[The author responds:]

Robert Ashforth and Shabbir Alibhai have underlined some of the difficulties inherent in creating a list of technologies using a computerized reviewer database and email. First, my initial survey was limited to those reviewers with accurate email addresses in the database. Second, *CMAJ*'s reviewer database includes only a small fraction of Canada's specialists, and certain specialties are clearly underrepresented. For example, of reviewers with email addresses in the database, there are 64 specialists in hematology–oncology, 14 in gastroenterology and only 13 representing radiology and nuclear medicine combined.

Furthermore, with space limitations in the journal, the challenge was to keep the list as complete as possible without being repetitive. Thus, specialties dealing with similar disease processes were combined under 1 heading. Although inhaled nitric oxide for hypoxemic repiratory failure was listed as a critical-care technology, it could just as easily have been described as a technology "belonging" to respirology. Similarly, telemedicine, a technology with important applications in many medical fields, was listed under the heading cardiology and cardiac surgery simply because several cardiologists cited telemedicine as a key development.

In this vein, my choice not to include diagnostic imaging as a heading was certainly not an attempt to attribute radiologic technologies and skills to other specialists, but was rather an effort to show the wide-ranging applications of imaging technologies in virtually all areas of the body and of medicine. As I emphasized in my editorial, new imaging techniques have changed the way we see disease, and technological advances in radiology have had an impact well beyond the bounds of a single specialty.

The list is by no means comprehensive. It was meant to give readers a sense of the directions technology has taken, to be a springboard for more detailed descriptions and to serve as an invitation to specialists, like Ashforth and Alibhai, to tell us more about what they do.

Caralee E. Caplan
Former *CMAJ* editorial fellow
Columbia University
New York, NY

A new register for clinical trial information

I applaud David Hailey for recognizing that "Schering Health Care and Glaxo Wellcome have taken important steps in making information available about ongoing trials in which they are involved."[1]

Having recognized the need for global access to information, Glaxo Wellcome recently introduced a clinical trials register to ensure that as much information as possible is available to researchers and clinicians. The goal is to facilitate systematic review of late-stage clinical data and, ultimately, to improve patient care.

Researchers already have access to much clinical trial information because the submission of clinical trial reports to peer-reviewed journals has long been established as a means of subjecting data to the rigorous scrutiny of the medical community. However, not all data generated through the drug-development process are published, meaning that an unpublished pool of potentially valuable data exists.

Medical researchers and other health care professionals can access the clinical trials register through a password-protected area of the Glaxo Wellcome external R&D Web site (www.glaxowellcome.ca). The site allows users to access our study protocols and unpublished late-stage clinical trial data when reviewing information on specific medications. The register will also make researchers aware of research in progress, thereby avoiding duplication of effort.

In addition to establishing and maintaining the register, we remain committed to publishing clinical trials in peer-reviewed journals. Each trial in the register will be assigned a unique identifier, which researchers can use to link each publication back to the original trial. Because a single trial may generate several publications, the unique identifier will help people reviewing the literature to identify specific trials and avoid duplication of trial data.

Because access to information about specific medications can improve patient care, Glaxo Wellcome has taken the lead in developing this clinical trials register for the use of medical researchers and clinicians. We encourage the rest of the research-based pharmaceutical industry to join us.

Michael D. Levy
Senior Vice-President, Research & Development
Chief Medical Officer
Glaxo Wellcome Inc.
Mississauga, Ont.

Reference
1. Hailey D. Scientific harassment by pharmaceutical companies: time to stop [commentary]. *CMAJ* 2000;162(2):212-3.

Migrants from China

I was upset to read the article "BC's Chinese migrants a healthy lot, MDs find."[1] The article stated that 34% of the passengers on the fourth boat had chronic hepatitis B, which means that these passengers are infective. If over one-third of them have a disease that, if transmitted, is life threatening, how can we call them a healthy lot? I find this outrageous. Even the outcome of the disease to the migrant and the cost to our medical system leave me wondering why our government allows this to continue.

Ann-Marie Robertson
Family physician
Vancouver, BC

Reference
1. Kent H. BC's Chinese migrants a healthy lot, MDs find. *CMAJ* 2000;162(2):256.

[The news and features editor

responds:]

The headline referred to the importance the "snakeheads" — the people who smuggled these migrants to Canada — placed on health status in choosing which people to bring. They did this because healthy migrants could pay them back faster. Even the chronic carriers of hepatitis B appeared to be in good health.

Patrick Sullivan

Red tape is strangling foreign-trained physicians

I would like to add my voice to that of Alex Porzecanski, whose letter lamented the lack of support for foreign-trained physicians.[1] Not only are there considerable stumbling blocks for these students, but there is considerable disincentive for them to return to Canada after their residency.

After completing my degree in a foreign medical school, I pursued a residency in Canada. I was met with a disheartening wall of bureaucracy and opted for a position in the US. At the end of my training and after completing the American Board of Internal Medicine (ABIM) exams, I inquired about practice in Canada. Even as a Canadian with American qualifications, I found that entry into the system was daunting.

At this point I am a graduate of a medical school recognized by the World Health Organization, have ABIM certification, hold 2 state licences and LMCC certification and practise in New Brunswick. Nevertheless, 3 years after embarking on a journey for the elusive Holy Grail of FRCPC certification, I'm being prevented from writing the Canadian exams. It seems that when every criterion has been met, a new form must be filled out or a new exam must be written. The latest roadblock is the requisition of my entire medical school transcripts in order to reinvent the wheel!

Therefore I have no sympathy for the governing bodies and medical societies that cry about physician shortages. This mess developed because of our own turf protection and short-sighted planning. The result is convoluted departments that justify their existence, and funding, by creating seemingly endless red tape.

I'm luckier than most, in that I can continue to work while wading through this quagmire of paperwork. But why are we surprised to learn that there has been a brain drain south when at home we have actively set out to exclude people from working here?

Ardavan Mahim
Internist
Miramichi, NB

Reference

1. Porzecanski A. Why do we force Canadians to study medicine abroad? [letter]. *CMAJ* 1999; 161(11):1389.

What exactly were you highlighting?

On the first page of the Jan. 11, 2000, issue of *CMAJ* there is a highlight[1] of a study published in that issue on HIV infection in young gay and bisexual men in Vancouver.[2] Accompanying the highlight is a photograph of 4 young children who by all appearances it can be safely assumed are African.

Could someone explain to me the connection between the photograph and the content of the article? What do 4 young African children have to do with HIV infection in Vancouver? It is said that a picture is worth a thousand words; what is this one telling us? Insensitivity can take many forms and this is one example of such.

W.S. Lofters
Department of Oncology
Kingston Regional Cancer Centre
Kingston, Ont.

References

1. Highlights of this issue. *CMAJ* 2000;162(1):1.
2. Strathdee SA, Martindale SL, Cornelisse PGA, Miller ML, Craib KJP, Schechter MT, et al. HIV infection and risk behaviours among young gay and bisexual men in Vancouver. *CMAJ* 2000;162(1):21-5.

On the highlights page[1] in the Jan. 11, 2000, issue of *CMAJ*, what is the relevance of the photograph under the headline "HIV complacency" to the synopsis or the articles described? Are the innocent children complacent about HIV, or were they the young gay and bisexual men in Vancouver?

I hope I am right in assuming that informed consent of the children and their parents was obtained for the photograph to (1) be taken and (2) be published without masking the faces.

Muri B. Abdurrahman
Pediatrician
Toronto, Ont.

Reference

1. Highlights of this issue. *CMAJ* 2000;162(1):1.

[Editor's note:]

The image was chosen to highlight editorialist Brian Willoughby's[1] concern for populations, such as children in sub-Saharan Africa, who face the prospect and the toll of HIV infection and AIDS[2] with little hope of sharing in the pharmacological advances available in Europe and North America. *CMAJ* is committed to the policy of obtaining consent from patients before publication of personal and medical information about them. However, the issues that surround this policy can become complex, and one might reasonably expect to run into grey areas from time to time.[3] In the present case, the image was taken from a stock photo library and was used to draw attention to a population at risk. There was no disclosure of personal or medical information.

References

1. Willoughby BC. HIV: the millennium bug. *CMAJ* 2000;162(1):52-3.
2. Mukwaya J. The AIDS emergency. In: *The progress of nations 1999*. New York: UNICEF; 1999. Available: www.unicef.org (accessed 2000 Feb 22).
3. Hoey J. Patient consent for publication — an apology. *CMAJ* 1998;159(5):503-4.

It's uncanny