However, a balance must be struck between enabling nontraditional students the chance to contend competitively for medical school spots while attracting the next generation of non–family medicine researchers and specialists. The development of medical schools that favour traditional students and those that favour nontraditional students runs the risk of creating a 2-tiered medical community.

What remains is the idea that students from the social sciences and humanities might have as innate an interest in the human element of medicine as the biochemistry student does in proton pumps. By attracting more students from broader academic backgrounds, Canada might just reach the coveted goal of 45% of medical graduates choosing family medicine.

—Gregory Sawisky
Calgary, Alta

Competing interests
None declared

References
1. Pimlott N. Who wants to be a family physician? *Can Fam Physician* 2011;57:643 (Eng), 645 (Fr).
2. College of Family Physicians of Canada. *Supporting the future family medicine workforce in Canada: is enough being done today to prepare for tomorrow? Report Card*. Mississauga, ON: College of Family Physicians of Canada; 2008.

Good intentions are not enough

Dr Hale raises some interesting thoughts in her commentary, "The greatest good,"[1] 2 of which deserve further exploration. In speaking of her encounter with a young Haitian boy, she states "[h]is only hope lies in the kindness of strangers." She later endorses the use of images of "emotionally or politically 'hot' topics, like malnourished children" by aid agencies to raise funds.

While I certainly appreciate the intentions behind these statements and the stories she shares that drive them, their implications are not benign. Too often when Canadians are asked to donate toward development projects or disaster relief in low-income countries, images of ragged, fly-covered women and children are put forward. Whether explicitly or implicitly, the message is clear: only through your donations and that nongovernmental organization's actions can the course of these lives be changed.

This fundraising tactic might be effective in the short term, but it feeds into a larger and very subversive narrative in the long term. It appeals to and cultivates feelings of pity and works to dehumanize those we seek to serve. We are not knights gallantly rescuing damsels in distress.

What if fundraising were focused instead on sharing stories of resilience, of innovation, and of empowerment? What would happen if the minority of non-governmental organizations doing so became the majority? Good intentions are not

enough, and we need to acknowledge this—even in the non-profit world.

—Danyaal Raza MD CCFP
Toronto, Ont

Competing interests
None declared

Reference
1. Hale I. The greatest good. *Can Fam Physician* 2011;57:868-9 (Eng), e273-5 (Fr).

Painful debate

In their letter,[1] Drs Jovey and Dubin assert that my statement "high prescribers ... were influenced by an intense and sustained pharmaceutical marketing campaign" is unsubstantiated. According to a US government report,[2] by 2000 Purdue's OxyContin campaign employed almost 700 full-time sales representatives and a total "call list" of 70 000 to 94 000 physicians.

Sales representatives were directed to focus their efforts on physicians with high rates of opioid prescribing, and they received substantial bonuses for OxyContin prescriptions by doctors on their list. From 1996 to 2002, OxyContin had a speakers' bureau of 2500 physicians and sponsored more than 20 000 educational programs on pain management.[2] This campaign was wildly successful; in the United States, OxyContin prescriptions for noncancer pain increased from 670 000 in 1997 to 6.2 million in 2002, accounting for $1 billion in annual sales.

The marketing campaign was based on several simple messages: addiction is rare in pain patients, controlled-release opioids are less addictive than immediate-release opioids, and opioids are much more effective and safer than alternatives. Unfortunately, these messages are not true. In 2007, Purdue pleaded guilty to felony misbranding of OxyContin and was fined $634.5 million.[3]

—Meldon Kahan MD MHSc CCFP FRCPC
Toronto, Ont

References
1. Dubin R, Jovey R. The real crisis of chronic pain [Letters]. *Can Fam Physician* 2011;57:762-4.
2. United States General Accounting Office. *Prescription drugs: OxyContin abuse and diversion and efforts to address the problem*. Washington, DC: United States General Accounting Office; 2003.
3. Meier B. In guilty plea, OxyContin maker to pay $600 million. *New York Times* 2007 May 11.

Correction

An error was introduced in the biography of the Hypothesis article that appeared in the September 2011 issue.[1] The biography should have read as follows:

Dr Ryan is a postdoctoral fellow in the Centre for Studies in Family Medicine in the Department of Family Medicine at the Schulich School of Medicine and Dentistry at the University of Western Ontario (UWO) in London, Ont. **Dr Cejic** is a family physician in an academic practice in London and Associate Clinical Professor in the Department of Family Medicine at the Schulich School of Medicine and Dentistry at the UWO. **Dr Shadd** is Assistant Professor, **Dr Terry** is Assistant Professor, **Ms Chevendra** is IT Consultant, and **Dr Thind** is Associate Professor, all at the Centre for Studies in Family Medicine in the Department of Family Medicine at the Schulich School of Medicine and Dentistry at the UWO.

Canadian Family Physician apologizes for this error.

Reference
1. Ryan BL, Cejic S, Shadd JD, Terry A, Chevendra V, Thind A. You and your EMR: the research perspective. Part 1. Selecting and implementing an EMR. *Can Fam Physician* 2011;57:1090-1.

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