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.

Noralou P. Roos, PhD
Professor and Co-director
Manitoba Centre for Health Policy
and Evaluation
Winnipeg, Man.
Peter Kirk, MB, ChB
Professor and Head
Department of Family Medicine
University of Manitoba
Winnipeg, Man.

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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
Ottawa, Ont.
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.

John W. Feightner, MD, MSc
Chair
Canadian Task Force
on the Periodic Health Examination
Parkwood Hospital
London, Ont.
Received by email

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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