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Quelling research excellence in residency programs

Canadian residency programs currently do not provide sufficient latitude for residents with research skills to pursue scientific questions. In contrast, US programs apply different training tracks that encourage research and provide certain advantages to the graduate.

The Canadian Institutes of Health Research funds about 20 to 30 students per year to pursue combined MD and PhD degrees. A stipend is provided during both medical and graduate school. Dual training is intended to cultivate skill in identifying promising therapeutics emerging from the morass of a growing literature.

Here in Canada, graduate residency training commences after 8 or more years of dual training in MD/PhD programs. Typically, we pursue a research project in the basic sciences, exploring molecular mechanisms of disease in graduate school after 2 years of preclerkship, then return to the MD program for clerkship.

The first 2 years of residency are clearly essential for clinical competency. Being underpaid and overworked as residents is held as a rite of passage to, one hopes, better days. But for MD/PhD graduates, another issue arises: How best to maximize our research potential? In spite of being trained to the gills, there is little hope of translating anything until late in our fellowships. This is 5 to 6 years since our last research contribution and makes our previous work an anachronism in the fast-paced world of molecular medicine.

In comparison, US MD/PhD programs offer residency tracks called "research pathways." The American Board of Internal Medicine (ABIM) allows MD/PhD residents to re-enter the lab in the third year and couple their specialty of choice with their research interest. So while the core training is fast-tracked (2 years v. 3), the specialty training is long-tracked (4 v. 2). The assumption is that 2 years of internal medicine is a sufficient foundation — a fair one when considering that senior residents spend an enormous amount of time on "scutwork" and micromanagement, rather than garnering clinical acumen. In short, the ABIM puts the emphasis on the specialty rather than the core for MD/PhD residents, thereby maximizing their research momentum. When will the Royal College see fit to introduce such research pathways into our programs? The corollary: Are we now compromising research excellence for the sake of "clinical rigour"? The absence of such pathways possibly defeats, in my view, one of the laudable objectives of MD/PhD programs: producing world-class clinician scientists.

Dylan Pillai
Intern, Internal Medicine
Stanford University Medical Center
Stanford, Calif.

Transparency at Health Canada

I was intrigued that Health Canada recently diverted $15 million from its population health fund into prostate cancer basic research,[1] even though this is expressly prohibited by their regulations. They disregarded their own selection process by awarding $2 million per year to the Vancouver Centre of Excellence in prostate cancer research, plus $1 million per year to the National Prostate Cancer Research initiative. Was this purely coincidental, or did the former national Minister of Health's bout with prostate cancer lead to the direct or indirect application of non-academic pressure? The high political profile of AIDS also appears to be distorting objective judgement. A project with unfavourable external peer reviews received $8.75 million, and the HIV/Aids Clearinghouse received a $2.5-million funding extension, in spite of noncompliant accounting and an earlier recommendation that $350 000 in prior payments should be recovered.

It's not that prostate cancer and AIDS aren't high-priority problems. As a male cardiovascular surgeon, I am at risk for both conditions. However, numerous internally and externally reviewed research projects must be turned down each year for lack of funding. Funding limitations also play a role in the continuing annual loss of highly talented Canadian medical researchers and teachers to the US. Thus it's critically important that Health Canada be free from the appearance of politically motivated decision-making. Health Canada needs to reassure all Canadians that limited resources are awarded in a transparent manner based primarily on merit.

G. Frank O. Tyers
Professor Emeritus
University of British Columbia
Cardiovascular Surgery
Vancouver, BC

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[Editor's note:]

Ian C. Green, the Deputy Minister of Health, did not acknowledge our request for a response.