

nificantly different from the 27% of people carrying a *BRCA* mutation in the survey by Dorval and colleagues who expressed moderate or great interest in support groups ($p = 0.19$, t -test for 2 proportions from independent groups). In another recently published needs assessment of Canadians carrying a *BRCA* mutation, 68% of women surveyed stated an interest in support groups and 34% said they would participate in a group if given the opportunity.²

Because the group support study by Helgeson and colleagues consisted of women receiving chemotherapy and “harm” was only noted for the physical and not the mental health parameters measured, it is not clear that their findings are relevant to healthy people carrying a *BRCA* mutation.³ Nevertheless, we acknowledge that there is potential for peer support groups to do harm.

We are currently developing a group therapy model for people carrying a *BRCA* mutation that involves careful attention to the content as well as the process of delivery, and in-depth training of the group leaders. Each group includes women who have and have not had cancer. Feedback from the participants has been almost universally positive.

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2. Metcalfe KA, Liede A, Hoodfar E, Scott A, Foulkes WD, Narod SA. An evaluation of the needs of female *BRCA1* and *BRCA2* carriers undergoing genetic counselling. *J Med Genet* 2000; 37:866-74.
3. Helgeson VS, Cohen S, Schulz R, Yasko J. Group support interventions for women with breast cancer: who benefits from what? *Health Psychol* 2000;19:107-14.

Funding of global health research

As I catch up on my reading of *CMAJ* while in La Paz, Bolivia, where I am a volunteer for the Canadian Society for International Health, it seems important to endorse comments made by Victor Neufeld and colleagues regarding funding by the Canadian Institutes of Health Research.¹ They reminded us of the 1990 recommendation of the Commission on Health Research for Development that “at least 5% of international aid for the health sector should be earmarked for research and strengthening of research capacity” in countries receiving aid from industrialized countries. Earmarking aid in this way is not only consistent with Canadian values, it is also in our self-interest to do so.

Multidrug resistance is a good example of a problem that does not recognize borders. But self-interest can be economic as well. Canada has spent and continues to spend millions of dollars to decrease mortality in children owing to diarrhea, yet recently it has been revealed that the overall incidence of diarrhea in countries receiving aid does not appear to have diminished.² Although there may be many reasons why the root of this health problem is not being affected, it is likely that underfunding of researchers in developing countries is a major factor. Experts in countries where childhood mortality owing to diarrhea is widespread are much more likely to design studies that will provide the necessary insights in this area than any of us in the First World, but they will probably need financial and other forms of collaboration.

Does it not make more sense to fund research that will lead to prevention than to pay to manage an ongoing problem?

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1. Neufeld V, MacLeod S, Tugwell P, Zakus D, Zarowsky C. The rich–poor gap in global health research: challenges for Canada [editorial]. *CMAJ* 2001;164(8):1158-9.
2. Bhutta ZA. Why has so little changed in maternal and child health in South Asia? *BMJ* 2000; 321:809-12.

[One of the authors responds:]

The endorsement by Bernadette Singer of our recommendations is welcome. Since we submitted our commentary,¹ there have been several encouraging developments that demonstrate increasing awareness of, involvement in, and funding of global health research by Canadians.

Four federal agencies (the Canadian International Development Agency, the Canadian Institutes for Health Research, Health Canada and the International Development Research Centre) have signed a framework agreement to pro-

mote Canadian collaboration in global health research. They are sponsoring a national consultation process led by Allan Ronald of the University of Manitoba.

Several of the institutes of the Canadian Institutes for Health Research are exploring possibilities for funding global health research. For example, the advisory committee of the Institute for Public and Population Health has included global health problems in poor to middle-income countries within its mandate.

The International Development Research Centre, in collaboration with several other agencies, has announced a small grants facility, the Partnership for Global Health Equity, to explore collaborative efforts between Canada and developing countries for research concerning global health issues and to explore the processes and challenges involved in building mutually respectful and beneficial research partnerships. This initiative will be managed by the Canadian Society for International Health.

Canadian universities are also paying greater attention to global health. For example, the Liu Centre for the Study of Global Issues at the University of British Columbia is sponsoring a symposium entitled "Canada and the 19/90 Gap: Correcting the Imbalance in Global Health Research Priorities" this month. More information is available through the Centre's Web site (www.liucentre.ubc.ca).

Encouraging as these initiatives are, there are big challenges ahead. These include creating a mechanism for efficient coordination, determining a niche for a distinctive Canadian contribution to the global effort and identifying the needed leadership. As James Orbinski noted recently, "Canada now has a chance to lead the way ... the right priorities depend on the right leadership."²

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2. Orbinsky J. The G8 Summit: focus on neglected diseases. *Globe and Mail* [Toronto] 2001 Jul 18; SectA:13.

Talking cigarette packs are not the answer

Programs to prevent youth smoking represent the height of hypocritical foolishness.¹ Anyone with even rudimentary parenting skills knows that the message "do as I say, not as I do" leads to an increase, not a decrease, in the undesirable behaviour. We now even have the obscenely self-serving absurdity of tobacco companies placing ads that urge young people not to buy their products.

As physicians we should stop all these counterproductive, tiresome and increasingly ridiculous efforts to educate, admonish, inform and warn adolescents about smoking, such as the development of talking cigarette packages.² Through the Canadian Medical Association, we should take the eminently reasonable position that the manufacture and sale of a product known to be fatally toxic should be treated as a criminal offence. Our public efforts should be directed at encouraging our legislators to uphold the common good and put into law the required legislation.

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1. Canada "behind eight ball" in fighting youth smoking. *CMAJ* 2001;164(10):1479.
2. A cigarette pack that talks the talk. *CMAJ* 2001; 164(10):1479.

Occupational health Web site

Our recent article on occupational health¹ contains a minor error that arose during editing of the manuscript. The second paragraph, which read, "One recent online offering is from the Physician Education Project in Workplace Health of the Ontario Workplace Safety and Insurance Board ..." should have read, "One recent online offering

is a manual from the Physician Education Project in Workplace Health (PEPWH), *Injury/Illness and Return to Work/Function: a Practical Guide for Physicians*; this is available at the Web site of the Ontario Workplace Safety & Insurance Board (www.wsib.on.ca)."

The PEPWH Steering Committee comprises a wide range of stakeholders from government agencies and worker and employer organizations. It started as an initiative of the Ontario Medical Association's Section on Occupational and Environmental Medicine and the Institute for Work and Health. Although it receives financial support from the Workplace Safety and Insurance Board, PEPWH was not initiated by that board.

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Reference

1. Liss G, Cheung L. Occupational health finds a home on the Net. *CMAJ* 2001;165(10):77.

Correction

The third recommendation in the text of a recently published clinical practice guideline for the care and treatment of breast cancer contains an error. The recommendation should read as follows: "Patients should be informed of the number of SLN biopsies performed by the surgeon and the surgeon's success rate with the procedure, as determined by the identification of the SLN and the false-negative rate (the presence of tumour cells in the axillary nodes when the SLN biopsy result is negative)."

This recommendation was printed correctly in the abstract.

Reference

1. Cantin J, Scarth H, Levine M, Hugi M, for the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer. Clinical practice guidelines for the care and treatment of breast cancer: 13. Sentinel lymph node biopsy. *CMAJ* 2001;165(2):166-73.