tient compliance. Although not all drug therapy is expensive the more severe dyslipoproteinemic states often require costly therapy. New and tolerable drugs have made this feasible and effective on a broad scale. However, these advances have not yet been evaluated from the point of view of cost-effectiveness or long-term safety, which compounds the physician's dilemma.

Although people are responsible for their own behaviour, putting all the onus on them for their obesity, drinking, smoking, dyslipoproteinemia, hypertension and diabetes mellitus will not relieve the genetic or environmental factors that may also underlie the risk of CHD or the associated risks of stroke, emphysema, lung cancer, cirrhosis, uremia, blindness and arthritis.

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Preventing suicide

Both "Prevention of suicide" (*Can Med Assoc J* 1990; 142: 1223-1230), by Jane E. McNamee and Dr. David R. Offord, and "Periodic health examination, 1990 update: 2. Early detection of depression and prevention of suicide" (*ibid:* 1233-1238), by the Canadian Task Force on the Periodic Health Examination, provide comprehensive reviews of current statistics on suicide and its relation with mental or physical illness. Unfortunately, both papers all but ignore the contribution of social breakdown and the dehumanizing effects of modern society, as outlined in Dr. Ray Holland's letter "Suicide among teenagers" (*ibid:* 1362).

The suicide rate is increasing despite improved screening procedures, better treatment of psychiatric illness and greater physician awareness, a fact that should at least suggest that suicide is not primarily a medical problem. My concern is that articles such as these, no matter how well intentioned, perpetuate the inappropriate medicalization of a social and political phenomenon. There are no figures to show that the prevalence of major depressive illness is increasing, but there is much to suggest that simple unhappiness with the world is. When the expectation that clinical medicine will provide the solutions is not met the next step logically accrues: society criticizes medicine for failing to prevent suicide.

The current stratagems suggested by the task force are not primary preventive interventions but secondary disease-detection ones. A truly preventive program would involve social, religious and political lobbying against the factors perceived to be responsible for social disintegration, existential nihilism and the spiritual despair of late 20th century society. The promotion of traditional values, the sanctity of the family, gender stereotyping and the male versus female parental role models of previous decades are not popular in this age of personal freedom. In Canada's case the rising incidence of suicide may well be one of the prices paid for the Charter of Rights and Freedoms.

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[McNamee and Offord respond:]

We fully agree that any comprehensive suicide prevention program must take into account the dehumanizing effects of modern society and the current social disintegration. We are also aware that suicide is not solely a medical problem with only clinical solutions.

Our article was written within the context of the periodic health examination and was aimed at recommending strategies that might help primary care physicians to evaluate suicide risk and implement effective prevention programs in their practices. The reason for addressing primary care physicians, who, moreover, are the focus of the task force's mandate, is that studies have indicated that many adolescents,[1] adults[2] and elderly people[3] who commit suicide contact their family physician shortly before the event. Therefore, the primary care physician is in a unique position to detect those at risk for suicide, particularly people in the high-risk groups we described. Our goal was to draw attention to these groups, document their risk, estimate the increased magnitude of risk over that of the general population and