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]

Charles Weijer
Department of Bioethics
Dalhousie University
Halifax, NS

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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.

Stephen N. Sullivan
Peripatetic Proctologist
Muscat, Oman

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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-

tion. Accurate case diagnosis is crucial to both the preventive management of contacts of a patient and the evaluation of our immunization programs. Case confirmation must occur rapidly to allow for timely public health interventions. Also, clinical specimens such as nasopharyngeal or throat swabs and urine can be subtyped by public health laboratories to describe the importation or endemic spread of measles or both.

Recently a case of measles involving a 13-month-old unimmunized child was linked to transmission in a clinic waiting room. As such, I would like to add a little more advice regarding "measles in your office."

Because measles is the most infectious of the communicable diseases, office visits involving patients suspected of having measles should be scheduled as the first or last of the day, and the office should be allowed to "breathe" for at least an hour after the patient departs. All surfaces contacted by the patient should be disinfected. Finally, the patient should not have contact with office staff members who are not known to be immune. This is a reminder that the immunization status of all staff should be checked and updated upon hiring.

Lori Kiefer
Medical Specialist and
Associate Medical Officer of Health
Communicable Disease Control
Toronto Public Health
Toronto, Ont.

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Air travel and thromboembolism

Those interested in Erica Weir's timely review on air travel and the risk of venous thromboembolism[1] might wish to read a recent article by Kraaijenhagen and colleagues.[2] In this prospective study, the travel history of 186 patients with confirmed deep vein thrombosis was compared with that of 602 patients who had similar symptoms but did not have the disease. A similar proportion of patients in each group had undertaken various types of travel. There was no increased risk of deep vein thrombosis among travellers. This report further weakens the potential association between symptomatic thrombosis and travel.

Michael J. Mant
Department of Medicine
University of Alberta
Edmonton, Alta.

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