tions such as ACE inhibitors for diabetic nephropathy would be provided free to all Canadians.

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Competing interests: See original article.[1]

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Access to the morning-after pill in BC

The primary goal of the BC emergency postcoital contraception initiative, which was discussed in a recent *CMAJ* article,[1] is to increase the availability of this important option for women's reproductive health. The resolution of the Society of Obstetricians and Gynaecologists of Canada calling for increased access to emergency postcoital contraception prompted the College of Pharmacists of BC to consider the situation in our province. It was clear that more work was needed to inform women about emergency postcoital contraception and to make it more accessible. Pharmacists can play a vital role in making this happen because of their knowledge of drug therapy and their availability. The threats and violence against physicians who perform abortions serve as a reminder that extreme emotions are associated with issues of reproductive choice and that much more needs to be done to prevent unintended pregnancies.

The *CMAJ* article states that BC will be making Preven a schedule II medication.[1] The hormones for emergency contraception are classed as prescription drugs at the federal level. The provinces cannot change the classification of a drug from prescription to nonprescription by placing it in schedule II. Provincial authorities can, however, explore avenues for permitting pharmacists to dispense a prescription drug without a physician's prescription. One mechanism may be to work in collaboration with a physician. Another option is to create a pharmacists' prescribing schedule. The College of Pharmacists of BC has submitted a resolution to the provincial government calling for the creation of schedule IV. The only drugs in the schedule would be the hormones for emergency contraception. By approving schedule IV, the provincial government would grant pharmacists independent prescribing authority for these products only.

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What exactly are we treating with the morning-after pill?[1] The absence of any medical facts is obvious. The morning-after pill is really an abortion pill. The joining of the sperm and the ovum in the fallopian tubes creates the beginning of a life. All of the DNA that we will require for the rest of our lives is present at that first moment. After that, only the amount of dependency on our parents decreases with time. The morning-after pill prevents the implantation of a unique human individual, tiny but unique and genetically complete.

Is it any wonder that some pharmacists are objecting on ethical grounds? They don't want to see themselves as abortionists. Who can blame them? Let's stick to the facts. Rhetoric about providing a service and reducing violence against physicians obscures the fact that this pill is ending a unique individual's life.

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Managing hypertension in patients with renal disease and diabetes

I congratulate the authors of the 1999 Canadian recommendations for the management of hypertension[1] for their diligent work, but question the recommendations regarding hypertensive patients with diabetic and nondiabetic renal disease. Ample evidence exists to support the use of angiotensin-converting-enzyme (ACE) inhibitors as first-line agents in both of these circumstances, but the selection of dihydropyridine calcium-channel blockers as an alternative therapy for nondiabetic renal disease and the lack of a recommendation for the use of nondihydropyridines in diabetic nephropathy are questionable.

A number of well-designed studies