

Estimated 1500 Canadians studying medicine abroad

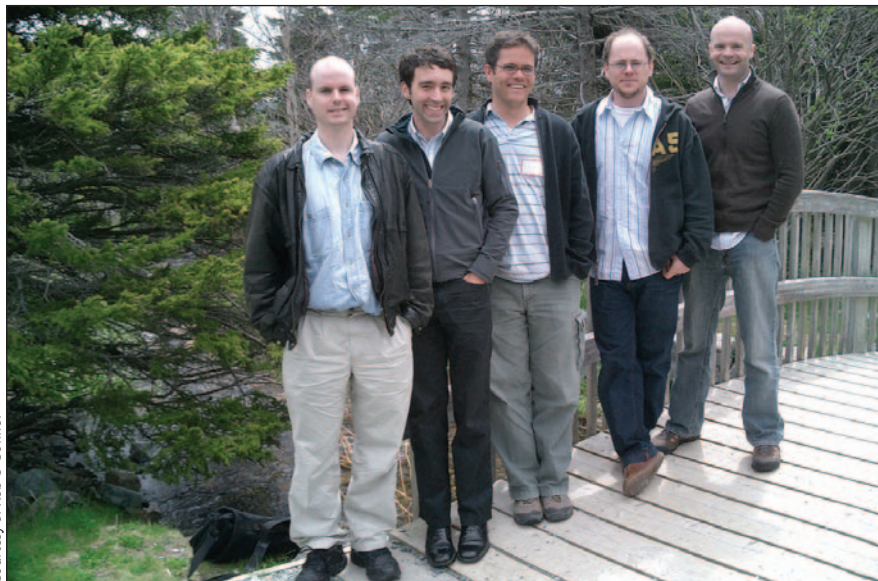
The number of Canadians studying medicine outside Canada is almost 4 times higher than previously estimated, a new survey indicates. The first of its type, the survey was completed for Health Canada last October by Canadian Resident Matching Service (CARMS) Executive Director Sandra Banner. After surveying offshore medical schools that accept Canadian students, she estimated that up to 1500 Canadians are studying medicine outside Canada and the US. Previous estimates pegged the number at 400.

Of the 13 offshore medical schools contacted, 7 completed a survey. All 13 schools distributed a separate survey to their Canadian undergraduates; 525 completed it.

The estimate of 1500 Canadian students comes from known Canadian offshore enrolment and information gathered during the study.

Peter Nealon agrees with Banner's estimate. The director of the California-based Atlantic Bridge Program that recruits North American students for medical and veterinary schools in Ireland says more than 300 Canadians are now studying at 4 Irish medical schools, and 60 to 70 new ones join them annually.

Although entry-level positions in Canada have increased, it's obviously not sufficient. Canada has 7.1 first-year medical school openings per 100 000 people, compared with 12.9 per 100 000 in the UK. The Association of Faculties of Medicine in Canada (AFMC), reports that 8700 students were enrolled in undergraduate studies at 17 medical schools in 2005-06. More than 2400 entry-level positions are available annually, an increase of more than 600 positions (34%) since 2000. However, there has also been a 20% increase in the number of applications for these openings during the same period. The bottom-line, according to AFMC, is that only 25% of applicants were admitted to Canadian schools in 2005-06.



Courtesy of Rob O'Connor

In 2003, these 5 Canadian graduates of Irish medical schools composed one-quarter of the residents in Memorial University of Newfoundland's family medicine program: (from left) Drs. Rob O'Connor, Graeme Gallins, Steve Fagan, Tino Depetrillo and Martin Leahy.

"Many outstanding candidates are turned down by the Canadian schools," says Nealon.

Schulich School of Medicine & Dentistry at the University of Western Ontario received 2400 applications for its 147 openings in 2007, meaning applicants have a roughly 6% chance of admittance.

"Every year I am saddened by our inability to train more of these outstanding young Canadians," says Dean Carol Herbert. "The only consolation is that many of them are persistent and get into another Canadian school, and some of them, who can afford it, go abroad for their education."

The CARMS study confirms that demand for medical training in Canada far outstrips supply. Banner surveyed 525 Canadian students studying at 13 offshore schools: 4 in the Caribbean, 4 in Ireland, 3 in Australia, 1 in Poland and 1 in England. (The figures do not include schools in several countries, such as Hungary, where Canadians are also known to study.) The survey revealed that 222 Canadians are studying at 3 Australian universities; 61 are studying in

Poland; 40 are at Trinity College in Dublin; 229 are at St. George's University in Grenada; and 26 are studying in the Netherlands Antilles.

When asked why they studied abroad, 46% of respondents (whose reasons could be determined) said they left Canada because they weren't accepted by a Canadian school. Another 27% cited similar reasons including the feeling that they were unlikely to be accepted by a Canadian school, the limited number of positions and tight competition in Canada, and less onerous admission requirements at the foreign schools.

The survey also revealed that gender differences among the Canadian expatriates is a reversal of Canadian demographics. "The proportion of [Canadian] males studying abroad is 55%, while in Canadian medical schools for 2005-06 it was 41%," says Banner.

Banner found that two-thirds (67%) of the Canadians studying abroad intend to seek postgraduate training at home, including almost three-quarters of those who will graduate in 2010.

So might these "offshore Canadians" be a partial solution to Canada's ongoing

ing MD shortages? Banner suggests there is a need to review Canada's "clinical educational capacity." If insufficient training capacity is available for the expatriates, she says, "there is a significant potential loss of physician resources for Canada. If repatriation is the goal, ways that opportunities can be provided to pursue undergraduate clerkships and postgraduate training in Canada in a broad range of disciplines must be studied."

However, she has a caveat: a call for an in-depth study of the offshore medical schools that are attracting Canadian students, "particularly in the Caribbean,

where the number of [for-profit] medical schools has quadrupled in the last decade." The study would include an assessment of curriculum quality, accreditation status, quality of clinical clerkships and the ease or ability to seek postgraduate training in the US.

The survey found that only 9% of Canadian students studying in the Caribbean had been able to schedule clinical elective rotations in Canada, compared with 41% of students studying in Western Europe.

Concern about the quality of some offshore training is emerging in the US. Last year, the *American Medical News*

reported that "a recent explosion in the number of for-profit Caribbean medical schools catering to US students" had forced the Federation of State Medical Boards to review systems used to evaluate graduates of these schools.

A 2006 report from the federation found that while more than 90% of graduates of American and Canadian medical schools pass step 1 of the US Medical Licensing Examination on their first try, only 53% of American students who studied at an overseas school do the same. Dale Austin, the federation's senior vice-president, told the *American Medical News* that state licensing boards "are increasingly concerned about international medical graduates from these schools, their calibre and the rigour of their basic medical education."

Those concerns don't extend to graduates of well-established, accredited schools in countries such as Ireland and Australia. Nealon says Canadian graduates of the Irish schools "routinely secure some of the most prestigious residency training positions in North America." He acknowledges that the training, which lasts from 4 to 6 years, is expensive: tuition and living expenses will cost \$60 000 to \$80 000 annually.

Dr. Ilana Porzecanski, a BC native who graduated from University College Dublin in 2002, says it is now easier for graduates of the Irish schools to return to Canada for residency training, but only in certain specialties, such as family medicine and psychiatry.

Those hoping to enter high-demand specialties that offer few openings — ophthalmology and dermatology are examples — have a much harder time because of the competition from in-country graduates. In the 2007 match, for instance, only one international medical graduate applied for training in each of those specialties, while 85 applied for family medicine slots.

Porzecanski, who completes her training in critical care medicine in New York City this spring, will not be returning to Canada — she has accepted a post at a hospital in Medford, Oregon. — Patrick Sullivan, Richmond, Ont.

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Ireland-trained Canadians go to the Rock

The impact of international medical graduates on Canadian medicine is well known, since they account for about 25% of the physician workforce. Now Newfoundland appears to be setting its recruiting sights on another type of international graduate: Canadian graduates of Irish medical schools.

In 2003 those sights fell on Dr. Rob O'Connor, a native of Morpeth, a tiny town in Southwestern Ontario. After graduating from University College Dublin (UCD) in 2003, he became 1 of 5 Canadian trainees from Ireland selected that year for the family medicine program at Memorial University of Newfoundland. In fact, the "Canadian Irish" accounted for one-quarter of the residents in Memorial's family medicine program in 2003.

"I entered the Canadian match, I ranked the Canadian programs, I got my first choice," says O'Connor, who now practises at the hospital in Twillingate, Nfld., covering emergency department shifts, providing inpatient service and working at a family medicine clinic.

Although acceptance into an American residency program would have been a formality — "they basically said, 'here's the form, sign it'" — O'Connor wanted to return to Canada. "I am more comfortable with the values in Canada," he says.

O'Connor isn't alone. Dr. Sujay Patel, a UK native who grew up in Newfoundland before graduating from UCD, "stepped off a plane" in 2003 and straight into a psychiatry residency at Memorial, where he is now chief psychiatric resident. Patel says he has no regrets about his decision to pursue offshore training, which he credits with allowing him to "excel" since returning to home. "Canadians who trained outside Canada are hard workers and truly cherish being afforded the opportunity to achieve a residency in Canada, even if they may have been disappointed at being turned down for medical training here."

O'Connor does advise anyone considering the offshore route to medical practice to tally the financial burden and to visit the offshore school and speak to alumni before making a commitment.

Patel thinks the answer to Canada's HR problems is to offer more opportunity for people to train in Canada. "If that isn't feasible, then yes, Canada should do everything it can to assist offshore Canadian graduates to complete their training outside the country and then to return here for residency, with obstacles no different from those facing the in-Canada medical graduate." — Patrick Sullivan, Richmond, Ont.

Federal budget delivers on health care but still disappoints

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A multi-million incentive for provinces to establish formal wait time guarantees and recourse mechanisms, and a \$300 million start on vaccinating young girls and women against quadrivalent human papillomavirus (HPV) were among \$1.4 billion in new health outlays unveiled Mar. 19 in federal Finance Minister Jim Flaherty's 2007/08 budget.

But critics, including CMA President Dr. Colin McMillan, say the outlays fall short of what is needed, particularly with regard to electronic health record-keeping and developing a comprehensive pan-Canadian strategy for educating, recruiting, licensing and equipping doctors.

Overall, Flaherty administered a \$10.3 billion hypodermic to Canadians in hopes of turning their hue to Tory blue in the anticipated election. Federal spending now totals \$233.4 billion.

Included is a \$1.2 billion increase in the Canada Health Transfer to the provinces, as agreed upon in the September 2004 federal/provincial/territorial 10-year Plan to Strengthen Health Care, under which recipients agreed to work towards Patient Wait Times Guarantees in 5 priority areas: cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration. But there was no real obligation to actually create programs or to specify patient recourse mechanisms when a benchmark isn't met.

To hasten the process, Flaherty gave the provinces until Mar. 31 to "publicly outline" a plan for a wait times guarantee, in at least 1 of the 5 priority areas, to qualify for a per capita allocation from a new \$612-million wait times fund. As of CMAJ's press deadline on Mar. 20, only Québec had announced such a plan, qualifying the province for \$126.6 million over 3 years.

CMA's McMillan says the \$612 million should have topped \$1 billion to

actually accomplish the wait time task. "It's not a care guarantee just yet."

Canadian Health Care Coalition President Sharon Sholzberg-Grey concurred, arguing that government wait time promises are meaningless without specific recourse mechanisms, like dedicated monies to help patients obtain treatment in another jurisdiction. "When is a guarantee, not a guarantee? When it doesn't define what is guaranteed."

McMillan is also concerned about the adequacy of new outlays for the Canada Health Infoway, an intergovernmental initiative to promote electronic health record keeping. Some \$400 million will be pumped into Infoway; \$1.2 billion has already been spent on the project, which is projected to ultimately cost \$10 billion. Spending thus far has been limited to the production of electronic "health" records and systems for developing them, rather than electronic "patient" records.

Outlays for the latter were "the cornerstone of what we were looking for," said a disappointed McMillan. "We think this is a very important thing for the delivery of health care, for its efficiency, certainly for the element of safety, and perhaps down the road it may have a cost factor, so we're a little surprised to hear that it's not going to doctor's offices."

As perplexing, McMillan added, was the absence of funding to implement a national strategy for health human resources, as recommended by Task Force Two (CMAJ 2006;174:1827). Systemic improvements to health can't be achieved "unless we have the doctors and nurses," he argued.

Flaherty's other big ticket health item was the creation of a \$300 million over 3-year per capita trust that provinces can draw upon to establish HPV vaccination programs in hopes of reducing the incidence of cervical cancer. (An estimated 1350 new cases were diagnosed last year.)

The new vaccine, Gardasil, will be made available to all women aged 9 to 26 at a projected cost of \$435 per patient. Given that Statistics Canada recently projected there are 175 000, 9-year-old girls in Canada, and vaccinating that group alone would cost \$75 million, Health Canada officials conceded during the budget lock-up that it will be all but impossible to vaccinate

all eligible women within current financial parameters, so the provinces will have to pick up the slack.

Among other health measures included in Flaherty's new \$1.4 billion health outlay are:

- \$20 million over 2 years and \$15 million annually starting in 2009 to establish a Canadian Mental Health Commission, as recommended by the Senate Committee on Social Affairs, Science & Technology last May.
- A \$22 million hike in the annual budget of the Canadian Institute for Health Information to \$57 million.
- \$2 million to the Canadian Medic Alert Foundation to provide free MedicAlert bracelets for children who suffer from peanut allergies or diseases such as diabetes.

Flaherty also unveiled several other health-related measures in addition to the \$1.4 billion. Those included:

- \$105 million to 8 research labs, including the Montréal Neurological Institute and UBC's Brain Research Centre, to essentially enhance their capacity to become world leaders in their fields. They and other research institutes will be in open competition next year for a new \$195 million pot of money set aside to create an undetermined number of national Centres of Excellence for Commercialization and Research.
- \$37 million or a 5% increase in the base budget of the Canadian Institutes of Health Research to \$737 million.
- \$30 million to the nonprofit Rick Hansen Man in Motion Foundation to support research on spinal cord injuries.
- \$30 million over 3 years for "innovative" pilot projects to reduce wait times.
- Expanded tax breaks for pharmaceutical firms to participate in international programs to provide drugs combating AIDS and tuberculosis in the developing world.
- \$10 million over 1 year to create 5 "Operational Stress Injury Clinics" across the country to treat Canadian soldiers suffering from stress-related disorders stemming from military service. — Wayne Kondro, CMAJ

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Saskatchewan successfully implementing best practices

One-quarter of family physicians in Saskatchewan have volunteered to participate in a groundbreaking initiative to implement best practices in the treatment of diabetes and coronary artery disease.

After one year, the Chronic Disease Management Collaborative reports an increase in the number of patients receiving the recommended drugs, tests and services, and a decrease in the time they wait to see their family physicians. For example, the number of patients with diabetes receiving annual kidney screening jumped from 48% to 68%, and the number of patients receiving antiplatelet therapy for coronary artery disease rose from 73% to 82%.

In one family practice in Saskatoon, the wait time for an appointment dropped from 17 to 3 days and a backlog of 100 annual check-ups was cleared in 5 months.

"It is clear that these efforts are helping to turn the tide on chronic disease in Saskatchewan," said Dr. Ben Chan, CEO of the Health Quality Council, an independent agency of the provincial department of health. The council is using a collaborative approach to set benchmarks and share effective strategies among 73 family practices across Saskatchewan, involving 216 family physicians, 400 other health care professionals and more than 12 000 patients.

"There isn't a collaborative initiative across the country of the scale that we are doing in Saskatchewan, and we were purposeful about that scale because we wanted to reach the tipping point. We wanted to go big," said Bonnie Brossart, deputy CEO of the Health Quality Council.

Representatives of each family practice attend 4 workshops during the year where they "share nuggets of what works and what doesn't work, and through that sharing, we're seeing a rapid improvement in results," said Brossart.

Patient data is entered into an electronic toolkit that lists the recommended best practices for each disease and tracks implementation. This Web-based toolkit allows physicians to cre-

ate flowcharts, measure progress, create reports and share information electronically with other health professionals, patients and the council.

The workshops were held in 2 stages during 2005–06 and 2006–07; data presented here are based on the first wave.

"In Saskatchewan, we have a shortage of physicians so you're always overworked and acute patients take up much of your time," says Vino Padayachee, a family physician from Estevan and chair of the Chronic Disease Management Collaborative. "We're making a concerted effort to bring chronic disease into the forefront. We will save money and time in the long run."

Padayachee says the Saskatchewan Medical Association is working with the provincial government to increase physician fees for chronic disease management.

To qualify, physicians will be required to follow best practice guidelines and document the results. — Amy Jo Ehman, Saskatoon, Sask.

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New deputy editor dedicated to knowledge transfer

CMAJ has revitalized its research focus with the appointment of a deputy editor for scientific content. Dr. Matthew Stanbrook, an assistant professor, researcher and specialist in respirology at the Toronto Western Hospital, will oversee reviews and research — including his own.

"The idea is to shape and build this core component of the journal," says Stanbrook, who is also an assistant professor of Medicine and Health Policy, Management and Evaluation at the University of Toronto. This includes encouraging publication of more randomized trials and increasing the quality of research and its relevancy to readers.

"We are very fortunate to have someone of Matthew's calibre join our team," says CMAJ Editor-in-Chief Dr. Paul Hébert. "He will substantially enhance the science we publish."

The move to CMAJ is a natural pro-

gression for Stanbrook whose long-time passion for publications began with the *University of Toronto Medical Journal*, where he was associate editor in 1992 and then editor-in-chief. "I got the bug early on," he laughs

After completing residencies in internal medicine and respirology at the University of Toronto, Stanbrook began a doctorate in clinical epidemiology. He asked respirologist Dr. Jeff Drazen, editor-in-chief at the *New England Journal of Medicine*, to take him on for a year so could look at the ways medical journals influence knowledge translation and research. For Stanbrook, Drazen created the editorial fellowship, a position that continues today.

At the time Stanbrook assumed his position at CMAJ on Feb. 19, he was a peer reviewer for 5 journals, an editorial board member of *Clinical and Investigative Medicine* and an associate editor of *ACP Journal Club*. He has nearly 40 publication credits to his name and has received several awards and scholarships, including the University of Toronto's respirology teaching award (2004).

His new position with CMAJ is an opportunity to "expand on my thesis and look at how medical journals influence patient outcomes."

Stanbrook will be looking at ways of presenting information, such as Web casts, that bolster its relevancy to Canadian and international readers.

Data show that CMAJ is increasingly



B. Sibbald

Respirologist and researcher, Dr. Matthew Stanbrook, will build and shape CMAJ's scientific content.

used internationally, a trend that is bound to continue as it is now the world's leading open-access, general medical journal. "We are open to the world through open access and the world is coming to us," says Stanbrook. "It's absolutely vital that we remain open access."

The Internet has revolutionized how we present science, he explains, citing examples such as preprints online and online-only journals like *PLoS Medicine*. "It's a time of transition for everyone. It's like science on speed."

To stay connected to practice, Stanbrook, like Hébert, will devote about a day a week to patient care. Stanbrook, 37, is married to general internist, Dr. Nadine Abdullah. — Barbara Sibbald, *CMAJ*

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Pharmacare for children

slow to gain ground in NS

Low-income families are not flocking to sign up for Nova Scotia's new Low Income Pharmacare for Children program. To date, approximately 6500 families out of a potentially eligible 35 000 have registered for the program, which was launched Oct. 1, 2006.

However, the small numbers are not necessarily a concern, says Linda Laffin, spokesperson for the Community Services department that oversees the program.

First, she notes, it's unclear exactly how many families actually qualify for the program, which requires participants to pay only \$5 per prescription. This uncertainty stems from the fact that eligible families must meet 3 criteria: they must have children under 18 years of age; an annual household income below \$20 921; and be in receipt of the Nova Scotia Child Benefit. However, the latter is administered by the federal government, which does not release its mailing list. It did, however, send a notice about the program to all Nova Scotia families on that list.

In addition, low-income families who are covered under a drug program through work are ineligible while those

on social assistance are already covered. These numbers are also not known.

As well, "People may not apply until they need it," Laffin says, noting that the number of applicants doubled in the first 2 months of 2007.

The slow growth means additional revenue for the province. It had committed \$1 million for the last 6 months of this fiscal year, but had only spent \$113 000 by the end of January.

The province is now planning to send a second letter to child benefit recipients and is exploring other options, including more advertising, for getting the word out. — Donalee Moulton, Halifax

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Proposed Alberta physician agreement sets new template

Canada's wealthiest province has traditionally set the benchmark for physician fee increases across the nation as most jurisdictions believe they must match Alberta or risk having their physicians poached or persuaded to pack their bags for Wild Rose Country.

From that perspective, the Mar. 13 trilateral fiscal agreement between the Alberta Medical Association (AMA), the provincial government and the province's 9 health regions augers well for other negotiators as it proposes a 4.5% pay increase in both the current and coming fiscal year.

However, the unique deal may also set a new template for redressing threats to the viability of community practice through a multi-pronged solution that includes retention bonuses and targeted monies for overhead costs.

AMA President Dr. Gerry Kiefer says this "made-in-Alberta approach" should help the province retain its 7100 physicians and attract the estimated 1500 additional doctors needed to handle a population boom of 11% over the past 5 years.

"I'm hopeful it will make practice in Alberta attractive," says Kiefer. It should also help redress financial pressures faced by family and community practitioners, he adds.

Alberta physicians are now voting on the agreement through a mail-in ballot. Results are expected in early May.

At the core of the proposed \$580-million deal lies the 4.5% hike in the fee schedule, which will increase Alberta's overall outlay to \$1.7 billion this year and \$2 billion in 2008.



Canapress

The proposed \$580-million deal for Alberta physicians should help mitigate some of the boom-related stressors.

The agreement also sets aside \$103.5 million over 2 years for initiatives to help cover skyrocketing overhead costs, including rent and salaries, associated with the province's oil and gas boom, as well as keep Alberta physicians at home by paying them an annual 2.8% retention benefit. The amount of the latter depends on how long a physician has practised in the province and the amount they bill. Doctors billing over \$80 000 annually are eligible for a 100% retention payment. The majority of the province's physicians are expected to receive either \$8000 (for 16–25 years of practice) or \$10 000 (for 26 or more years).

The agreement also provides \$56.5 million for a new clinical stabilization fund targeted at under-served communities, like Fort McMurray. Some \$17 million of that fund will be set aside to help offset higher overhead costs associated with practice across the province.

The agreement also reserves roughly \$175 million over 2 years for continuing

operations in Alberta's 19 existing primary care networks, and the creation of new ones. About one-half of family physicians are projected to be linked to such networks by 2008.

Some \$70 million over 2 years will be used to extend the Physician Office System Program, which covers up to 70% of costs associated with a physician's move to electronic patient records. About 70% of Alberta MDs have enrolled.

The AMA's 116-member representative forum unanimously recommended the agreement be ratified by physicians and medical residents but Kiefer isn't forecasting the outcome. "There's lots of unrest, especially amongst family physicians and northern Alberta physicians about whether this deal would have enough in it to maintain viable practices." — Wayne Kondro, *CMAJ*

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News @ a glance

Residency match: In a break with tradition, first-round results of the 2007 match of medical school graduates to discipline and residency positions weren't publicly released at the conclusion of the first iteration (Mar. 14) on the grounds that it would be unfair to students forced to seek spots in the second iteration, says Canadian Resident Matching Services (CaRMS) Executive Director Sandra Banner. "We've worked with the AFMC [Association of Faculties of Medicine of Canada] on this and we all feel this is the best way to approach this very new matching reality." Earlier this year, CaRMS announced that for the first time it is running a national 2-iteration match for international medical graduates, although Alberta is not participating (*CMAJ* 2006;175[3]:236). A traditional 2-iteration match is being held for Canadian medical graduates. Manitoba and Quebec, however, have opted to throw both Canadian medical graduates and international graduates (whether Canadian- or foreign-born) into 1 competition hopper. Roughly 5% of Canadian medical graduates remained unmatched after the first iteration in 2006.

Managing patients at risk of thromboembolic events: Point-of-care monitoring devices can be effective in managing patients on long-term oral anticoagulation therapy, resulting in significantly fewer deaths and thromboembolic events, according to a recent assessment by the Canadian Agency for Drugs and Technologies in Health. Compared with laboratory testing, using point-of-care devices in a clinic or for self-testing at home results in better control of anticoagulation status. Point-of-care devices in anticoagulation clinics are cost saving for Canada's publicly funded health-care system, compared with conventional laboratory testing. View the report at www.cadth.ca/pocjnews or contact Kirsten Gartenburg at kt@cadth.ca.

Wanted: budding research superstars: Must be willing to relocate to Alberta to oversee lucrative \$20 million, 10-year research program, on subject within 12 broad categories. Negotiable salary. Excellent skiing. Three positions available, commencing in 2008; more positions possible in the future. Contact: Alberta Heritage Foundation for Medical Research for details regarding new Polaris Awards to be established at the universities of Alberta, Calgary and Lethbridge. The awards, says AHFMR Chair Gail Surkan, are a "signal that Alberta is ready for the world stage."

Prenatal genetic screening: The Society of Obstetricians and Gynaecologists of Canada is recommending that all Canadian women, irrespective of age, be offered the option of noninvasive prenatal genetic screening during pregnancy. The results would help physicians determine whether to use more invasive screening methods, such as amniocentesis or chorionic villi sampling, or whether to offer health counseling to pregnant women who discover their



Digital Stock

children may have genetic disorders, the SOGC argued.

ED shift in NB: About a dozen community physicians are filling shifts at the Saint John Regional Hospital's emergency department after 4 ED physicians resigned in January despite incentives negotiated with the New Brunswick government. Fourteen ED doctors originally tendered their resignations citing understaffing and overcrowding; 10 agreed to stay after the province offered an overtime bonus. The ED now employs about 13 doctors but needs 20. — Bobbi-Jean MacKinnon, Saint John, NB

Quebec elects CMA presidential candidate: The Quebec Medical Association has nominated its president, Dr. Robert Ouellet, as CMA president-elect. If the Laval radiologist is ratified at CMA's annual meeting in August he will become CMA's president in 2008–09. Ouellet defeated family physicians, Dr. André Senikas and Dr. Daniel Wagner, to win the nomination.

\$139-million AIDS initiative: The federal government and the Bill and Melinda Gates Foundation are establishing the Canadian HIV Vaccine Initiative. The government is contributing up to \$111 million; Gates has pledged \$28 million. The initiative will support Canadian researchers working with international partners through the Global HIV Vaccine Enterprise, an alliance of international organizations.

Colorectal kits: Manitoba and Ontario are both introducing broad screening programs for colorectal cancer. This spring Manitoba will mail screening kits to about 20 000 people between the ages of 50 and 74 in 2 health regions. In 2008 Ontario family physicians and pharmacists will provide home screening kits to Ontario residents. Alberta, BC and Quebec are contemplating similar programs. Colorectal Cancer Association of Canada President Barry D. Stein stated that such programs are past due and will result in a decrease in mortality. Some 8500 Canadians died last year from the disease.—Compiled by Wayne Kondro, *CMAJ*

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