

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.

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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.

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The problem of evidence-based medicine in developing countries

In a recent article, Caleb Alexander and associates¹ elucidate the issue of prioritizing and stopping prescription medicines, pointing to a lack of data on the safety and optimal means of discontinuing drugs.¹ 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.² 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.³

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.⁴

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.

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Private health insurance needs consent

Loreen Pindera¹ 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."² According to the white paper, "This is the first step: the mechanism could be extended to other types of hospital services. . . ."²

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."³ 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-