were introduced in Hungary. Canadian experts also provided valuable support in introducing health technology assessment.[2] 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.[3,4]

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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.[1] 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)? 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.[1] 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.[2,3] 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.[4]

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.[5] Leung wrote, "We should be cautious of adopting the competency based approach universally across stages of medical training for which well defined and validated competencies are unavailable."[6]

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,[1] gave me much joy, along with