favourably with those following radical prostatectomy. This is part of the reason that patients are keen on being treated with brachytherapy. With the introduction of sophisticated technologies to further enhance the precision of the seed implant procedure, such approaches offer even greater promise for improved success rates, lower rates of side effects and an enhanced quality of life.[5]

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References
1. Crook J, Lukka H, Klotz L, Bestic N, Johnston M, and the Genitourinary Cancer Disease Site Group of the Cancer Care Ontario Practice Guidelines Initiative. *CMAJ* 2001;164(7):975-81.
2. Nickel JC. Brachytherapy for prostate cancer: Effective, but …? [editorial]. *CMAJ* 2001;164(7): 1011-2.
3. Noldus J, Graefen M, Haese A, Henke RP, Hammerer P, Huland H. Stage migration in clinically localized prostate cancer. *Eur Urol* 2000;38:74-8.
4. Jhaveri FM, Klein EA, Kupelian PA, Zippe C, Levin HS. Declining rates of extracapsular extension after radical prostatectomy: evidence for continued stage migration. *J Clin Oncol* 1999; 17:3167-72.
5. Zelefsky MJ, Yamada Y, Cohen G, Venkatraman ES, Fung AY, Furhang E, Sivern D, Zaider M. Post implantation dosimetric analysis of permanent transperineal prostate implantation: improved dose distributions with an intraoperative computer-optimized conformal planning technique. *Int J Radiat Oncol Biol Phys* 2000;48(2):601-8.

[Two of the authors of the research article respond:]

We appreciate Ross Halperin's insightful comments on our review of the evidence for brachytherapy in clinically localized prostate cancer.[1] He is absolutely correct that there is a lack of level 1 evidence from a properly conducted randomized clinical trial. We hope that the soon-to-be-open cooperative randomized trial from the American College of Surgeons Oncology Group (trial Z0070) and the National Cancer Institute of Canada (trial PR10) comparing radical prostatectomy and permanent seed brachytherapy will eventually provide the evidence that is currently lacking. This cooperative trial has been named SPIRIT (Surgical Prostatectomy v. Interstitial Radiation Intervention Trial). Interestingly, the patients who will participate in this large multicentre randomized trial are exactly the same type of patients for whom we suggested that brachytherapy was suitable as monotherapy (with favourable, low-risk T1c or T2a tumours, a Gleason score of 6 or lower and a serum prostate-specific antigen level of 10 μg/L or less).

Patients at intermediate risk (those with a Gleason score of 7 or a serum prostate-specific antigen level greater than 10 μg/L but less than 20 μg/L) are not a homogeneous group for whom one can make a single recommendation. The evidence suggesting the prognostic factors that will subdivide this group is still very young. As the data mature, recommendations can be revisited and altered appropriately.

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Reference
1. Crook J, Lukka H, Klotz L, Bestic N, Johnston M, and the Genitourinary Cancer Disease Site Group of the Cancer Care Ontario Practice Guidelines Initiative. *CMAJ* 2001;164(7):975-81.

Who should foot the bill for continuing review of research?

Charles Weijer addressed the important issue of continuing review of research approved by research ethics boards in a recent commentary[1] on an article by Jane McCusker and colleagues.[2] Resources must be found when already-overburdened research ethics boards are asked to undertake new activities; higher personnel costs are the most important factor. Where, one might ask, should this money come from?

Weijer suggests that "research ethics boards may choose to pay for continuing review by charging for such activities." The burden of the cost for continuing monitoring should not rest with the research ethics board, but rather with the institution itself. In fact, the case can easily be made that the research ethics board should not even be involved in the collection of protocol fees because of a possible conflict. What if not enough money is raised from protocol review? Many protocols being reviewed have no budgets. Should personnel be fired and continuing monitoring stopped? Clearly not.

Research ethics boards serve a vital function and must be supported adequately to protect research participants. The public expects this. Contracts from pharmaceutical companies already serve as a source of revenue for institutions' administrations, and protocol review fees provide additional revenue. Research cannot take place without research ethics boards. Institutions must shoulder their responsibilities.

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References
1. Weijer C. Continuing review of research approved by Canadian research ethics boards [editorial]. *CMAJ* 2001;164(9):1305-6.
2. McCusker J, Kruszewski Z, Lacey B, Schiff B. Monitoring clinical research: report of one hospital's experience. *CMAJ* 2001;164(9):1321-5.

[The author responds:]

I would like to thank Jack Mendelson and Franca Cantini for giving

me the opportunity to clarify an important point. They quite rightly state that "the burden of the cost for continuing monitoring should not rest with the research ethics board, but rather with the institution itself." In a previous article in *CMAJ* my colleagues and I wrote that "local institutions, through their research ethics boards (REBs), are obligated to ensure appropriate monitoring of research involving human subjects. ... Continuing review requires institutions to commit substantial financial resources and personnel to the process."[1] I still believe this to be the case and erred in not making this point more clearly in my recent commentary.[2]

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References

1. Weijer C, Shapiro S, Fuks A, Glass KC, Skrutkowska M. Monitoring clinical research: an obligation unfulfilled. *CMAJ* 1995;152(12): 1973-80.
2. Weijer C. Continuing review of research approved by Canadian research ethics boards [editorial]. *CMAJ* 2001;164(9):1305-6.

Have 'scope, will travel

I am a Canadian physician who has been working around the world (Saudi Arabia, New Zealand, Australia, Saipan, Oman) for the last 11 years. When I stumbled across your article "One country, one medical licence!"[1] a very loud bell rang.

When I was on faculty at the University of Western Ontario I used to offer senior residents in gastroenterology a summer locum in my practice at the end of their training. My secretary would book them solid (just like I was booked) and they could take home everything they earned. It cost them nothing but a small gift for my secretary, whose salary I continued to pay. It meant they had a little money to start out with, and for me it was invaluable — I could take a relaxing holiday and know that when I returned everything would be as I had left it, or even better. Some even left detailed notes on what they would like me to do with patients they had seen.

When I return to Canada I would like to return the favour to these former residents of mine. In fact, there are many other harried GI doctors I would like to offer my services to: "Take a holiday! Leave on a Friday, return on a Monday and everything will be the same as you left it. In fact I'll even pay your secretary's salary." But the doctors I helped to train are now scattered across Canada, as are my GI colleagues. To do what I would like to do would mean getting a medical licence from almost every province.

When we graduated from medical school we all wrote the nationwide LMCC exams. When we finished our residency training we all took the nationwide Royal College exams. When we started our practices we all joined the nationwide Canadian Medical Protective Association. Most of us are members of the nationwide CMA.

Canada has become too small a country not to have a nationwide medical licence and a nationwide medicare billing system. Are our provincial medical associations bold enough to implement the former and are our provincial and federal politicians brave enough to implement the latter? I fear they are not, but I live in hope.

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Reference

1. Wharry S. One country, one medical licence! *CMAJ* 2001;164(9):1335.

Dealing with measles

I was pleased to see your recent public health article on measles.[1] Because measles has become a rare disease in Canada, it is harder for clinicians to differentiate the clinical syndrome of measles from other rash-type illnesses (such as parvovirus B19). At the same time, it is important to diagnose it accurately through laboratory confirma-