extent of the relationship need to be clear; we must recognize that each specialty serves a different purpose.[10] Certainly, linkages exist that warrant careful attention (eg, around vaccinations, screening, reportable diseases, and using population data in diagnosis). However, suggesting that family doctors should lead on broader population health planning ignores the training and primary work of their public health physician colleagues.[11]

To that end, I want to believe that the authors intended to call for better exposure to public health concepts in family medicine training, with the goal of improving the existing partnerships between public health and family medicine. Indeed, while I am grateful for the authors' interest, I cannot help but feel that a better understanding of the real work of public health would have helped to clarify many of the concepts as presented in the original article.

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Competing interests
None declared

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Some cold water on the realities of modern public health

As someone who completed the additional training (a Master of Public Health degree through part-time studies) suggested by Drs B-Lajoie and Chartier,[1] and even worked part time for a number of years at an Ontario public health unit, I agree that public health is something of a forgotten stepchild in medicine. However, before initiating an expansion of public health training for physicians, we need to think carefully about what it is we are hoping to achieve.

With regard to the education component, I enjoyed my Master of Public Health program, but would be lying if I thought that most of the curriculum applied to medical work. In fact, a good chunk of the material went well beyond the scope of activities performed in public health work, and bordered on promoting a particular political leaning. *Many* doctors I know are strongly devoted to their patients and their art, but have little patience for being told what to think about tax policy and politics.

The typical job of a public health doctor is also something of an elephant in the room. Yes, there is good work to be done on health promotion, and medical insight is essential in managing an outbreak. But large parts of the job—tedious ministry teleconferences, hostile (often personality-driven) media, political agendas of governing boards, organizational administration, squabbles over budgets—could hardly be construed as medicine. What exactly is the goal of training more doctors in public health, if not to work at a public health unit?

Finally—and this situation might be unique to Ontario—we also have to bear in mind that a pivot to work in public health constitutes a change in scope of practice. That triggers the College of Physicians and Surgeons of Ontario (CPSO) to begin its intensive meddling into one's career. My own experience tells the tale, as the CPSO continually moved the goalposts on me, demanding ever more red tape and supervision, despite my ever greater experience on the job. Had I known the CPSO would see fit to do as it did, I would not have bothered at all.

I suppose we can all champion having more public health content in medical school. But how do you convince a brand-spanking-new class of science-minded medical students that if they really want to save lives, they need to take action on poverty and homelessness? As memory serves, the material and themes were there, and were even stressed in medical school—they were just promptly forgotten once we started rotating on the wards.

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Routine screening pelvic examinations have a negative effect on patients

Jones et al stated that researchers and doctors should not harm patients and should work to help individual patients, not patients in general.[1] In 2016, the Canadian Task Force on Preventive Health Care recommended not performing pelvic examinations in asymptomatic women. Dr Ladouceur proposes that discontinuing