Les «dysnutritions» dans les pays en développement

Le commentaire du Dr Pulfrey[1] sur la malnutrition grave est particulièrement pertinent. Rappelons aussi que si la malnutrition modérée est moins dramatique, elle n'en est pas moins un important facteur de surmortalité infantile dans les pays en développement (PED)[2], où elle affecte environ 20 % des enfants de moins de 5 ans.

Le Dr Pulfrey a raison de souligner le contraste entre l'obésité qui préoccupe nos sociétés privilégiées et la faim et la malnutrition qui affectent les PED. Une nuance est toutefois nécessaire, car il y a aussi de plus en plus d'obésité dans les PED, alors que la faim et la malnutrition ne reculent que lentement. Le terme de «dysnutrition» peut désigner ces deux formes de malnutrition en apparence opposées, mais qui coexistent dans les PED. Ce double fardeau nutritionnel pèse lourd pour les sociétés. On estime à 300 millions le nombre d'obèses dans les PED, contre 800 millions de sous-alimentés.

L'obésité est associée à la pauvreté dans les pays riches, alors qu'elle est encore un signe d'opulence dans plusieurs PED. Toutefois, avec le développement économique, l'obésité s'accroît dans les couches pauvres, alors qu'elle tend à diminuer chez les privilégiés[3]. En outre, on trouve de plus en plus d'obésité dans les populations urbaines, même pauvres, entre autres sous l'effet de l'urbanisation et de la mondialisation. L'obésité n'est plus une maladie de riches et les PED doivent non seulement lutter contre la malnutrition infantile, mais en même temps prévenir l'obésité et les co-morbidités qui engorgent les systèmes de santé. Cette prévention s'impose d'autant plus que la malnutrition tôt dans la vie augmente encore les risques ultérieurs de maladies chroniques métaboliques lorsque l'environnement devient «obésogène»[4].

Hélène Delisle
Olivier Receveur
Centre collaborateur de l'OMS
sur la transition nutritionnelle
et le développement
Département de nutrition
Faculté de médecine
Université de Montréal
Montréal, Que.

RÉFÉRENCES

1. Pulfrey S. Malnutrition: a silent emergency. *CMAJ* 2006;174(13):1837-8.
2. Pelletier DL, Frongillo EA, Habicht JP. Epidemiologic evidence for a potentiating effect of malnutrition on child mortality. *Am J Pub Health* 1993;83 (8):1130-3.
3. Monteiro CA, Moura EC, Conde WL, et al. Socioeconomic status and obesity in adult populations of developing countries: a review. *Bull WHO* 2004; 82:940-6.
4. Delisle H, Ghadirian P, Shatenstein B, et al. Early nutritional influences on obesity, diabetes and cardiovascular disease risk. International Workshop, Université de Montréal, June 6–9, 2004. Evidence and implications for research and action — a summary. *Maternal Child Nutr* 2005;1:216-22.

DOI:10.1503/cmaj.1060192

Obesity registers

Given the health risks associated with obesity, especially the increased potential for cardiovascular disease and type 2 diabetes, we should consider obesity to be a chronic disease and should treat it as such. Many Canadian family physicians have already set up chronic disease registers; an obesity register could be set up without too much difficulty in every practice that has an electronic medical record system.

In the United Kingdom, general practitioners are being taught how to set up obesity registers in their own practices (for patients over 16 years of age who have had a body mass index greater than 30 kg/m^2 for 15 months) and receive remuneration for doing so.[1,2] Canada could learn from this initiative.

However, it is debatable whether an obesity register should be based upon the body mass index or upon the ratio of waist and hip circumference. The former is simple to calculate from height and weight measurements, which can quickly be taken by an office assistant or nurse. The waist and hip circumferences require accurate measurements at precise locations. Most people know their height and weight but not their waist and hip circumferences. However, the ratio of waist and hip circumference is the strongest predictor of future cardiovascular disease.[3]

There has been little primary care research focusing on identifying and managing the care of obese Canadian.[4] Encouraging family physicians to keep obesity registers would initiate a process whereby patients could be identified for practical assistance and future studies. The primary care community needs to start formalizing a process for setting up obesity registers in family practices, before the problem starts to outweigh the solution.

Gina Agarwal
Assistant Professor
Department of Family Medicine
Canadian Diabetes Association
Post Doctoral Fellow
McMaster University
Hamilton, Ont.

REFERENCES

1. Haslam D. Weighing up the danger: obesity in the context of cardiovascular risk. *The New Generalist* 2006;4:21-2.
2. *New GP contract Q&O framework implementation: dataset and business rules. Obesity indicator set.* London (UK): Department of Health. Available: www.pcc.nhs.uk/uploads/QOF/business_rules_june_06/obesity_ruleset_r4_v8.5.pdf (accessed 14 Nov 2006).
3. Merchant A, Yusuf S, Sharma AM. A cardiologist's guide to waist management. *Heart* 2006;92:865-6.
4. Sokar-Todd HB, Sharma AM. Obesity research in Canada: literature overview of the last 3 decades. *Obes Res* 2004;12:1547-53.

DOI:10.1503/cmaj.1060166

Do you really know how tall you are?

Whereas it is customary for patients seen in ambulatory care settings to have their weights measured, heights are usually taken from the patient's recollection. To see if this practice may result in incorrect estimates of body mass index for people with diabetes, 100 consecutive adult outpatients newly referred for consultation regarding diabetes (32 patients with type 1 diabetes and 68 patients with type 2 diabetes; 47 women and 53 men) were asked what they believed their height to be, then had their height and weight measured.

Only 18 of the 100 patients correctly estimated their height within 0.5 inch of its measured value. Of the remaining 82 patients, 76 overestimated their height by more than 0.5 inch (including 14 who overestimated their height by 2 inches, 5 by 2.5 inches, 4 by 3 inches and 1 by 4 inches). Only 6 patients underestimated their height by more than 0.5 inch.

When measured rather than recollected heights were used, 4 patients moved from the normal range of the body mass index (18.5–24.9 kg/m^2) into the overweight range (25.0–29.9 kg/m^2), 11 patients moved from the overweight range into the obese class I range (30.0–34.9 kg/m^2) and 6 patients moved from the obese class I range into the obese class II range (>35.0 kg/m^2). In contrast, 2 patients were reclassified as being in the normal range rather than the overweight range and 1 patient was reclassified as being in the obese class I range rather than the obese class II range.

The patient's type of diabetes was not a predictor of their ability to accurately estimate their height, nor was their age. (The mean age of patients estimating their height within 1 inch of its measured value was 48 years; the mean age of those estimating their height to be more than 1 inch greater or less than its measured value was 50 years). Women, however, were more likely to accurately estimate their height (35 of 47 women v. 24 of 53 men estimated their height within 1 inch of its measured value, $p = 0.003$).

Aspirations for greater stature in life are clearly more than just figurative.

Ian Blumer
Internist
Ajax, Ont.

Author's note: Subsequent to the completion of this study I measured my own height. This was 5 feet, 8.5 inches, which is exactly 1 inch shorter than I had thought.

DOI:10.1503/cmaj.1060160

Safe prescribing

Kaveh Shojania proposes several solutions to the pitfalls associated with illegible or hard-to-interpret prescriptions, including 2 suggestions of ways to prevent misinterpretation of written prescriptions.[1] The first and best, according to the author, is to have physicians indicate both the generic and the brand names of a medication on the prescription, with the example "Zyrtec (cetirizine)" mentioned for illustration. Although this idea may appear logical and foolproof, it might lead to the dispensing of more expensive medications, since, on reading the prescription, the pharmacist may interpret it to mean that only the branded version of the product should be used.

The second proposed solution is to write the indication along with the product (as in "Zyrtec for rash"), but this approach, too, has drawbacks. What would the author have written if prescribing Zyprexa (olanzapine) for the dishevelled person described in case 1? I also wonder if the legal and ethical aspects of this suggestion have been reasonably examined. These concerns arise from my experience as a former pharmacist and a practising psychiatrist. With this background, I recognize that although physicians may take for granted the confidentiality of data on their prescribing habits (as collected by IMS and sold to pharmaceutical companies),[2,3] this may not be the case. At present, disclosing too much information without adequate safeguards has the potential to create problems not easily anticipated by prescribing physicians.

Finally, the author suggests that electronic prescribing will prevent medication errors. I agree that it may aid in this arena, although the safeguards against legal and ethical issues are far from clear. Wouldn't it be a shame to see e-prescribing evolve into mass marketing, whereby prescribers are bombarded by email messages from competing pharmaceutical companies for each product that they prescribe?

Nadeem Bhanji
Assistant Clinical Professor
University of Calgary
Calgary, Alta.

REFERENCES

1. Shojania KG. Safe medication prescribing and monitoring in the outpatient setting. *CMAJ* 2006; 174(9):1257-8.
2. Zoutman DE, Ford BD, Bassili AR. A call for the regulation of prescription data mining. *CMAJ* 2000;163(9):1146-8.
3. Whitney J. Pharmaceutical sales 101: inside information. Guernica [serial on Internet] 2006 Apr. Available: www.guernicamag.com/features/159/inside_information/ (accessed 2006 May 29).

DOI:10.1503/cmaj.1060105

[Dr. Shojania responds:]

Even the most plausible, well-intentioned interventions to improve care can be undermined in unexpected ways.[1] Thus, I fully support subjecting proposed safety interventions to the type of critique offered by Nadeem Bhanji. Nonetheless, I think the recommendations I made remain reasonable.

Bhanji worries that pharmacists will interpret prescriptions that include both the generic and the brand names of a medication as requiring dispensation of the brand name drug. If "Do not substitute" is not written on the prescription, I think most pharmacists would proceed with whatever generic substitution they would usually make. In fact, many provinces mandate such substitutions.[2,3]

I agree that the alternative solution of stating the indication for the medication requires discretion. For potentially sensitive conditions I would suggest that physicians use the generic name plus brand name approach and ask their patients for permission to include specific diagnoses on their prescriptions. Another possibility is to use preprinted pre-

scriptions with categories of conditions (or symbols for organ systems) that the physician simply ticks off[3] (e.g., "cardiovascular" or "neurology or mental health"). The vast majority of prescriptions are for conditions that are unlikely to generate privacy concerns for patients, such as hypertension, diabetes and gastroesophageal reflux. Stating the indication for the prescription will also provide important information for patients, many of whom have difficulty keeping track of which prescription is for which medical condition.

Bhanji's concerns about the legal and ethical protections for electronically stored medical information and about the possibility that commercial interests will hijack electronic prescribing for mass marketing have received widespread attention. They should not stop us from proceeding with important advances in managing health information; similar concerns in other sectors have not prevented us from now routinely making electronic transactions involving important personal information.

Kaveh G. Shojania
Clinical Epidemiology Program
Ottawa Health Research Institute
Department of Medicine
University of Ottawa
Ottawa, Ont.

REFERENCES

1. Shojania KG, Duncan BW, McDonald KM, et al. Safe but sound: patient safety meets evidence-based medicine. *JAMA* 2002;288:508-13.
2. Anis AH. Pharmaceutical policies in Canada: another example of federal–provincial discord. *CMAJ* 2000;162(4):523-6.
3. Canadian Pharmacists Association. Restricted drug selection. Vol 4 of *Pharmaceutical cost-containment strategies* series.Ottawa (ON): The Association; 2006. Available: www.pharmacists.ca/content/about_cpha/whats_happening/cpha_in_action/pdf/RestrictedDrugSelection.pdf (accessed 2006 Nov 7).
4. Cohen MR, editor. *Medication errors: causes, prevention, and risk management.* Sudbury (MA): Jones and Bartlett; 2000.

DOI:10.1503/cmaj.1060130

Prescribing powers for pharmacists

At a time when the impact of diagnostic error on patient safety is finally being appreciated, the news that pharmacists in Alberta will be allowed to diagnose medical conditions[1] will generate alarm and some despondency among researchers in this area.

There is now abundant evidence that delayed or missed diagnoses are widespread and that in more than 50% of such cases there are serious adverse outcomes. They are the primary source of litigation against both family physicians and emergency physicians.[2] Not infrequently, apparently simple presentations of illness turn out to be incipient catastrophes. Dissecting aortas present as constipation; subarachnoid hemorrhages as muscle tension headaches; acute myocardial infarctions as stomach upset; and meningitis, encephalitis, cavernous sinus thrombosis, peritonsillar abscess and epiglottitis as the common cold. It is extremely easy to be fooled, and one is more easily fooled when one fails to elicit a history of the presenting illness and a relevant past medical history and to perform a physical examination. The money that pharmacists will have to pay for $2 million in personal professional malpractice insurance[1] will be well spent.

Besides this overarching safety concern, the other major problem is the potential for conflict of interest: pharmacists have a commercial interest in what they prescribe. Pharmaceutical companies will certainly waste no time in "detailing" pharmacists. Sadly, physicians have adapted poorly to the variety of creative, insidious and sometimes unethical marketing practices that the pharmaceutical industry has used to influence them.[3] Human nature being what it is, pharmacists will be especially vulnerable in this regard owing to their proximity to the patient–medication interface.

Pat G. Croskerry
Department of Emergency Medicine
Dalhousie University
Halifax, NS

REFERENCES

1. Priest A. Alberta pharmacists may get prescribing powers. *CMAJ* 2006;175(5):463.
2. Graber M. Diagnostic error in medicine: a case of neglect. *Jt Comm J Qual Patient Saf* 2005;31:106-13.
3. Kassirer JP. *On the take: how medicine's complicity with big business can endanger your health.* New York: Oxford University Press; 2005.

DOI:10.1503/cmaj.1060193

Preventing adverse drug events

I read with interest Alan Forster's article on preventing adverse drug events after hospital discharge.[1] In the 2 cases he outlines, it is likely that the involvement of a hospital pharmacist would have helped to prevent the adverse outcomes described.

The pharmacists in our small community hospital, which serves a largely geriatric population, offer a service that helps to minimize some potential problems with medications at discharge. For many patients, the pharmacists create a "discharge medication profile," which is reviewed with the patient or their family members or both at discharge. These profiles are typically provided for patients who take more than 5 medications on a chronic basis, for whom several new medications have been prescribed, or whose medication types and dosages have been changed during their hospital stay.

To create the profile, the pharmacist completes a table that includes all current medications, directions, times to take each medication, the medical condition for which each medication is prescribed and any special instructions, all in easy-to-understand language. The pharmacist ensures that the patient has any new prescriptions that are required and will contact the prescribing physician if the prescriptions have not yet been written. The pharmacist also informs the patient which medications he or she should stop taking or take differently at home. The pharmacist may liaise with the patient's community pharmacist to arrange dosette or blister packing or to update him or her about medication changes.

The discharge medication profile is an accurate and legible medication list that can be used by other health care providers, such as home care nurses and community pharmacists. A copy is sent to the patient's general practitioner

so that he or she also has a summary of the patient's medications at discharge.

Ann Davidson
Pharmacist
Peace Arch Hospital
White Rock, BC

REFERENCE

1. Forster AJ. Can you prevent adverse drug events after hospital discharge? *CMAJ* 2006;174(7):921-2.

DOI:10.1503/cmaj.060801

Novel technique for critical care training

Capital Health provides care for 2 million Albertans across 9800 km². Many critically ill patients require transfer to Edmonton. Long distances, climatic factors and resource pressures complicate how we stabilize and transport patients and then triage them at the receiving hospital. A major communication aid is the critical care line, a 24-h service with teleconference capabilities and contact numbers for both transferring and receiving staff.

Given the importance of optimal communication, we have incorporated simulated calls from the critical care line into the education of trainees in critical care medicine. Senior trainees are paged during a normal workday by the line. A facilitator assumes the role of a physician in a distant town. Relevant staff members are notified of this exercise and asked to act as they normally would. For example, emergency physicians and internists are notified that they may be brought into the call if the trainee decides, for instance, to bring the patient through the emergency department for further workup or if no bed is currently available in the intensive care unit. All calls are recorded to aid debriefing.

These simulated calls allow us to ascertain how well trainees obtain focused histories, offer practical advice appropriate to the skill set of the referring physician and deal with complex ethical issues (e.g., deciding what to do if a family wants to override a patient's wishes about medical intervention or deciding how aggressively to treat a terminally ill patient with whom no discussions have occurred about end-of-life care). We can test not only factual knowledge but also how that knowledge is applied in practice.

The Royal College of Physicians and Surgeons of Canada has decreed that physicians must be not just medical experts but also communicators, collaborators and managers.[1] Our novel, simple and cost-free addition to training helps to address these laudable goals. The technique has been very well received, and we hope others may consider using it.

Peter Brindley
Medical Lead for Patient Simulation
Capital Health
Edmonton, Alta.

REFERENCE

1. Royal College of Physicians and Surgeons of Canada. The CanMEDS roles framework. Ottawa: The College; 2005. Available: rcpsc.medical.org/canmeds/index.php (accessed 21 Nov 2006).

DOI:10.1503/cmaj.1060159

Training Canada's future clinician–teachers and researchers

Although Mark Baerlocher's review of data from the 2004 CFPC/CMA/RCPSC National Physician Survey[1] suggests that medical students have a greater desire to engage in teaching or research than physicians currently in practice, it fails to address the key issue revealed by the data: a noticeable disparity between student intention and physician action. Do current students have a genuine commitment to teaching and research or are they simply being optimistic about their future career?

In the survey, residents in family medicine programs were not asked whether research training was included in their residency program, let alone whether they perceived such training to be necessary. Residents in specialty programs fared somewhat better: they were asked to evaluate the necessity and quality of their research training. However, none of the residents were asked about the pedagogical content of their programs.

If we wish students to retain an interest in teaching and research we must foster it early in their training programs.[2] Knowing the current status of pedagogy and research training in residency is the first step to ensuring a future supply of clinician–teachers and scientists.

Andrew J. Perrin
MD/PhD Program
University of Toronto
Toronto, Ont.

REFERENCES

1. Baerlocher MO. Canada's future physicians: clinicians, researchers or teachers? *CMAJ* 2006;174(11):1549.
2. Pillai D. Quelling research excellence in residency programs [letter]. *CMAJ* 2002;167(3):236.

DOI:10.1503/cmaj.1060142

[Dr. Baerlocher responds:]

In his interesting letter, Andrew Perrin makes a good point: intention may not translate into action when it comes to participating in research during one's medical practice. If this is true, it may be due in part to a lack of research training, but other factors may also play a role, such as the negative impact of research on income or a lack of time. One solution that has been proposed is the creation of research chairs, which provide protected research time.

I fully agree with Perrin that we must foster student interest in teaching and research early in medical training programs. All residency training programs, including family medicine, should include a compulsory research project. After all, every physician will need to evaluate research at some point and personally performing some research is a great way to learn how to critically evaluate the work of others.

Mark O. Baerlocher
Radiology Residency Training Program
University of Toronto
Toronto, Ont.

DOI:10.1503/cmaj.1060143

Free access to medical information: A moral right?

In a recent *CMAJ* editorial,[1] Bruce Squires echoes a sentiment expressed by Virginia Barbour and colleagues[2] that society has a moral right to medical information. They tell a chilling tale of what they describe as the "deadly" consequences of practitioners in the field having access to incomplete information. They claim that the dissemination of science must be driven not by publishers "but rather by the needs of society."

Squires states that "publicly funded researchers have a moral obligation to make the results of their research freely available to everyone," citing initiatives of the Canadian Institutes of Health Research in support of open-access publication as a model. But is this truly a moral obligation? Certainly one could argue that publicly funded researchers should be accountable to the public. However, the argument that there is a moral obligation to make such information freely available is problematic when considered in this specific context, and a series of broader interrelated questions must then be answered.

How are the interests of distributive justice served if publicly funded research is made freely available, but not any other research? It has previously been argued that ethically information on all research involving human subjects should be made publicly available, regardless of study design or funding source.[3]

What are the obligations of researchers to research subjects with respect to the dissemination of knowledge, and should funding source influence such obligations? If the obligations of publicly versus privately funded researchers differ, do researchers have a duty to disclose these distinctions to their human research subjects? What are the obligations of research ethics governance bodies to human subjects regarding both the availablity of such information and the disclosure of the researchers' obligations?

An analysis of the harms and benefits of public access to the results of medical research along the lines described by Barbour and colleagues[2] would suggests that if there is a moral obligation to disclose medical information, it should be irrespective of the design, phase, nature and source of funding of the study.

Michael Goodyear
Department of Medicine
Dalhousie University
Halifax, NS

REFERENCES

1. Squires B. *Editorial policy*: The right to medical information. *CMAJ* 2006;175(6):557.
2. Barbour V, Chinnock P, Cohen B, et al. The impact of open access upon public health. *Bull World Health Organ* 2006;84(5):337.
3. Goodyear M, Golec L, Watts SC. Commentary on WHO International Clinical Trials Registry Platform [posting from an Open Comment session]. Available: www.who.int/ictrp/MichaelGoodyear_11Nov2005.pdf (accessed 2006 Nov 22).

DOI:10.1503/cmaj.1060203

Canadian mnemonics for heart sounds

A critical part of the physical examination is auscultation of the heart. Auscultation is fun, but the heart sounds are hard to learn, hard to teach and hard to remember without constant practice. As a teacher, I have struggled to make them easier to hear and to remember. Sure, the first 2 heart sounds are easy, once you get the timing right. But gallops are tougher. As a student, I could never remember the correct pronunciation of "Kentucky" or "Tennessee" as memory aids to describe the third and fourth heart sounds, perhaps in part because they had no relevance to my own experience.

Quite a few years ago, I began teaching Canadian mnemonics for the extra heart sounds. Canadian students understand and remember these memory aids because they are relevant to them and fun. Before I leave clinical practice, I wish to share these little aids.

The third heart sound (S3) sounds like "Montreal," pronounced as only the Anglophones mispronounce it, with the last syllable very soft (MON TRE al). The presence of this heart sound means the ventricle is like that city: dilated and congested (this is to be taken in fun only, please; I love Montréal). The fourth heart sound (S4) sounds like "Toronto," with emphasis on the middle syllable (tor ON to). The presence of this heart sound means that the ventricle is stiff and noncompliant, just like that city (sorry, Toronto). When the ventricle is in serious trouble, both S3 and S4 are present, sounding like "Saskatchewan." Enough said.

My students and my patients have had fun with these mnemonics and they do remember what they stand for. Patients even ask, "Do I still sound like Montreal [or Toronto] today?"

J. Wayne Warnica
Cardiac Intensive Care Unit
Foothills Hospital
Calgary, Alta.

DOI:10.1503/cmaj.1060180

Registration requirements

Why does each province and territory have different registration requirements? The expectation that a physician has to go through a registration process with each province or territory in which he or she may wish to work is undoubtedly contributing to the shortage of physicians in remote areas.

I recently looked into doing short-term locum work in Nunavut, the Northwest Territories and the Yukon. I would love to visit these areas of Canada, and it seemed like a good idea to go and work in them for 4–8 weeks as a family physician. My visit would also fill a very real need: some communities in the territories have difficulty finding locum physicians to supply holiday relief. However, after discovering that I would be required to supply notarized copies of my degrees and to pay significant amounts of money for a short-term licence, I am deterred. In addition, if I were to choose to go back a year later I would have to repeat the entire process. I may as well stay within my own province to do any locum work.

I think it is time that the colleges in each province and territory got together and decided on a plan to allow physicians to work anywhere in Canada with the same registration and

licensing. If rural medicine is to survive, changes will have to be made to the current system.

Marianne Willis
Family physician
Vanderhoof, BC

DOI:10.1503/cmaj.1060207

Clarification

In a recent News article[1] concerning the growing number of satellite campuses, Dr. Joanna Bates' title was incorrect. Dr. Bates is the Senior Associate Dean, Education, University of British Columbia Faculty of Medicine.

REFERENCE

1. Kondro W. Eleven satellite campuses enter orbit of Canadian medical education. *CMAJ* 2006;175(5):461-2.

DOI:10.1503/cmaj.061607

Corrections

The DOI published with a recent News article[1] was mistakenly listed as 10.1503/cmaj.061349. It should have read 10.1503/cmaj.061351.

REFERENCE

1. Silversides A. Complex and unique HIV/AIDS epidemic among Aboriginal Canadians. *CMAJ* 2006;175(11):1359.

DOI:10.1503/cmaj.061608

The photo credit that appeared in a recent Public Health article[1] should have read istock.com.

REFERENCE

1. Poulin C. Gambling. *CMAJ* 2006;175(10):1208-9.

DOI:10.1503/cmaj.061609

Letters submission process

CMAJ's enhanced letters feature is now the portal for all submissions to our letters column. To prepare a letter, visit www.cmaj.ca and click "Submit a response to this article" in the box near the top right-hand corner of any *CMAJ* article. All letters will be considered for publication in the print journal.

Letters written in response to an article published in *CMAJ* are more likely to be accepted for print publication if they are submitted within 2 months of the article's publication date. Letters accepted for print publication are edited for length (usually 250 words) and house style.

Mécanisme de présentation des lettres

Le site amélioré des lettres du *JAMC* est désormais le portail de réception de tous les textes destinés à la chronique Lettres. Pour rédiger une lettre, consultez un article sur le site www.jamc.ca et cliquez ensuite sur le lien «Lettres électroniques : répondre à cet article», dans la boîte en haut à droite de l'article. Toutes les lettres seront étudiées pour une éventuelle publication dans le journal imprimé.

Les lettres répondant à un article publié dans le *JAMC* sont plus susceptibles d'être acceptées pour publication imprimée si elles sont présentées dans les deux mois de la date de publication de l'article. Les lettres acceptées pour publication imprimée sont révisées en fonction du style du *JAMC* et raccourcies au besoin (elles doivent habituellement compter au maximum 250 mots).