case that was the subject of a discipline hearing at the College of Physicians and Surgeons of Ontario. Although discussion of case details is accurate, the outcome of the case was not. In this case, the penalty ordered was a recorded reprimand and suspension of licence for 2 months.

Thank you for bringing this important issue to the attention of your readers.

—John M. Bonn, MD, LLB
Toronto, Ont
by mail

Reference

1. Maurice WL. Talking about sexual matters with patients. Time to re-examine the CMPA's policy. *Can Fam Physician* 2000;46:1553-4 (Eng), 1558-60 (Fr).

Clarification needed for raloxifene use

I appreciate the content and design of *Canadian Family Physician*, particularly its clinical relevance to my practice.

In the Prescrire article[1] in the August issue, two potential uses of raloxifene were suggested in the "Possibly Helpful" box at the beginning of the article. The first use said "in early menopause, when *estrogen is contraindicated*..." (emphasis added). I was unaware that estrogen is contraindicated in early menopause. Can we no longer switch women from oral contraceptive pills to hormone replacement therapy? Is this what the author meant? Is there a reference that would help me?

—M. Reinders, MD, CCFP
Orillia, Ont
by e-mail

Reference

1. Prescrire. Evidence-based drug reviews. Raloxifene. Not better than estrogen [Prescrire]. *Can Fam Physician* 2000;46:1591-6 (Eng), 1598-1603 (Fr).

Response

We should have been more precise. Of course, treatment with estrogen is not generally contraindicated in early menopause: indeed, some disorders linked to menopause are indications for estrogen-based drugs.

But there are circumstances that contraindicate treatment with estrogen and that can occur in early menopause, such as breast cancer and genital hemorrhage of undetermined origin. In these cases, raloxifene is not contraindicated and can therefore be useful. Of course, deep vein thrombosis contraindicates both estrogen and raloxifene.

—Dr Bruno Toussaint
Editor-in-chief
La revue Prescrire
Paris, France

Eligibility for MAINPRO-C credits

I am a member of the College of Family Physicians of Canada (CFPC) residing outside of Canada. I recently passed my first sitting of the American Family Practice Board examination and was disappointed to learn that my initial certification is not eligible for MAINPRO-C credits, although recertification is eligible.

Because members are allowed to claim only two life support courses (ie, Advanced Cardiac Life Support, Advanced Trauma Life Support, Advanced Life Support in Obstetrics) per cycle, it becomes very difficult for non-resident members to acquire sufficient MAINPRO-C credits, as most MAINPRO-C activities are based in Canada. If a member has sampled the Self-Learning Suite and has not found it conducive to ongoing medical education, this further limits the availability of MAINPRO-C credits.

I would like to see the CFPC consider allowing the American FP certification examination count for MAINPRO-C credits. Practitioners are not eligible to sit this examination until they have been in practice for at least 1 year, and many CFPC members will have been practising family medicine for well over a year when they first take the American certification examination.

I propose that the CFPC consider allowing non-resident members to claim more than two life support courses per cycle for MAINPRO-C credits, in light of the barriers (for non-residents) to accessing many MAINPRO-C activities.

—Andrea Hillerud, MD, CCFP, ABFP DIPLOMATE
Madison, Wis
by e-mail

Response

The College of Family Physicians of Canada's National Committee on Continuing Medical Education (NCCME) is aware that some of our members in the United States and abroad find it difficult to access

continuing medical education (CME) activities accredited for MAINPRO-C credits. There are recent changes to both of the activities mentioned by Dr Hillerud that should help.

Large-scale family medicine examinations

Over the last few years, the Recertification Examination of the American Board of Family Practice (ABFP) has been an option for MAINPRO-C credits. The ABFP is the family medicine certifying body in the United States. We felt it would be appropriate to recognize their Maintenance of Certification process in lieu of our own for US-based members. The ABFP process involves CME and a practice audit exercise in addition to the examination.

We have received requests from many members to claim MAINPRO-C credits for other examinations, especially the ABFP Certification Examination. We are happy to report that, in response to this input, the NCCME decided recently to include *all* large-scale family medicine examinations for MAINPRO-C credits. Examinations that can be submitted under this new option include the CFPC Examination of Special Competence in Emergency Medicine (if done as a practice-eligible candidate), both of the ABFP examinations (certification and recertification), and the American Board of Emergency Medicine Certification Examination. Any other equivalent examination related to family medicine is eligible. This option is available to all members regardless of where they live and is retroactive to July 1, 1999.

To be acceptable within the framework of the model of practice-linked reflective learning upon which MAINPRO-C accreditation is based, members who wish to claim MAINPRO-C credits for an examination have to submit proof of successful completion and a brief letter describing how they prepared and how this affected subsequent practice.

Life support courses

Most of the available full-length advanced life support programs are accredited for eight MAINPRO-C credits. More good news: we are now allowing members to claim four MAINPRO-C credits for any of the shorter recertification courses. Members can claim any combination

of full and short courses to a maximum of 16 MAINPRO-C credits toward their minimum requirement of 24 MAINPRO-C credits over 5 years.

The NCCME has always believed that members should participate in MAINPRO-C accredited activities that cover, at least minimally, the scope of family practice or emergency medicine. Even in large tertiary emergency rooms, a wide array of problems are confronted, not just those requiring acute high-level intervention. So the NCCME decided to restrict the total number of MAINPRO-C credits to life support courses. At least some MAINPRO-C credits have to come from other content areas. The committee stands by this approach.

The NCCME continues to explore new options for MAINPRO-C credits. As we get more experience, we are better able to define the educational principles of practice-linked, critical, and reflective learning upon which MAINPRO-C accreditation is based. We can become both more specific and inclusive in the kind of activities deemed to be acceptable. In fact, the committee is developing an approach that would allow members to generate their own MAINPRO-C credits for many different learning activities as long as they can demonstrate how they apply them to this model. All these changes mean that all of our members, even those in the United States and elsewhere, will find it easier to collect MAINPRO-C credits.

—Paul Kerr, MD, CCFP
Chair, National Committee on Continuing Medical Education,
College of Family Physicians of Canada

—Richard Handfield-Jones, MD, CCFP, FCPC
Director of Continuing Medical Education,
College of Family Physicians of Canada

Should these be third-year positions?

Due to a recent move, I have only now read the July issue of *Canadian Family Physician*. The list of third-year residency programs[1] omitted the University of Manitoba's palliative care program.

But my other reason for writing this letter is to invite debate as to whether these programs should be looked upon as third-year residency positions. I was a family physician for 15 years before deciding to undertake further training in palliative care. My colleagues in