

Free access to medical information: A moral right?

In a recent *CMAJ* editorial,¹ Bruce Squires echoes a sentiment expressed by Virginia Barbour and colleagues² that society has a moral right to medical information. They tell a chilling tale of what they describe as the “deadly” consequences of practitioners in the field having access to incomplete information. They claim that the dissemination of science must be driven not by publishers “but rather by the needs of society.”

Squires states that “publicly funded researchers have a moral obligation to make the results of their research freely available to everyone,” citing initiatives of the Canadian Institutes of Health Research in support of open-access publication as a model. But is this truly a moral obligation? Certainly one could argue that publicly funded researchers should be accountable to the public. However, the argument that there is a moral obligation to make such information freely available is problematic when considered in this specific context, and a series of broader interrelated questions must then be answered.

How are the interests of distributive justice served if publicly funded research is made freely available, but not any other research? It has previously been argued that ethically information on all research involving human subjects should be made publicly available, regardless of study design or funding source.³

What are the obligations of researchers to research subjects with respect to the dissemination of knowledge, and should funding source influence such obligations? If the obligations of publicly versus privately funded researchers differ, do researchers have a duty to disclose these distinctions to their human research subjects? What are the obligations of research ethics governance bodies to human subjects regarding both the availability of such information and the disclosure of the researchers’ obligations?

An analysis of the harms and benefits of public access to the results of medical research along the lines de-

scribed by Barbour and colleagues² would suggest that if there is a moral obligation to disclose medical information, it should be irrespective of the design, phase, nature and source of funding of the study.

Michael Goodyear
Department of Medicine
Dalhousie University
Halifax, NS

REFERENCES

1. Squires B. *Editorial policy: The right to medical information.* *CMAJ* 2006;175(6):557.
2. Barbour V, Chinnock P, Cohen B, et al. The impact of open access upon public health. *Bull World Health Organ* 2006;84(5):337.
3. Goodyear M, Golec L, Watts SC. Commentary on WHO International Clinical Trials Registry Platform [posting from an Open Comment session]. Available: www.who.int/ictcp/MichaelGoodyear_11Nov2005.pdf (accessed 2006 Nov 22).

DOI:10.1503/cmaj.1060203

Canadian mnemonics for heart sounds

A critical part of the physical examination is auscultation of the heart. Auscultation is fun, but the heart sounds are hard to learn, hard to teach and hard to remember without constant practice. As a teacher, I have struggled to make them easier to hear and to remember. Sure, the first 2 heart sounds are easy, once you get the timing right. But gallops are tougher. As a student, I could never remember the correct pronunciation of “Kentucky” or “Tennessee” as memory aids to describe the third and fourth heart sounds, perhaps in part because they had no relevance to my own experience.

Quite a few years ago, I began teaching Canadian mnemonics for the extra heart sounds. Canadian students understand and remember these memory aids because they are relevant to them and fun. Before I leave clinical practice, I wish to share these little aids.

The third heart sound (S₃) sounds like “Montreal,” pronounced as only the Anglophones mispronounce it, with the last syllable very soft (MON TRE al). The presence of this heart sound means the ventricle is like that city: dilated and congested (this is to be taken in fun

only, please; I love Montréal). The fourth heart sound (S₄) sounds like “Toronto,” with emphasis on the middle syllable (tor ON to). The presence of this heart sound means that the ventricle is stiff and noncompliant, just like that city (sorry, Toronto). When the ventricle is in serious trouble, both S₃ and S₄ are present, sounding like “Saskatchewan.” Enough said.

My students and my patients have had fun with these mnemonics and they do remember what they stand for. Patients even ask, “Do I still sound like Montreal [or Toronto] today?”

J. Wayne Warnica
Cardiac Intensive Care Unit
Foothills Hospital
Calgary, Alta.

DOI:10.1503/cmaj.1060180

Registration requirements

Why does each province and territory have different registration requirements? The expectation that a physician has to go through a registration process with each province or territory in which he or she may wish to work is undoubtedly contributing to the shortage of physicians in remote areas.

I recently looked into doing short-term locum work in Nunavut, the Northwest Territories and the Yukon. I would love to visit these areas of Canada, and it seemed like a good idea to go and work in them for 4–8 weeks as a family physician. My visit would also fill a very real need: some communities in the territories have difficulty finding locum physicians to supply holiday relief. However, after discovering that I would be required to supply notarized copies of my degrees and to pay significant amounts of money for a short-term licence, I am deterred. In addition, if I were to choose to go back a year later I would have to repeat the entire process. I may as well stay within my own province to do any locum work.

I think it is time that the colleges in each province and territory got together and decided on a plan to allow physicians to work anywhere in Canada with the same registration and