But still, you might say, "I'm not planning on doing any of those bad things! I just want to make half a dozen copies of a great article in your journal for the people in my department! What does all this have to do with me?"

Well, I'm not going to quote Canadian copyright law or try to offer hair-splitting legal interpretations of what it means and how it should be interpreted. But I will point out that if you were to ask a traffic cop if it was legal to drive at 101 km per hour on a highway with a posted speed limit of 100, the answer would be no—and the self-evident reason would be that if 101 were acceptable, so might be 102 or 110, and so on, until the speed limit was completely unenforceable.

Would you get a speeding ticket if you drove at 101 km per hour? Probably not, but the law clearly reserves that option. Would you get a letter from our lawyers if you made 2 copies of an article in *CFP?* Probably not, but you can see why we have to reserve that right.

More to the point, perhaps, we also ask our readers and our colleagues in the medical world to understand why it is important to play by the rules and to help us maintain the integrity of the work published in our journal.

—David Dehaas
Publisher,
Canadian Family Physician
Mississauga, Ont

Reference

1. Ladouceur R. Droit d'auteur et droit de savoir. *Can Fam Physician* 2010;56:1037-9.

Care over castigation

As a practising physician I am able to recognize and sympathize with Mr van der Pol's comments about improving Medicare.[1] One of his observations stood out, however, as a reason why physicians should not create public policy. Mr van der Pol promoted making certain habits less socially acceptable in order to reduce their prevalence. My observation is that those suffering from unhealthy habits need more care and less castigation, certainly from their doctors.

The government can restrict advertising, create tax penalties or incentives, and otherwise mold people's choices. Physicians should be exploring areas in which applied care can be brought to those suffering. I encourage your readers to be proactive in applying care models rather than reactive in creating punitive social measures. Let's hear from those ready to be part of the physician solution. Anyone can make a law against an activity or group they find distasteful. Physicians can uniquely identify what is effective to assist those individuals who have inappropriately self-medicated with food, alcohol, or cigarettes. May Tommy Douglas be proud!

—Gordon Dyck MD
Steinbach, Man

Reference

1. Van der Pol CB. Improving Medicare. *Can Fam Physician* 2010;56:859-61 (Eng), 863-5 (Fr).

Good review!

The article on adolescent suicide prevention published in the August 2010 issue of the journal[1] is a very thorough review with excellent resources and links. I found one of the most helpful points was assessing a patient's level of intent. I often find teenage patients to be ambivalent about their intent. Rating intent on a scale of 1 to 10 can help quantify and assess these patients' degree of risk.

I also appreciated the hint about asking whether the teen believes that suicide is an acceptable option. However, I am not sure whether a teen saying that suicide is not acceptable would change my opinion of whether a teen was at imminent risk.

I appreciate the resources you included. It would be interesting to know whether these "help lines" actually reduce the number of completed suicides. My understanding is that help lines might field many calls, but the number of completed suicides before and after implementation do not change.

A worthwhile read!

—Carly Thompson MD
Barrie, Ont

Reference

1. Kostenuik M, Ratnapalan M. Approach to adolescent suicide prevention. *Can Fam Physician* 2010;56:755-60.

Incomplete analysis

I wanted to comment on MacLellan and colleagues' research article,[1] which was also featured on the cover of the September issue, regarding examination outcomes of international medical graduates (IMGs). I am a family physician devoted to teaching in an academic centre, and I worked at McGill University in Montreal, Que, last year; I am also a recent graduate of University College Dublin in Ireland. As such, I believe that I have some insight into the data presented, which was not mentioned in the article.

The authors comment that "in spite of the pre-residency assessment tools" IMGs in Quebec have substantially lower pass rates on their Certification in Family Medicine examinations. They speculate on many possible causes, but omit a big flaw in the Quebec selection process: Recent graduates of international medical schools are actively discouraged from even applying to Quebec because of the "pre-residency requirements" imposed on them. Personally speaking, despite family ties to Montreal and an undergraduate degree from McGill University, I did not apply to a single Quebec University in the Canadian Resident Matching Service because it would have meant not working for at least an entire year before beginning residency. Very few of my colleagues, many of whom are now working at highly rated institutions in Canada and the United States, could have afforded to take a year off to only *potentially* get a spot in Quebec, given the extra requirements. Further, these extra pre-residency courses, French tests, and examinations impose further financial burden on already highly indebted students. My suspicion, based on anecdotal experience from working in Quebec, is that the IMGs captured in this study are further away from their medical training and thus less familiar with many of the modern patient-centred and evidence-based approaches crucial to the Certification examination. I would be curious to see national data comparing the results of graduates from other programs in which the applicant pool was of a higher standard. Residency matching is undoubtedly a competitive process and there are many highly capable applicants; to suggest that adding an extra year of assessments will make better physicians is counterproductive. The reality is that inviting the best candidates—trained locally and abroad—to compete for spots will lead to the highest-quality graduates. Imposing extra requirements, which force recent graduates to delay further training, only pushes the top applicants to schools in the United States or Europe rather than having them return to Canada. I hope that the authors will consider comparing national data to their further research to determine whether these trends are consistent in programs able to recruit direct-entry medical graduates without the undue imposition of extra requirements.

—Alexander Singer MB BAO BCh CCFP
Winnipeg, Man

Reference

1. MacLellan AM, Brailovsky C, Rainsberry P, Bowmer I, Desrochers M. Exmination outcomes for international medical graduates pursuing or completing family medicine residency training in Quebec. *Can Fam Physician* 2010;56:912-18.

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