footprint of both cigarette production and the health care burden of tobacco-related illness.

Producing just 1 cigarette takes 3.7 L of water and 3.5 g of oil, making cigarette production responsible for 0.2% of global carbon emissions.[2] Additionally, tobacco and cigarette production reduces the capability of agricultural land to produce food for consumption, increasing food insecurity in vulnerable populations and contributing to deforestation.[2,3]

Every health care activity has an environmental impact. Every procedure, test, and treatment consumes energy and resources, and produces waste.[4] By enabling our adolescent patients to stop smoking, we can substantially improve their health, and also reduce the carbon emissions that would have been associated with tobacco production and tobacco-related illness.

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Competing interests
Nore declared

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Can Fam Physician 2021;67:882-3. DOI: 10.46747/cfp.6712882_1

Focusing on breadth of competence

Dr Sandell[1] has some interesting arguments in the September issue of *Canadian Family Physician* as to why we should call ourselves GPs. Is the term *family physician* inaccurate? Perhaps. As a recent Canadian family medicine graduate, I currently work in a beautiful rural community hospital—the only hospital in a 150-km radius of dense forest with a single access road. We serve a diverse population of locals, including Indigenous people who compose the backbone of our community, and numerous visitors and tourists. Here, physicians trained in family medicine truly are GPs.

With the vital support of our nurses, allied health care professionals, and few specialist colleagues, GPs allow our hospital to function. In fact, despite being undervalued and often criticized for systemic shortcomings, they allow our entire health care system to operate smoothly. Their versatility, breadth of knowledge, and skills enable them to treat both acute and chronic conditions in patients of all ages, from the first day of life to the very last. Witnessing the excellent work my GP colleagues accomplish, whether in the family medicine clinic, emergency department, hospital ward, delivery room, palliative care unit, short stay geriatric unit, or in home visits and long-term care homes makes me proud to be part of this group. In the end, physicians trained in family medicine are the most versatile physicians out there. And whether we decide to call ourselves family physicians, GPs, or even primary care physicians, we are all truly making a difference.

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Competing interests
Nore declared

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The opinions expressed in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

Correction

In the article "Primary care clinicians' knowledge, attitudes, and practices concerning dementia. They are willing and need support,"[1] which appeared in the October issue of *Canadian Family Physician,* an author was omitted. The correct byline and affiliations are below:

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The online version of the article has been corrected.

Reference
1. Arsenault-Lapierre G, Henein M, Rojas-Rozo L, Bergman H, Couturier Y, Vedel I. Primary care clinicians' knowledge, attitudes, and practices concerning dementia. They are willing and need support. *Can Fam Physician* 2021;67:731-5 (Eng), e275-9 (Fr).

Can Fam Physician 2021;67:883. DOI: 10.46747/cfp.6712883_1

Correction

Dans l'article intitulé «Les connaissances, les attitudes et les pratiques des cliniciens de soins primaires. Ils sont réceptifs et ont besoin de soutien»[1] et publié dans le numéro d'octobre du *Médecin de famille canadien,* une auteure a été omise de la liste des signataires. La légende et les affiliations devaient se lire comme suit:

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