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-serviced 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 children may have genetic disorders, the SOGC argued.

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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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