and pedestrians is sorely needed. The external costs in terms of population morbidity and mortality are too great for collision incompatibility issues to continue to go unregulated.

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Competing interests: None declared.

DOI:10.1503/cmaj.1060110

Why the surprise?

Mark Baerlocher[1] expresses surprise that, according to results in the 2004 National Physician Survey, geriatricians constituted the second most satisfied group of doctors.

Geriatricians' high level of satisfaction with their current professional life is not surprising and has in fact been reported before. For example, a US study found that physicians in geriatric medicine were more than twice as likely as family physicians to be very satisfied with their careers.[2] In Britain, geriatrics is the largest medical specialty, and its practitioners are reportedly the happiest.[3]

What should be surprising is that Baerlocher (and presumably many others) are gobsmacked by this finding. I suspect that this attitude is a manifestation of ageism.[4] A unique feature of this form of prejudice is that the members of the "in" group (younger folk) will, if they survive, eventually join the "out" group (older people). With the aging of Canadian society, nearly all physicians should be embracing the principles of good geriatric care, and a good (and hopefully growing) proportion of them will have to make the care of older patients the focus of their professional practice. Negative stereotyping of older individuals creates barriers to the achievement of both goals.

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DOI:10.1503/cmaj.1060103

The perverted irony of Health Canada's Special Access Programme

The *Oxford English Dictionary* defines the word "irony" as "a state of affairs that appears perversely contrary to what one expects." A recent description of the use of Health Canada's Special Access Programme (SAP) to obtain breast implants[1] is by all means "perversely contrary" to what we expect from the SAP — or is it?

The SAP is designed for patients with serious or life-threatening conditions and who require "emergency" and/or "compassionate" access to drugs not authorized for use in Canada, when conventional therapies have "failed, are unsuitable, or are unavailable."[2]

According to the news story,[1] 67% of SAP requests annually are for breast implant devices, and over the past 5 years, the SAP has approved over 21 000 requests for silicone implants. The cosmetic surgeons interviewed explained that "small breasts" and "slight rippling of the skin through saline implants" are the medical conditions for which implants are sought through the SAP.

In April 2005, we applied to the SAP for "emergency" access to 2 experimental drugs on behalf of 6 patients with advanced AIDS who could no longer derive a clinical benefit from the anti-HIV drugs available in Canada. SAP denied our application and all appeals.

Hence, we question the raison d'être of the SAP and its mode of operation. One of our patients died during this 10-month battle, but no one has ever died from "small breasts" or "slight rippling of the skin." Without disparaging the difficulties experienced by women who need breast implants, we cannot contain our moral outrage at the ineffectiveness of the SAP in dealing with this truly life-threatening matter.

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DOI:10.1503/cmaj.1060054

Changes at *CMAJ*

I have been shocked by recent events at the *CMAJ*, including the firing of John Hoey and Anne Marie Todkill as editor-in-chief and senior deputy editor. In a situation like this one, what are the rights of long-time CMA members, like me, whose fees have helped to support the association and its flagship journal over the decades? What are the rights of readers, who have relied on *CMAJ* for high-quality intellectual honesty and the bravery to question the increasing corruption of academic medicine by outside interests? What about those whose intellectual creativity has helped to make *CMAJ* an important international force in medical and health science?

When free speech is suppressed,