We will consider for publication only letters submitted by mail or courier (not fax) in duplicate, printed in letter-quality type without proportional spacing and not exceeding 450 words. Letters must not duplicate material being submitted elsewhere or already published. We routinely correspond only with authors of accepted letters. Rejected letters are destroyed. Accepted letters are subject to editing and abridgement.

Seules peuvent être retenues pour publication les lettres reçues par la poste ou par messager (non pas par télécopieur) en double dont la longueur n'excède pas 450 mots. Elles doivent être mécanographiées en qualité «lettre» sans espacement proportionnel. Les lettres ne doivent rien contenir qui ait été présenté ailleurs pour publication ou déjà paru. En principe, la rédaction correspond uniquement avec les auteurs des lettres retenues pour publication. Les lettres refusées sont détruites. Les lettres retenues peuvent être abrégées ou faire l'objet de modifications d'ordre rédactionnel.

Clinical-trial registration

The continuing discussion on clinical-trial registration, as described in the article "Clinical-trial registration: a call for its implementation in Canada" (*Can Med Assoc J* 1993; 149: 1657–1658), by David Moher, might be more efficient if approached in terms of outcome. The creation of yet another bureaucracy to undertake such registration will not be an improvement.

Our community might be better served by a more efficient use of existing resources. For example, it has generally been difficult to establish continuing working relations among academic research communities, industry and government. Bill C-22, which amended the Patent Act and affected research into prescription drugs, has resulted in more collaborative undertakings through the initiatives of the Medical Research Council of Canada. Such strategies may stimulate new approaches to research and development that do not require additional resources.

This cooperative approach has also extended into the drug approval process. Although still in its infancy a recent move to involve experts in the evaluation of new drug submissions may make the approval mechanism more transparent and open to expert opinion. The establishment of expert panels could be a next, logical step. Such panels would not only benefit the approval process but also improve communication between academia, industry and government. As well, they would facilitate the more complete dissemination of knowledge, including negative results from clinical trials. This dissemination is needed for economy of effort in future research and will save needless expenditure and exposure of clinical populations to risk.

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[The author responds:]

Drs. Lapierre and Mohr suggest that the development of a Canadian clinical-trial registry would create more bureaucracy and might not achieve the desired goal of compiling information about all trials conducted in Canada.

Developing a clinical-trial registry does incur costs, to employ a director, manager, computer programmer, computer communications specialist, data-entry clerk and part-time secretary. Once a registry is developed it must be maintained, which is very time-consuming. Estimates of the cost of developing and maintaining a clinical-trial registry are $30 000 to $40 000 per year.[1] Costs could be kept to a minimum if the registry were located in a research facility that had personnel with expertise in clinical trials, computer programming, electronic communications and clinical-trial registries.

Collaborative relations between academia, industry and government are important and need to be fostered. However, these links alone may be inadequate to address the problems posed by publication bias. As well, they do not address the need for public access to information about clinical trials.

Publication bias is still a problem for peer-review granting agencies.[2] The World Health Organization has recommended that the pharmaceutical industry be more forthcoming about registering trials and making information about them available.[3] Investigators should be encouraged to report their results, whether positive or negative: "negative" may simply mean that a statistical threshold was not reached, not that that the trial had no importance.

In Canada a significant number of clinical trials are funded through agencies that receive their monies from federal and provincial taxes and voluntary contributions by members of society. However, there is no database accessible to the public that could provide information on what trials are being funded and conducted.

Information about all clinical trials exists within research ethics boards. Registering clinical trials during the process of approval by these boards could be, I believe, the most pragmatic approach. Investigators could complete a registry information form and then forward it to the Canadian clinical-trial registry office. To ensure that a form was

← For prescribing information see page 2041

completed for all trials, investigators would be asked to include a copy of the completed form with their application for approval. Once the form had been processed by the registry office the trial would be considered registered.

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2. Dickersin K, Min YI: NIH clinical trials and publication bias. [article] *Online J Curr Clin Trials* 1993; Apr 28 (doc 50): 53 paragraphs
3. Regional Office for Europe, World Health Organization: *Drug Information: Report of a WHO Meeting, 16–18 October 1991* (EUR/ICP/DSE 168), WHO, Geneva, 1992

"Abuse" in medical school?

The essay "Differences in abuse reported by female and male Canadian medical students" (*Can Med Assoc J* 1994; 150: 357–363), by Drs. Rebeka Moscarello, Katalin J. Margittai and Miriam Rossi, would have been far more useful if the nature of each incident of abuse had been described. A mere catalogue of types of abuse doesn't help one understand the problem or learn how to prevent it.

What is verbal abuse? Does it mean being sworn at? Should we abandon the spoken word as a means of discipline? The concept of emotional abuse eludes me; a description of it would have been helpful.

Does sexual abuse mean an overt attempt at unwanted sexual intercourse, a leer or a friendly hug? The only abuse the authors investigated that is understandable to me is physical abuse, which I believe includes forceful blows, kicks or stabs. It is difficult for me to believe that a hospital staff member, intern, resident or nurse (a woman, in my old-fashioned male mind) would do such things to a person of either sex. Some examples of these incidents of abuse would have been informative.

Also, the authors should have included a copy of the questionnaire. Without it, readers can't interpret the message.

I worry that we are becoming so obsessed with "abuse" that we can't see the forest for the trees. If the problem of abuse of medical students exists I hope that the authors will write another essay describing the nature of this abuse and giving suggestions for prevention.

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[The authors respond:]

Although Dr. Harris refers to our article as an essay it was accepted and published as a report of original research. Therefore, the article meets broader criteria than those defined by an essay, "a literary composition usually dealing with a subject from a limited or personal point of view."[1]

Table 1: Types of abuse before and during medical training at the University of Toronto reported in February 1991 by first-year and fourth-year medical students in response to the question "Have you ever experienced any of the following?" on the Medical Student Abuse Survey questionnaire

Type of abuse	No. (and %) of respondents (n = 347)
Verbal	
Yelling or shouting directed at you	77 (22.2)
Humiliation or put-down (disparaging remarks about being in medicine etc.)	116 (33.4)
Racial or ethnic discrimination (slurs, jokes, prejudiced remarks etc.)	84 (24.2)
Clearly unhelpful comments, unconstructive criticism, threats to your academic standing (threatening to fail you, to lower your grade, to give you a poor evaluation etc.)	86 (24.8)
Threats to your physical integrity (threatening to hit you, to cause others to harm you etc.)	6 (1.7)
Emotional	
Prearranged time for teaching not followed up or cancelled by intern, resident or staff physician	115 (33.1)
Being assigned work or duties for the purpose of punishment rather than for educational value	25 (7.2)
Having others take credit for your work (papers, projects, clinical work or research)	42 (12.1)
Sexual	
Being stared or leered at, ogled; unwelcome sexual comments, jokes, innuendos or taunting remarks about your body, attire, age or marital status; malicious gossip pertaining to your sexual habits etc.	53 (15.3)
Use of sexist teaching material; display of pornographic, sexually offensive or degrading pictures	42 (12.1)
Sexual advances; unnecessary physical contact (touching, pinching, patting etc.)	25 (7.2)
Sexual intimacy with or without actual intercourse; exchange of rewards for sexual favours	2 (0.6)
Physical	
Pushed, shoved, shaken or tripped	15 (4.3)
Slapped, hit, punched or kicked	17 (4.9)
Assaulted with a "weapon" (needle, surgical instrument etc.); objects thrown at you	4 (1.2)