

were introduced in Hungary. Canadian experts also provided valuable support in introducing health technology assessment.<sup>2</sup> In 2006, a new milestone was reached with the establishment of a doctoral program in health sciences at the University of Pécs.

In Hungary, the the definition of health sciences is broader than the 6 basic disciplines discussed by Hall and colleagues; we include some subjects related to economics and management. This broader definition results in a greater possibility for interdisciplinary research in health economics and health services.<sup>3,4</sup>

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### The 1% solution

I read with interest *CMAJ's* list of health-related charities to which one could make donations as an alternative to buying Christmas gifts.<sup>1</sup> Most physicians I know will readily give \$20 for a worthwhile cause (for example, they will buy not-so-good chocolate bars that the neighbour's kid is selling to fund his trip to a South American polo tournament), but how many go all the way and donate the "recommended dose" of 1% of their pre-tax annual salary (see

[www.pledgebank.com/justonepercent](http://www.pledgebank.com/justonepercent))? Such a commitment would require one to write quite a few \$500 cheques year after year to one's favourite charities; this is the very least we should do.

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### Please slow down the CanMEDS express

Louise Samson, President of the Royal College of Physicians and Surgeons of Canada, recently wrote about a planned revision of the entire medical education curriculum at the Université de Montréal based on the CanMEDS competency categories.<sup>1</sup> She indicated that the "success of the project lies in a sound faculty development program that aims to upgrade and adjust professors' teaching skills" and that "the response to date has been very positive;" however, only 70 of about 2000 educators have become involved.

I have been on the receiving and delivering ends of medical education since 1978. I have watched as educational reforms have been introduced. Problem-based learning spread worldwide in various forms despite persistent reservations about its efficacy.<sup>2,3</sup> The use of interviews in the medical school admission process was intended to improve our ability to select the best future doctors, but the validity of this technique remains unclear.<sup>4</sup>

Competency-based education, which appeared in the 1970s and is the root of the CanMEDS framework, is not a proven approach. Brown University School of Medicine introduced a competency-based curriculum in 1996, but judging by the few published reports it remains a work in progress.<sup>5</sup> Leung wrote, "We should be cautious of adopting the competency based ap-

proach universally across stages of medical training for which well defined and validated competencies are unavailable."<sup>6</sup>

Although I agree with the ideals of the CanMEDS competency framework, I have found that implementing the framework can be difficult. More distressingly, I have found that the requirements for documentation are so rigorous that my time is consumed by paperwork. As a consequence, my enthusiasm for actually teaching anything is drained.

I predict that wholesale introduction of CanMEDS-based reform will be costly, time-consuming and frustrating. I hope that other medical schools in Canada will wait several years to see how the implementation goes in Montréal before doing the same thing. Let us use evidence-based information in our medical education as well as in our medical practice.

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### Inspired by Banting and Best

The reprinting of the first page of the original report on the use of pancreatic extracts in the treatment of diabetes mellitus by Banting and Best, with the wonderful accompanying commentary by Cathy Younger-Lewis,<sup>1</sup> gave me much joy, along with

a heightened sense of the continuity of investigation motivated by curiosity and by the desire to help human beings in trouble.

Reading the page I felt humble as I was reminded of the brilliance of scientific perception at a point, 84 years ago, when the tools of both practice and research were so elemental. The ingenuity and perspicacity of the authors were anything but primitive, and their doggedness sets the bar for us today.

Publishing a facsimile of the title page rather than merely reprinting the words enhanced the impact 10-fold. Thank you for this antidote to all the money-related and other pressures that distract us from the idealism of our work. It is a privilege to be reminded that we belong to the same noble profession as Banting and Best and to read their words in the journal in which they were first published.

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## Self-managed oral anticoagulation therapy

Dean Regier and colleagues successfully demonstrated that there are fewer thrombotic events, fewer major hemorrhagic events, fewer deaths and substantial cost savings for oral anticoagulation therapy self-managed by the patient compared with the same therapy managed by a physician.<sup>1</sup> Several clinical trials have shown patient self-management of oral anticoagulation therapy to be cost-effective, and it reduces the demand for scarce health care resources.<sup>2,3</sup>

The biggest challenge preventing large-scale adoption of the self-management model is that such models have been shown to be appropriate

for only a significant minority of patients.<sup>4</sup> Special attention has to be paid to selecting appropriate patients, training them how to adjust dosages and providing clinical supervision. Not all patients have the ability to understand the concept of oral anticoagulation therapy and the risks of overtreatment. Patient self-management might have turned out to be not all that attractive from an economic standpoint if the effort required to select and train patients as well as product maintenance had been factored into the analysis conducted by Regier and colleagues. The generalizability of their results to a broader population and the cost-effectiveness of this program remain to be demonstrated.

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#### [Two of the authors respond:]

In our study examining the cost-effectiveness of warfarin self-management<sup>1</sup> we incorporated patients with a mechanical heart valve or atrial fibrillation receiving long-term anticoagulant therapy into our model; as such, this is the clinical population of interest. We also stated that warfarin self-management may not be appropriate for all clinical populations receiving long-term anticoagulation therapy. Although this is true, we would like to clarify that for those patients who

wish to manage their own therapy, are deemed competent to do so and receive appropriate training, this option is expected to be cost-effective. We also highlight the statement by Fitzmaurice and colleagues that "patients with long-term indication for warfarin should be considered for self-testing or -management."<sup>2</sup>

To address the concerns of Jeevan Marasinghe and A.A.W. Amarasinghe that our model did not include patient selection, patient training and product maintenance, we first direct readers to the online Appendix 2 of our article, which shows that we included the costs of patient training, among other things.<sup>1</sup> Also modelled were the costs of the device and INR strips, which includes the cost of maintenance and calibration because each device has self-maintenance tools and calibration chips are often included in each box of INR strips. No costs were included for physicians selecting patients because the marginal increase of this fixed cost is negligible.

In the last 2 paragraphs of our Interpretation section, we focused on the 2 limitations of our model. We acknowledged that the results could only apply to those who meet strict criteria. Second, we acknowledged that some patients might prefer physician management over self-monitoring. This latter point was considered in our model through the 20% attrition rate in the self-management arm. As such, we stand by our original conclusions: in patients who are suitable candidates and are willing to perform self-monitoring, this strategy is highly cost-effective.

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