viding more of what the IRP called "academic leadership." The IRP argued the committee should be handed oversight of all CIHR funding, including determining a suitable balance between investigator-initiated and strategic initiatives for each discipline. The risk in such an approach, of course, is that larger, more biomedical disciplines, like neurosciences, might gobble up a larger chunk of available monies, at the expense of smaller disciplines in the other 3 pillars. There'd also be less incentive to pursue multidisciplinary and interdisciplinary research, and fewer mechanisms and programs to promote such research.

Bernstein declined to discuss the recommendations in any detail, saying that although the governing council discussed them at a late August retreat, no decisions have been taken. Moreover, the CIHR wants to undertake extensive consultation with the research community before making changes.

Broadly speaking, though, Bernstein said it may be timely for CIHR to devolve some of its decision-making authority. "How I read that is [the IRP] wanted to have more transparency and clarity as to how overall decisions are made and suggested one way to do that would be to devolve down to what they called this research committee."

But governing council felt they needed "more time, and more input from scientific interests and the broader community" before agreeing to limit its powers, Bernstein added. "But clearly, if they're going to devolve more, we need to look at the structures underneath."

The IRP also took the CIHR to task for its plethora of strategic programs and the impact those have on peer review. "We were told that researchers are now suffering from significant review fatigue. Ensuring that panels are supplied with high quality and senior scientists is apparently proving difficult and the changing of panels due to potential conflicts of interest makes these problems even more difficult. The small size and short duration of some grants, the establishment of a large number of new grants committees and the presence of committees that see few proposals suggests that the peer review system is not being optimally managed. There appears to be no open and transparent process for the establishment of new panels. Nor does there appear to be clear criteria or process for their evaluation and, in the event that a particular panel is no longer needed, how this decision is to be reached. There have many been new panels established and none eliminated in the past 6 years."

> In many respects, the recommendations can be viewed as a call for limitations on CIHR's expansion.

Yet, it's difficult to imagine an argument that would generate less political sympathy than complaints from the scientific community about the trials and administrative tribulations of having to administer ever larger pots of taxpayer dollars, for both basic and strategic research.

Bernstein carefully sought middle ground.

The scientific community, he said, greatly appreciates that the federal government has in recent years trusted the CIHR (and therein, the academic community) to administer new pots of money, like ones for HIV/AIDS, the flu pandemic and cancer. "It expresses a confidence on government's part that the CIHR is capable and will respond to the country's strategic needs."

Still, a tighter leash on strategic programming may be warranted, Bernstein said, adding the future may see fewer strategic grants awarded, at a higher level. To that end, CIHR has already done some trimming. "If you look at the last of our RFAs [request for applications] that came out in June, there's fewer of them, considerably fewer, about 20% fewer."

As for the strain on peer reviewers that's caused by the explosive growth in public spending on health research, Bernstein was quick to dispel any notion that the solution is to cut funding, arguing that far more productive solutions can be found by either promoting more interagency peer review and by convincing "more senior people in the scientific community in Canada that they should be part of the review process. They can't be above it."

In response to the IRP's assertions that governing council needs to clarify its roles and responsibilities by becoming more of an advisory committee, rather than "a committee with executive functions or as a main Board of the CIHR," Bernstein said council isn't adverse to a less hands-on approach. "It has no difficulty accepting the notion that council should be more involved in policy and strategic direction. But they did not want to become aloof, in the sense of meeting in a perfunctory way and just looking at the books and making sure they were balanced every year."—Wayne Kondro, *CMAJ*

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Ibuprofen redux

The news article "Ibuprofen should go behind-the-counter says expert panel" (*CMAJ* 2006; 175[3]:253-4) requires further elaboration of Health Canada's position on this issue. Health Canada started its internal scientific review on the safety of long-term use of COX-2 more than 6 months before convening an Expert Advisory Panel on the Safety of COX-2 Selective Non-steroidal Anti-Inflammatory Drugs. The Health Canada review did not initially specifically look at the safety of ibuprofen. However, according to Dr. Marc Berthiaume, director of the Marketed Pharmaceuticals and Medical Devices Bureau: "Health Canada has since studied the available safety data on ibuprofen and has found no evidence of increased cardiovascular risk when the product is used over-the-counter as directed, i.e. for short-term and at low-dose [200-400 mg].

However, Health Canada acknowledges that increased cardiovascular risk may be associated with high-dose ibuprofen, as with COX-2-selective and other "non-selective" NSAIDs. Berthiaume added: "Patients have the responsibility to use as directed any nonprescription or prescription drug, and ibuprofen is no exception." In general, he says there is a need for more long-term comparative studies to further characterize cardiovascular safety concerns surrounding NSAID drugs including ibuprofen and COX-2. — Barbara Sibbald, *CMAJ*

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Injection site gets 16-month extension

As summer ran its course in Vancouver, a 3-year experiment to provide heroin addicts with a medically supervised injection site neared its scheduled Sept. 12 expiration. Canada's former Liberal government had granted the facility, InSite, a permit exempting it from federal drug laws. To remain open, InSite required a new permit from the Conservative government — some of whose members argued it's morally wrong to aid illegal drug addiction.

InSite is in the Downtown Eastside, Vancouver's impoverished neighbourhood of concentrated HIV and hepatitis sufferers, drug addicts and dealers, sex-trade workers and criminals. North America's first and only such site, it daily serves about 600 addicts who bring in illegal street drugs and then inject themselves with syringes dispensed by InSite, under the watch of health professionals. Nurses and doctors intervene if users overdose and offer general health care, while counselors are present to offer addiction treatment.

Some 50 similar sites exist worldwide, but InSite remains audacious given the US "War on Drugs" next door. In British Columbia, however, it has massive public and political support under a popular "Four Pillars" drug strategy of prevention, enforcement, harm reduction and treatment.

During InSite's 3 years, a remarkable consensus that the facility reduces harm to users and the public developed among scientists, criminologists and even the Vancouver Police Department. Research, all positive, was published in 15 peer-reviewed journals, including the *CMAJ* (2004;171:731-4), *Lancet* (2005; 366:316-8) and the *New England Journal of Medicine* (2006;354:2512-4).

In the spring of 2006, the province wrote to Ottawa formally applying for a 3.5-year renewal of InSite's permit.

Ottawa's response was a long silence.

Over the summer, InSite became a *cause célèbre*. Activists, politicians and even scientists lobbied for it, and at the international AIDS conference in Toronto researchers spoke in support while AIDS activists demonstrated in the streets. Lawsuits were threatened. Ethicists joined the fray, including Margaret Somerville of McGill University's Centre for Medicine, Ethics and Law, who said given that addicts would continue to be addicts, reduction of serious harms such as HIV and hepatitis infection is an ethical requirement. One of the few opponents was the Canadian Police Association, which in late August demanded that Ottawa close InSite and focus instead on a national drug strategy.

Less than 2 weeks before InSite's scheduled closure, on Sept. 1, federal Health Minister Tony Clement announced he was deferring a decision on InSite pending more research, but it could remain open until Dec. 31, 2007. Clement's announcement asked: "Do safe injection sites contribute to lowering drug use and fighting addiction? ... Right now the only thing the research to date has proven conclusively is drug addicts need more help to get off drugs."

The Canadian HIV/AIDS Legal Network accused the government of "playing politics with people's lives."

Dr. Evan Wood, an epidemiologist at the BC Centre for Excellence and HIV/AIDS and assistant professor of medicine at University of BC who is, with Dr. Thomas Kerr, principal investigator for evaluation of InSite, argues that science clearly shows the benefits of InSite, and seemed nonplussed to find himself one of InSite's most vehement backers.

"I am a scientist, and I hate to be referred to as an advocate," he said. "But Dr. Kerr and I ... want to see the problem improved as scientists, because the benefits have been so positive."

Wood added, "I felt like the federal government was politicizing this because the science is that strong." — Deborah Jones, Vancouver

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Canapress, F. Gunn

Activists protested the imminent closure of InSite at the 16th World AIDS Conference held in Toronto this August.