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

evaluate the strength of the evidence for the effectiveness of suicide prevention programs implemented by the family physician in an office setting. It was never our intention to "medicalize" the issue of suicide.

To address the spiritual or social aspects of suicide within the framework of our research paper would have been inappropriate. The relation of changing values and attitudes to suicide is a contentious issue and needs much research. It is not necessarily pertinent to the family physician's role in the prevention of suicide in his or her practice.

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In his letter practising psychiatrist Ray Holland invokes the reported increasing rate of suicide among teenagers to promote his political views.

The issues of adolescent depression and suicide are serious and complex. Although it is Holland's prerogative to opine that "never-ending socialistic universal programs" are the main cause of the rise in the rate of teenage suicide, it is mine to point out that such opinions are egregious nonsense. Which "socialistic" programs does he suggest we scrap? OHIP? What remedy does Holland propose for those he believes to be troubled because they are "overinformed by the media"? Ignorance? Of what clinical or public health use is his attribution of an increased adolescent suicide rate in Quebec to the putative "identity crisis the province is going through"?

The authorities quoted in "Teen suicide",[1] on which Holland based his letter, offer several proposals. These include a national school-oriented suicide prevention program with medical backup, the organization of social support systems, a therapist for every troubled teenager and improved skill of physicians in recognizing depression in adolescence. Rather than limiting social programs and the spread of information, as Holland suggests, these physicians would expand them. By contrast, Holland offers no solutions other than (presumably) to undo all social change since Queen Victoria. Even this much is guesswork for the reader: Holland's reactionary cri de coeur is clearer about what it is against than what it is for.

I challenge Holland's view that modern society is more "dehumanizing" than earlier ones. Not long ago, physical abuse of children was common (and underreported), sexual abuse was socially invisible, and medical care was a privilege of the financially comfortable. Many "traditional" families were held together by an abused wife who had no alternative. Holland seems to yearn for an idyllic past that is largely myth. For many, life then was elitist, sexist, racist and, further back, "solitary, poor, nasty, brutish and short".[2]

Although Holland has a perfect right to his political views I deplore his tactic of foisting them on the readers of *CMAJ* in the guise of commentary on an important clinical issue.

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[Dr. Holland responds:]

Instead of giving reasons for the escalation of the teenage suicide rate in Canada Dr. Yates merely states that it is a serious and complex subject, then explodes into a tirade and accuses me of exploiting such a tragic issue to promote my particular political views.

By not only completely ignoring the role of social breakdown and the dehumanization of modern society in suicide but actually applauding today's society, Yates exhibits cultural illiteracy and not just evidence of the "medicalization of suicide", as discussed in the letters of Holden and of McNamee and Offord.

This is not the first time Yates has demonstrated myopia.[1]

The point about the apparently never-ending socialistic government programs is that they are legislated regardless of what political party is in power.

My friend and colleague Dr. Hugh Sampath, in his 1989 presidential retirement speech to the Canadian Psychiatric Association, referred to the increasing unhealthy dependency being fostered in Canada by self-perpetuating "government helping" agencies (personal communication). However, as a rich country Canada can afford to continue with such programs for longer and at less evident cost than poorer countries.

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