No vast numbers of untreated women

Oh dear. Another article from academic medicine[1] telling us how badly we are doing. Are the authors really telling us that an asymptomatic woman in her late 80s with a casual blood pressure of 160/60 mm Hg has to reduce her systolic blood pressure to 140 mm Hg?

Why is there no mention of adverse effects or the number needed to treat to prevent 1 stroke? Why are specific drugs mentioned? Do the authors have conflicts of interests with companies making these drugs? Retrain every 6 months to take a blood pressure? Take blood pressures at every visit? Have a nonphysician take the measurements? Does anyone in the present climate have resources to divert staff for this?

I have 6 centenarian women in my small practice of 800 patients, most of whom I have looked after for decades. My municipality has the oldest cohort of people in the country. More than 60% of my patients older than 65 are taking antihypertensive drugs. There are not vast numbers of untreated patients out there.

Most older ladies die of dementia or a neurodegenerative disorder whose relationship to hypertension is unclear. A substantial number die of complications of falls, which are more often than not complications of drug therapy.

—Peter Loveridge MBBS DMRD FRRMS
Glenwood, NS

Competing interests
None declared

Reference
1. Gelfer M, Bell A, Petrella R, Campbell NRC, Cloutier L, Lindsay P, et al. Take urgent action diagnosing, treating, and controlling hypertension in older women. *Can Fam Physician* 2020;66:726-31.

Can Fam Physician 2020;66:879. DOI: 10.46747/cfp.6612879

MAID is a Rigorous process

I am deeply offended by Dr Ladouceur's suggestion that medical assistance in dying allows us to dispose of life.[1]

As someone who has experienced a loved one hang himself years ago to end his terrible, terminal suffering (his wife found him), and more recently a loved one (Dr Jay Keystone) who chose medical assistance in dying to end his terrible, terminal suffering surrounded by his family, I cannot imagine that either chose to dispose of their lives.

Dr Ladouceur is frightened by how simple it is to die. It is not simple. It is a rigorous process that leads to a peaceful and dignified death. It is also very courageous. I look forward to the courts extending the criteria for people who choose to die with dignity.

—Donna Keystone MD CCFP FCFP
Toronto, Ont

Competing interests
None declared

Reference
1. Ladouceur R. Medical assistance in dying. *Can Fam Physician* 2020;66:709 (Eng), 710 (Fr).

Can Fam Physician 2020;66:879. DOI: 10.46747/cfp.6612879_1

Thankful to have a choice

In response to Dr Ladouceur's editorial,[1] in my practice I do not have the opportunity—the privilege—of being with patients who have the ability to choose the time and mode of their own death. In my practice, death would be terrifying, unexpected, and without family members. I would not wish it on anyone, and I am thankful that I and my family members finally have—with informed consent—options about our deaths that we already have about our lives. No physician is forced to provide medical assistance in dying unwillingly, but no physician is allowed to prevent a patient from accessing that which is their right. And so it should be. Philosophizing about the nature and meaning of death and suffering is important, but I will not impose the result of my personal philosophical musings on others. I would not even impose it on a suffering pet.

—Sowmya S. Dakshinamurti MD
Winnipeg, Man

Competing interests
None declared

Reference
1. Ladouceur R. Medical assistance in dying. *Can Fam Physician* 2020;66:709 (Eng), 710 (Fr).

Can Fam Physician 2020;66:879. DOI: 10.46747/cfp.6612879_2

Recognizing white privilege

I was struggling with expressing what "white privilege" and "systemic racism" mean to my neighbours and community members only to open the October issue of *Canadian Family Physician* and follow the thread back to Dr Dhara.[1] I identify as a white heterosexual cis female. My contribution to this discussion is as follows*:

It was embarrassing to watch the RCMP commissioner stumble over the presence of systemic racism but, sad as it might be, she might have the questionable benefit of innocence. While she recognized the presence of racism in the police force, like many white people, she has had no idea what systemic racism was.

Indeed, we are taught to see racism in individual or group acts of violence against persons or people of colour. When pressed, we might find a policy or principle that subtly discriminates (eg, facial recognition software). This narrowness allows us to ignore the implications of membership in the dominant white race, an automatic privilege that our skin colour bestows upon us.

As soon as the notion of white privilege is mentioned, white people deny it—they have an honest disbelief that this type of conferred privilege exists. "I worked hard for what I have," they say. "I do not have any privilege. I am mortgaged for everything I have." Some will go so far as to claim that people of colour "have more advantages than they do" or that they have more protection under law.

White privilege is like that. If you are white and do not think that you are privileged because of the colour of your skin, you likely do not know what systemic racism is. So, of course, you cannot know what white privilege is.

When my friend and I became lost in the countryside, I had no fear of driving into a farmyard, getting out of the truck, and walking to the door. I even opened the porch door and went to the open door beyond. I did not hesitate. I could be certain that no one would meet me with a gun. My Cree friend did not feel the same confidence.

When I go into the bank to negotiate a loan, I can expect that the person across the table will likely be my colour and understand my culture and my predicament. My people are usually still the heroes in Canadian history books. As I am a WASP (white Anglo-Saxon Protestant), my culture is reflected by the place names on maps. My whiteness has meant that no patient has ever refused to have me treat them because of the colour of my skin. It means that practically never have I been submitted to the beady eyes of the store walker. I can be certain that police have never stopped me because of my race.

The sense of belonging to the human circle should not be a privilege to a few. It should be an unearned entitlement of every human being. At present, as only a few have it automatically, it is both an unearned advantage and, in fact, confers unwarranted dominance.

To change the system, we cannot merely disapprove of white privilege, although it helps to have key individuals change their attitudes. The first giant step toward change is admitting that it exists. This is why, for the police to shed racism, it is important for the RCMP commissioner to admit that systemic racism exists—and for her to do that, she must recognize the presence of white privilege.

It serves us well to be oblivious of white advantage if we are white—by being oblivious, we can maintain the myth of our meritocracy, and the myth that democratic choice is equally available to us all. People of colour might tell us about white privilege but until we become sufficiently aware of it and willingly—and humbly—give up the unwarranted advantage that white privilege confers, systemic racism will continue.

—Dale Dewar MD FCFP FRRMS
Wynyard, Sask

Competing interests
None declared

Reference

1. Dhara A. Our complicit role in systemic racism. *Can Fam Physician* 2020;66:596-7.

Can Fam Physician 2020;66:879. DOI: 10.46747/cfp.6612879_3

*Inspired by "White privilege: unpacking the invisible knapsack" by Peggy McIntosh, printed in the July-August 1989 issue of *Peace & Freedom*.

Correction

In the editorial "The legacy of Motherisk,"[1] which appeared in the November issue of *Canadian Family Physician,* one of the physicians mentioned was incorrectly named. The correct text is as follows:

> The latest concern about Motherisk content published in *[Canadian Family Physician]* and in other medical journals came to light earlier this summer after Dr Jonathan Zipursky and ....

The online version has been corrected. *Canadian Family Physician* apologizes for the error and any confusion it might have caused.

Reference

1. Pimlott N. The legacy of Motherisk. *Can Fam Physician* 2020;66:787 (Eng), 789 (Fr).

Can Fam Physician 2020;66:882. DOI: 10.46747/cfp.6612882

Correction

Dans l'éditorial intitulé «L'héritage de Motherisk»1 publié dans le numéro de novembre du *Médecin de famille canadien*, le nom de l'un des médecins mentionnés comportait une erreur. Le texte correct se lit comme suit :

> La plus récente inquiétude à propos du contenu de Motherisk publié dans le *Médecin de famille canadien* et dans d'autres revues médicales a fait surface plus tôt cet été, après que les Drs Jonathan Zipursky et ....

La version en ligne a été corrigée. *Le Médecin de famille canadien* s'excuse de l'erreur et de toute confusion qu'elle aurait pu causer.

Référence

1. Pimlott N. L'héritage de Motherisk. *Can Fam Physician* 2020;66:787 (ang), 789 (fr).

Can Fam Physician 2020;66:882. DOI: 10.46747/cfp.6612882_1

Correction

In the statement "Risks of maternal codeine intake in breastfed infants: a joint statement of retraction from *Canadian Family Physician* and the *Canadian Pharmacists Journal,*"[1] which appeared in the November issue of *Canadian Family Physician,* one of the physicians mentioned was incorrectly named. The correct text is as follows:

> In May 2020, Drs Jonathan Zipursky and ....

The online version has been corrected. *Canadian Family Physician* apologizes for the error and any confusion it might have caused.

Reference

1. Pimlott N, Tsuyuki RT. Risks of maternal codeine intake in breastfed infants: a joint statement of retraction from *Canadian Family Physician* and the *Canadian Pharmacists Journal*. *Can Fam Physician* 2020:66:793-4, 796.

Can Fam Physician 2020;66:882. DOI: 10.46747/cfp.6612882_2