

First Nations, Inuit and Métis people, and we have taken care to build such relationships in the conduct of our work.

The study on death and renal transplantation among Aboriginal people undergoing dialysis¹ was the first in a planned series of investigations that will include community representation and ongoing input from Aboriginal communities and Aboriginal leaders in Alberta and Ontario. These investigations have been approved by the appropriate institutional review boards, and no concerns have been raised about the ethics of the work.

To ensure that our work appropriately addressed the unique situation of Aboriginal people, the final manuscript for this study¹ was reviewed in detail by 2 First Nations elders, neither of whom expressed the concerns raised by Smylie.

To strengthen our research team (and provide the unique insights to which Smylie refers), we have established ongoing collaboration with leading Aboriginal researchers. Through their involvement, as well as the collaboration and partnership of members of the Aboriginal communities, we are formulating a plan for dissemination of these research results and will suggest changes to health policy accordingly.

Smylie also raises methodological concerns about our study. As stated in our article,¹ the assumptions of the Cox proportional hazards models were tested and met. We agree that the possibility of an interaction between socioeconomic status and race on health outcomes seems plausible. However, as we reported, this hypothesis was tested and was nonsignificant, which suggests that such an interaction did not exist in the population we studied.

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[Dr. Wenman and colleagues respond:]

Janet Smylie expresses ethical and methodological questions about our study.¹ In the first instance, it is important to realize that our study did not constitute participatory action research,² which would indeed require what Smylie suggests in terms of involvement of ethnic groups. Rather, as stated in the Methods section, our study involved a hospital-based cohort of pregnant women and did not initially target any specific ethnic group. Data on ethnic origin, among other variables, were collected as part of the study, and demographic and clinical details have been published elsewhere.³ The decision to prepare the *CMAJ* paper for publication arose from our analysis of the data, during which we found important differences between ethnic groups that we thought should be reported because of their public health implications.

Smylie also raises some methodologic concerns. We are unsure what is meant by her reference to "methodologic problems with the way in which ethnicity was determined," since no details are given about where we might have erred. We used standard questions and classified ethnicity according to current standards. Smylie is concerned about the exclusion of "multiple-ethnicity responses, such as Caucasian and First Nations." Only 3 First Nations and 3 Métis women also checked off Caucasian ethnicity, and these people were not coded as Caucasian because the categories were mutually

exclusive for analytical purposes. In our initial analysis we separated out various ethnic groups, but during the peer review and revision process we were asked to present pooled results for our Table 1 and for the final logistic regression. Nevertheless, we did specifically discuss differences between ethnic groups in our Results section. With regard to potential underpowering, we acknowledged small numbers as a limitation of the study and understand that there may have been a lack of power to detect other potential differences.

We believe it is both scientifically and ethically sound to view this study as having the potential to improve the lives of people who have suffered and continue to suffer health disparities.

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[Dr. Cass responds:]

Janet Smylie appropriately stresses the need for mutual respect, understanding and partnership if research relating to indigenous communities is to truly benefit those communities. Her argument is supported by our research in the Northern Territory of Australia, which

explores the extent of miscommunication in health care delivery and its impact on quality of care.¹ In that study health care professionals used participatory action methodology to collaborate with Aboriginal patients and community members in planning and conducting the research and then in using the results to improve delivery of services for people with chronic kidney disease.

Smylie also expresses concern about use of the categorization “Aboriginality” in health research, arguing that it has “little grounding in the day-to-day realities of the heterogeneous groups to which it refers.” Despite concerns regarding the quality of indigenous identification in health data sets, this categorization can be used to demonstrate inequitable access to care and inequitable health outcomes.² Such data will be required to support efforts to improve health equity.

As outlined in my commentary,³ the “indigenous” or “Aboriginal” label needs to be unpacked to determine which specific factors maintain health disparities and which particular characteristics of individual communities should shape policy interventions so that they are both appropriate to local conditions and sustainable.

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Clinical trials registry

The requirement of the International Committee of Medical