that a better way of determining physician supply requirements is needed. Our approach recognizes the unique characteristics of rural practice and goes a long way toward providing a better alternative.

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**Reference**
1. *Physician resource requirements for Saskatchewan. Phase I report*. Saskatchewan Physician Resource Planning Task Force; 1994.

## A futile search

For their article "Provision of preventive care to unannounced standardized patients" (*CMAJ* 1998;158[2]:185-93), Dr. Brian Hutchison and colleagues might have found greater use of the recommendations of the Canadian Task Force on the Periodic Health Examination if these recommendations were more readily available. I was unable to find them on the CMA Web site or through any Internet search. I phoned Health Canada and was told that the purchase price of the 1994 recommendations is $69.95 — but the book is currently out of print. These guidelines probably need revision and would be well suited for posting at an independent Web site.

**Ronald A. Blattel, MD**
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Received by email

**[Dr. John W. Feightner responds:]**

Dr. Blattel raises some important issues related to the availability of guidelines and recommendations for physicians. The Canadian Task Force on the Periodic Health Examination shares his concerns about the importance of dissemination. In the past, apart from the publication of our 1994 *Canadian Guide to Clinical Preventive Health Care*,[1] we have disseminated most of our recommendations and background evidence through *CMAJ*. We are fortunate in that *CMAJ* has a wide readership, and this has been an important vehicle for our work. Increasingly, however, we and others have recognized the need for additional means of dissemination, in particular the electronic media. The task force is now developing its own Web site, which will provide access to its recommendations and the background evidence. Discussions are also under way to explore the feasibility of a limited run of additional copies of the 1994 publication.

Although we hope that the electronic route will enhance the availability of the task force's recommendations, dissemination is only the starting point. Regrettably, it is rarely sufficient to ensure full "uptake" of the recommendations.[2] Full implementation across the primary care system is much more complex and challenging. The work of Dr. Hutchison and his colleagues provides important additional information to those concerned with how best to support family physicians in their efforts to provide effective preventive health care.

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**References**
1. Canadian Task Force on the Periodic Health Examination. *The Canadian guide to clinical preventive health care*. Ottawa: Health Canada; 1994.
2. Davis DA, Taylor-Vaisey A. Translating guidelines into practice. A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. *CMAJ* 1997;157(4):408-16.

**Editor's note:** *The Canadian Guide to Clinical Preventive Health Care* is available electronically through the Health Canada Web site (**www.hc-sc.gc.ca/hppb/healthcare**).

## The torch is lit and burning, thank you!

The article "First the bad news . . ." (*CMAJ* 1997;157[12]:1675-6), by Drs. J. Dick MacLean and Brian J. Ward is in general a succinct and informative summary of recent news on tropical medicine. However, the authors assert that a bad-news item has been the closure of the Health Sciences Division at the International Development Research Centre (IDRC), and they claim that the Canadian International Development Agency (CIDA) "has been too slow to pick up *the torch dropped by IDRC*" (emphasis added). These statements could not be further from the truth. The IDRC did not close its Health Sciences Division any more than it closed its Social Sciences or Environmental Sciences divisions. What it did was move away from a unidisciplinary approach to development research and toward defining 6 development research themes and 15 programming units that zero in on specific issues, including health-related problems.

The Strategies and Policies for Healthy Societies theme incorporates 3 program initiatives with a strong health component. Moreover, health research is present in other programs that focus on the impact of macroeconomic policies and structural adjustment programs on health and health care in the South. Since the "closure" of the Health Sciences Division, the IDRC has spent $12.7 million funding 50 health projects in 35 countries. Furthermore, the IDRC has been active in developing a new initiative on lung problems, which account for 25% of the total burden of disease in

developing countries. This initiative focuses mainly on acute respiratory infections such as viral pneumonias and tuberculosis. The IDRC has recently renewed its commitment to the Essential Health Intervention Project in Tanzania[1] with another disbursement of $1 million and has moved on to the next phase of its support for insecticide-treated bed nets through a grant that will be used to investigate the use of the nets in sub-Saharan Africa.

The claims in the article not only damage the IDRC's hard-earned prestige and credibility in Canada and internationally but are also unfair to dedicated program staff who are struggling to keep the torch burning in times of dwindling resources.

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**Reference**

1. Finlay JF, Law MM, Gelmon LJ, de Savigny D. A new Canadian health care initiative in Tanzania. *CMAJ* 1995;153:1081-5.

**[The authors respond:]**

It was not our intention to slight the efforts of Dr. Baris and his (few remaining) colleagues at IDRC who have a strong interest in the health sciences. Indeed, their accomplishments with dwindling resources should be applauded and their continued excellent work encouraged.

However, the description of the latest IDRC reshuffle/renewal/re-organization in no way explains the deplorable situation in which Baris and his colleagues find themselves.

- Federal funding for international development and research is at a 30-year low.
- The number of IDRC employees with a primary interest in health-related issues has dropped by 50% to 75% in recent years.
- Health-related problems of the developing world are certainly not going away.
- The global nature of health-related problems should be obvious to all through examples such as HIV, Hong Kong's avian influenza and the like.

Our "barb" was directed neither at Baris nor even at his counterparts at CIDA (although the latter could invest their funds more wisely by supporting projects like those outlined by Baris). Rather, it was aimed at the wrong-headed parsimony of the federal policy-makers who have set international aid at a shamefully low 0.31% of the gross national product,[1] a level well below the mean for developed countries.

Our prime minister likes to trumpet Canada's recent recognition as the world's best place to live. How can a country that is among the least generous be the best?

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**Reference**

1. Tomlinson B. Canada. In: Randel J, German T, editors. *The reality of aid 1997/98. An independent review of development cooperation*. London: Earthscan Publications; 1997. p. 42-8.

## Physician–patient communication

I am doing research for a book to help improve physician–patient communication and am seeking physicians from across Canada to respond to an electronic survey. A survey form for physicians is posted at