

pose a serious threat to the privacy of individual research subjects. In the absence of clear evidence that the publication of anonymized data sets would deter the publication of flawed or fraudulent research, and in the absence of a clear standard for anonymizing data sets to ensure that individuals cannot be re-identified, alternative means of validating research findings should be considered.

**Ann Cavoukian**  
Information and Privacy  
Commissioner of Ontario  
Toronto, Ont.

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## One country, too many licensing bodies

Having worked in the medical profession in both Canada and abroad, I have come to the conclusion that Canada, the second-largest country in the world (in geographic terms), is too small to have separate medical licensing boards for each province and territory.

Let me explain. Prospective medical students in Canada compete for all the first-year medical school slots across Canada. Of those accepted, the vast majority finish medical school by writing the examinations for the Licentiate of the Medical Council of Canada (LMCC). They then compete for the available internship positions, and many go on to do advanced training, eventually writing the Canada-wide examinations of the Royal College of Physicians and Surgeons of Canada (RCPSC).

The net result is a pool of hundreds, perhaps thousands, of highly qualified Canadian physicians who might like to practise or do locums in some of the more remote areas of our vast country. But they have to get a licence for each province or territory where they might want to do a locum.

One country, one LMCC credential, one RCPSC, and one Canadian Medical Protective Association (CMPA), but 13

licensing bodies (colleges) — it's time to clean up our act.

Here is my proposal. If a physician has a valid medical licence to practise in any province or territory of Canada, along with a clean bill of conduct and CMPA coverage, he or she should be allowed to do locums anywhere in Canada without further licensing requirements.

**Stephen Sullivan**  
Victoria, BC

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## The problem of evidence-based medicine in developing countries

In a recent article, Caleb Alexander and associates<sup>1</sup> elucidate the issue of prioritizing and stopping prescription medicines, pointing to a lack of data on the safety and optimal means of discontinuing drugs.<sup>1</sup> This may be the core problem in developed countries, but the situation is altogether different in developing countries, where a poor research culture is the biggest obstacle to the promotion of evidence-based medicine and in turn to the prioritization and discontinuation of prescription medicines.

The utilization and production of research, along with human and institutional development, are 2 important components of health research.<sup>2</sup> Without these, it is very difficult to practise evidence-based medicine.

The utilization of research, which is the backbone of evidence-based medicine, is in a terrible state in developing countries. A recent study conducted in a hospital in Pakistan found that only 20% of residents read medical journals monthly, only 12% had ever written for medical journal publication, and 12% had never read a medical journal.<sup>3</sup>

The state of the production of research is also not encouraging. In all disciplines of science and technology, India and Pakistan combined have 208 researchers per million citizens; the comparable figure for the United States is 4526 researchers per million.<sup>4</sup>

By highlighting this issue of poor research culture, we hope to contribute to increased awareness among those who read journals and who can bring about positive change.

**Ahmad A. Sabri**  
Physician  
Faisalabad, Pakistan  
**Muhammad Ahad Qayyum**  
Physician  
Mayo Hospital Lahore  
Lahore, Pakistan

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## Private health insurance needs consent

Loreen Pindera<sup>1</sup> describes the Quebec health ministry's recently released white paper, which recommends private health insurance as a means of reducing waiting time for "elective hip, knee and cataract surgeries, and to cancer-related surgeries."<sup>2</sup> According to the white paper, "This is the first step: the mechanism could be extended to other types of hospital services. . . ."<sup>2</sup>

However, the Romanow Commission "heard from Canadians through the Citizens' Dialogue and other consultations [that] the large majority of Canadians do not want to see change in the single-payer insurance principle for core hospital and physician services."<sup>3</sup> Given this evidence of citizens' resistance to changes such as those proposed for Quebec and to ensure respect for the autonomous choices and preferences of Quebecers, it seems to me that any proposed changes in hospital and physician care must have explicit "informed consent" from the public.

Moreover, the method of consulta-

tion for most Quebeckers (by Internet only) and the short period allowed (consultations are now closed) excluded those who do not have a computer and limited the options for those who do. I believe that the only ethical way for the Quebec government to implement its recommendations would be a province-wide referendum specifically addressing its proposals for private health insurance for services currently covered by publicly funded health care. Such a referendum would permit citizens to decide on the sort of health care system they want and would be congruent with practices in other democracies, such as Switzerland, which holds referenda on important issues like this one.

### Joseph Erban

Member

Clinical Ethics Committee

Sir Mortimer B. Davis — Jewish

General Hospital

Montréal, Que.

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## Hepatitis C: reviewing the options

Tom Wong and Samuel Lee<sup>1</sup> mention some extrahepatic manifestations of infection with hepatitis C virus (HCV), but they do not discuss the urticarias. Internists and primary care physicians need to be aware that several forms of urticaria can be associated with asymptomatic HCV infection.

The link between HCV and urticaria is controversial,<sup>2</sup> because various studies have failed to differentiate between acute urticaria, chronic urticaria and urticarial vasculitis, all of which have

been proposed as being associated with HCV infection. The estimated prevalence of urticaria varies from 1.8% to 24%, and one case-control study disputed the association altogether.<sup>2</sup> The association with other hepatitis viruses is more certain. For example, electron microscopy was used to identify hepatitis B surface antigen-antibody complexes in cryoprecipitates taken from patients during the acute urticarial episode.<sup>3</sup>

Immune-complex deposits of viral hepatitis can activate the complement system, which results in a serum-sickness-like syndrome, with arthritis, excruciating headache and urticaria (known as Caroli's triad).<sup>4</sup> Urticaria resolves on treatment with interferon, and more benefit is seen when urticarial vasculitis is associated with mixed essential cryoglobulinemia.<sup>5</sup>

HCV testing should not be a routine screening test for all urticarias, but it is good clinical practice to consider viral marker studies in a patient with urticaria who presents with icterus or elevated transaminase levels (or both). The awareness that urticaria or urticarial vasculitis may be caused by hepatitis C is important, as early antiviral treatment can reduce significant morbidity and mortality.

### Sujoy Khan

Specialist Registrar Immunology

PathLinks Immunology

Scunthorpe General Hospital

Scunthorpe, North Lincolnshire, UK

W.A.C. Sewell

PathLinks Immunology

Scunthorpe General Hospital

Scunthorpe, North Lincolnshire, UK

University of Lincoln

Brayford Pool, Lincoln, UK

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As Tom Wong and Samuel Lee mention in their article about hepatitis C,<sup>1</sup> patients with genotype 2 or 3 "are expected to have a high likelihood of treatment success"; however, the conclusion that these patients "may not require a liver biopsy and do not require a baseline viral load measurement" seems premature.

First, several clinical trials<sup>2,3</sup> have demonstrated a lower likelihood of sustained virological response in patients with genotype 2 or 3 who also have advanced fibrosis. Other researchers were unable to reproduce these findings, probably because such patients are often underrepresented in clinical trials.<sup>4</sup> Additional studies are now showing that steatosis is another independent predictor of sustained virological response in these patients.<sup>4,5</sup> Interestingly, findings in patients with genotype 3 indicate that only metabolic (but not viral) steatosis is associated with lower sustained virological response.<sup>6</sup>

Second, current evidence suggests that among patients with genotype 3, viral load is an important predictor of both sustained virological response<sup>3,4,7,8</sup> and early virological response.<sup>3</sup> Moreover, for patients with genotype 2 or 3 and early virological response at week 4, shorter courses of therapy (12–16 weeks) were as effective as the recommended course of 24 weeks.<sup>3,7,8</sup> Whether patients with genotype 2 or 3 who have a high viral load and/or absence of early virological response (with or without advanced liver fibrosis) will benefit from longer treatment should be investigated in further clinical trials.

It therefore appears that both baseline histologic findings and viral load may be useful for tailoring treatment in certain subgroups of patients with genotype 2 or 3 in whom the standard duration of therapy might constitute overtreatment.

### Michal R. Pijak

Consultant in Internal Medicine,

Rheumatology, Allergy and Clinical

Immunology

Department of Internal Medicine

University Hospital

Bratislava, Slovakia