and interactions.[7] Asking patients about their use of these products is of paramount importance in determining actual or potential drug allergies or other reactions. I wonder if the 16 Canadian medical schools have specific instruction on this type of history taking.

The evidence-based approach to CAM education is not mentioned in your Research Letter. In a recent survey at a Canadian medical school, 65% of first-year students wanted a course in CAM. The authors recommended that evidence-based but nonjudgmental education on CAM be a required component of undergraduate medical education.[8]

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Blood money

I was astonished to read that the Canadian Blood Service will spend $20 million annually for genome amplification testing to allow the detection of an additional 5–7 cases of hepatitis C among blood donors each year and an additional case of HIV infection every 2–3 years.[1] The costs seem high when considered against the gains; this is exactly what cost-effectiveness analyses are about. It is not at all clear whether the long-term impact of their strategy was assessed. The government, through the Canadian Blood Service, may have unwittingly established a benchmark, in a Canadian context, for what constitutes a medically cost-effective intervention. After all, they seem willing to spend $2.9–4.0 million per *potential* case of hepatitis C and $40–60 million per *potential* case of HIV infection identified. These are orders of magnitude higher than previously published recommendations.[2]

The money spent by the Canadian Blood Service does not seem to be technically, productively or allocatively efficient.[3] It is not so much that $20 million is being spent annually for so little gain, it is the lost opportunity of not being able to fund other, perhaps more worthwhile, initiatives given the competing claims for limited funding. How many lives might be saved if $20 million were applied annually to the waiting list for coronary artery bypass surgery?

Perhaps it is time to establish an agency to appraise medical technologies (drugs and devices) for consideration of additional funding to hospitals.[4] At present, the cost of most new advances must somehow materialize from within the global, and shrinking, budget of individual hospitals. This may explain some aspects of variations in practice patterns through implicit rationing, and the government is able to avoid both costs and blame. It is high time for evidence-based budgeting, at both the macro and micro levels.

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