case-finding or population screening?

These recommendations will be interpreted and acted upon by the family physicians in our communities. As a

laboratory physician, I try to provide services within a defined budget and I have to live with recommendations and decisions taken in faraway places.

Roland Jung, MD
Fundy Laboratory Consultants
Kentville, NS

Reference

1. Mendelssohn DC, Barrett BJ, Brownscombe LM, Ethier J, Greenberg DE, Kanani SD, et al. Elevated levels of serum creatinine: recommendations for management and referral. *CMAJ* 1999;161(4):413-7.

[One of the authors responds:]

Roland Jung raises important questions. Neither the Canadian Society of Nephrology nor the Canadian Task Force on Preventive Health Care has issued a directive about whether serum creatinine testing should or should not be included as part of periodic health examinations. Certainly, widespread population screening is not what we are advocating.

Many physicians perform serum creatinine testing as part of a routine panel of biochemical tests, which may be ordered for many different reasons. The guidelines do suggest a case-finding approach in describing characteristics of patients at high risk for renal failure, in whom serum creatinine should be tested. The guidelines are meant to recommend what should happen when an elevated serum creatinine level is discovered in these settings.

The question about frequency of testing is a difficult one to answer. It was considered by the committee but was not included in the guidelines because there are so many factors that must be considered. For example, annual or biannual testing is sufficient if a patient has mild, chronic and relatively nonprogressive renal failure, whereas monthly testing might suffice for a patient with severe chronic renal failure. Weekly or even daily testing might be required for a patient with rapidly progressive glomenulonephritis.

David C. Mendelssohn, MD
University of Toronto
Toronto, Ont.

Should we preach parsimony for health care?

Webster's dictionary defines parsimony as "extreme or excessive economy or frugality; stinginess." Surely Vahé Kazandjian is not serious in suggesting this as a goal in the provision of health care.[1] "Parsimonious" exactly describes the Canadian health care system at present.

Gerald E. Sinclair, MD
Silton, Sask.

Reference

1. Kazandjian, V.A. Power to the people: taking the assessment of physician performance outside the profession. *CMAJ* 1999;161(1):44-5.

[The author responds:]

In my review of the Physician Achievement Review initiative launched in Alberta, I discussed aspects of performance and quality by placing them within the context of quantitative analysis. The spirit of that analysis is to be scientific in its inquiry, implementation, and evaluation. As a guiding principle I proposed that such a series of steps be undertaken with "parsimony" in mind, or parsimoniously.

The golden rule of science is, indeed, that of parsimony. The Law of Parsimony, also called Ockham's Razor, goes back to the 14th century; William Ockham (died *circa* 1349) stated that *non sunt multiplicanda entia praeter necessitatem*, meaning that one should not increase, beyond what is necessary, the number of entities required to explain anything. This law, used sharply by Ockham (hence the razor), assumes that simpler explanations are inherently better than complicated ones. The scientific method of hypothesis generation and testing relies heavily on this powerful tool. In its recommendation to cut to the essence of things, the Law of Parsimony has shaped Western scientific thinking from Galileo to Einstein, who adapted the law as "make things as simple as possible – but no simpler." Epistemological in nature, the principle can be interpreted as saying that simpler models are more likely to be correct than complex ones.

The Law of Parsimony has also been used in the context of the definitions of quality health care in a seminal work by Donabedian.[1] He stated that "the use of redundant care, even when it is harmless, indicates carelessness, poor judgement, or ignorance on the part of the practitioner who is responsible for care. It contravenes the rule of parsimony which has been, traditionally, the hallmark of virtuosity in clinical performance."[1]

The societal dimension of parsimony is also critical to health care: providing the appropriate care, at the appropriate time, without waste is the responsibility of the health care provider, who should take into account both quantitative and qualitative aspects of diagnosis, patient management and resource utilization.

It is within the context of scientific rigor, clarity of causal relationships and appropriate decision-making that I have proposed that we should be "parsimonious." The scientifically trained mind functions at its best when the desk is cluttered but the decision paths are stingily chosen.

Vahé A. Kazandjian, PhD, MPH
President
Center for Performance Sciences
Elkridge, MD

Reference

1. Donabedian A. *Explorations in quality assessment and monitoring, vol. 1. The Definition of quality and approaches to its assessment*. Ann Arbor: University of Michigan Health Administration Press; 1980. p. 29.

What's in a name?

The report by Roanne Segal and colleagues on the Oncology Rehabilitation Program at the Ottawa Regional Cancer Centre[1] is interesting, but they do not describe how this program differs from those designed for other diseases. For the label "Oncology Rehabilitation Program" to be valid, the program should deal specifically

with the effects of cancer. Programs are needed to strengthen muscles that may be weakened as a result of peripheral neuropathy, loss of muscle bulk from chemotherapy or the tiredness that can accompany cancer.

The weakness seen in many cancer patients is different from that in patients with other diseases and it requires different techniques. Attention should also be given to problems such as lymphedema following radiation and the pain that accompanies many tumours.

C.M. Godfrey
Princess Margaret Hospital
Toronto, Ont.

Reference

1. Segal R, Evans W, Johnson D, Smith J, Colletta SP, Corsini L, et al. Oncology Rehabilitation Program at the Ottawa Regional Cancer Centre: program description. *CMAJ* 1999;161(3):282-5.

[One of the authors replies:]

On the basis of the traditional medical model, I understand how the label "oncology rehabilitation" would be considered very specific. However, rehabilitation can encompass more than the physical aspects associated with cancer care. It is a process by which a person is restored not only to an optimal physiological but also to a psychological, social and vocational level of functioning. Perhaps "A Comprehensive Rehabilitation Program for Patients Living with Cancer" would be acceptable.

Before this program was launched patients' needs were evaluated, and our initial efforts were in direct response to the views expressed. Previous research showed us that interventions such as a structured physical activity program could influence not only patients' physical needs but also their psychological, social and emotional ones.

Remember when patients were told to rest following a myocardial infarction? With time and research, we have learned otherwise. Similarly, patients living with cancer are unsure of what to do. How much activity or exercise is possible or safe? What can or should they do or not do? In addition, cytotoxic therapy is well known for the metabolic and hematological problems it causes, and this forces both physician and patient to be wary.

Because of this, recommendations for exercise programs are rarely if ever prescribed for fear of overexertion. To make matters worse, patients are told to rest and this can potentially lead to further decline in both physical functioning and psychological well-being.

We recognize that our program is incomplete in its current form, in part owing to resource limitations. With ongoing research and further funding, we hope to be able to develop guidelines in all domains of oncology rehabilitation.

Roanne Segal, MD
Ottawa Regional Cancer Centre
Ottawa, Ont.

The teaching contributions of residents

In an editor's preface regarding the recent 10-fold increase in resident tuition fees (from $190 to $1950) at the University of Toronto,[1] you referred to an article on the teaching activities of attending staff[2] and stated that you were "unaware of any published attempts to create a similar accounting of residents' contributions to teaching."

Numerous reports on the extent, quality and impact of the teaching performed by residents have been published. The time residents spend in teaching activities, which includes supervising, instructing and evaluating students and junior residents, has been estimated to be as high as 25% of all resident activities[3,4] and is likely to exceed the teaching time of attending staff. Medical students have rated teaching by residents to be an important source of learning; they have estimated that one third of their knowledge is derived from teaching by residents.[5,6] Resident and faculty teaching behaviours are different and complementary.[6] Students have responded that residents contribute more to their learning in the clinical setting than do faculty members.[7,8] Investigators are exploring means by which resident teaching may be improved[9,10] as well as evaluating the relationship between teaching and learning in residency.[11] Although no study has fully documented the number of hours residents spend teaching by year or discipline, and no study has ever evaluated the monetary value of residents' contributions to teaching, there is little doubt that residents are expected to perform a great deal and are recognized by medical students as an important source of learning.

The fact that residents perform a great deal of teaching is a separate issue from that of resident tuition fees. There is a lack of acknowledgement and remuneration for clinical teaching activities performed by both attending staff and residents. The decrease in government revenue for medical schools is also an important issue that needs to be addressed. However, to increase resident tuition fees, especially as dramatically as has been attempted, is not an appropriate, effective or fair response. As noted in your editor's preface, teaching must remain a privilege and a duty for both faculty and residents; a concentrated effort to evaluate, promote, improve and increase teaching performed by residents and staff would better support this goal.

Andrew J.E. Seely, MD
Resident (R4), General Surgery
McGill University
Montreal, Que.

References

1. The bean counters and the residents [editor's preface]. *CMAJ* 1999;161(5):469.
2. Shea S, Nickerson KG, Tenenbaum J, Morris TQ, Rabinowitz D, O'Donnell K, et al. Compensation to a department of medicine and its faculty members for the teaching of medical students and house staff. *N Engl J Med* 1996;334:162-7.
3. Tonesk X. The house officer as teacher: what schools expect and measure. *J Med Educ* 1979;54:613-6.
4. Brown RS. House staff attitudes towards teaching. *J Med Educ* 1970;45:156-9.
5. Bing-You RG, Sproul MS. Medical students' perceptions of themselves and residents as teachers. *Med Teach* 1992;14(2/3):133-8.
6. Tremonti LP, Biddie WB. Teaching behaviours of residents and faculty members. *J Med Educ* 1982;57:854-9.
7. Barrow MV. Medical student opinions of the

house officer as a medical educator. *J Med Educ* 1966;41:807-10.
8. Byme N, Cohen R. Observational study of clinical clerkship activities. *J Med Educ* 1973;48:919-27.
9. Edwards JC, Kissling GE, Brannan JR, Plauche WC, Marier RL. Study of teaching residents to teach. *J Med Educ* 1988;63:603-10.
10. Bing-You RG, Greenberg LW. Training residents in clinical teaching skills: a resident managed program. *Med Teach* 1990; 12:305-8.
11. Seely AJE, Pelletier MP, Snell LS, Trudel JL. Do surgical residents rated as better teachers perform better on in-training examinations? *Am J Surg* 1999;177:33-7.

Methadone treatment

Ann Mullens' account of the initiative by the College of Physicians and Surgeons of British Columbia to expand its methadone program clearly illustrates the need for better facilities for opioid addicts.[1] However, the wider debate about methadone should also incorporate the fact that methadone is a tried and tested drug for the treatment of chronic pain and for pain in terminal illness. It is cheap, long lasting and well absorbed when taken orally. However, many pain and palliative care specialists hesitate to prescribe this useful drug because, without a permit, the referring physician is usually unable to continue therapy.

No one would argue against making sure that those who care for people addicted to opioids have the necessary training and experience. Restricting physicians' ability to prescribe methadone may achieve this, but it places an extra administrative burden on those who care for those with intractable pain or who are near death.

Saifee Rashiq, MB
Director, Division of Pain Medicine
Department of Anesthesiology
and Pain Medicine
University of Alberta
Edmonton, Alta.

Reference

1. Mullens A. BC college works to change attitudes, attract physicians to methadone treatment. *CMAJ* 1999;161(5):579-80.

Je voudrais attirer votre attention sur le point suivant tiré d'un article récent : «All patients start with daily witnessed doses of methadone, usually at about 80 mg daily»[1]. La dose de 80 mg par jour est, à mon avis, une dose d'entretien usuelle et non une dose initiale souhaitable. La dose initialle devrait plutôt être dans la zone de 15–30 mg par jour. De plus, l'on rapporte des mortalités chez les patients recevant des doses initiales de 70 mg ou plus[2].

Frank R. Lord, MD
Moncton, NB

Références

1. Mullens A. BC college works to change attitudes, attract physicians to methadone treatment. *CMAJ* 1999;161(5):579-80.
2. Brands B, Brands S, editors. *Methadone maintenance: a physician's guide to treatment.* Toronto: Addiction Research Foundation; 1998.

Members of the Advisory Committee on Opioid Dependence were delighted with the *CMAJ* article on the work of the College of Physicians & Surgeons of British Columbia with respect to methadone treatment,[1] which we believe communicated the sense of challenge, excitement and hope that our methadone-prescribing physicians now feel. However, 2 issues in the sidebar deserve clarification.

First, the recommended starting dose is 20–40 mg, and the maintenance dose depends upon the needs of the patient. Second, a physician must submit a registration and assessment form to the college for each patient, with sufficient information to enable the college to advise the physician whether the approved criteria have been met, and if so to register the patient in the methadone program.

A.W. Askey, MD
Chair
Advisory Committee on Opioid
Dependence
College of Physicians & Surgeons of
British Columbia
Vancouver, BC

Reference

1. Mullens A. BC college works to change attitudes, attract physicians to methadone treatment. *CMAJ* 1999;161(5):579-80.

Correction

A copyediting error was made in a recent article by Michael Bliss.[1] The reference to "sisterhood of nuns" on page 833 should have read "sisterhood of nurses."

Reference

1. Bliss M. William Osler at 150. *CMAJ* 1999; 161(7):831-4.

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