general requirement of informed consent in medical research. Although IMS conducts prescription data mining in accordance with self-serving ethical standards,[3] university research ethics boards would not likely approve a study that used IMS methodology. Academic physicians using IMS data might consider the ethical standards under which the data were compiled and encourage IMS to collect physician prescription data with informed consent.

Roger Korman's central thesis is that our article does not reflect the *current reality* of IMS business practices. We endeavoured to present a balanced portrayal of prescription data mining; we even provided drafts of the article to IMS and incorporated many of their suggestions. Our research led us to conclude there should be independent regulation of the industry.

IMS lauds their aggregation of prescription data sold to pharmaceutical companies. However, aggregation with physician identification does not preclude the generation of individual physician prescribing profiles. Each physician's identification number is part of such reports and can be linked to contact information and other reports on their prescribing practices. The value of prescription data sold to pharmaceutical companies would be greatly depreciated if it were not possible to link physicians to their prescribing practices.

The pharmaceutical companies pay the freight and it is principally their interests that are being served. Any benefits accruing to researchers, medical educators, physicians, politicians, policy analysts and the public are secondary and offered in exchange for allowing IMS's business practices. The value of these data does not negate the obligation to collect and sell this information with the informed consent of physicians.

Korman points out that IMS's practices have been approved by their own Health Information Advisory Board. This is peculiar, as IMS's data mining operations are specifically excluded from the board's mandate.[4] Although IMS may be certified by the Canadian Standards Association, informed consent is a tenet of the Canadian Standards Association privacy code except where deemed inappropriate.[5] A note in the code defining "inappropriate" cites legal, medical and security reasons, but not business concerns.

We do not think the mailings to physicians in Ontario in 1996[6] and in Quebec in 1999,[7] which did not include consent-response forms and did not publicize the relevant Web sites, are adequate to inform Canadian physicians about IMS's business practices. We recommend that affirmation of informed consent be sought on a regular basis from all physicians across Canada.

The *current reality* is that prescription data mining practices are at variance with all 5 of the CMA's principles for the sale and use of physician prescription data.[2] The conduct of IMS bespeaks the *current reality* of the need for independent regulation of this industry.

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For the record

I read with interest the letters from Canadian physicians who finished medical school at a young age.[1–5] I graduated from the University of Cape Town in 1947, having just turned 22. I went straight into general practice in the Northwest Cape area, and what a pumped-up ignoramus I was. The patients very kindly referred to me as "the young doctor." I thought I knew everything. I had to learn the hard way.

Now, in my dotage, I will likely write a book about my medical experiences, to stand side by side with my 2 volumes of verse (neither of which are best-sellers).

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[Editors' note:]

According to the Guinness World Records Web site (www.guinnessworldrecords.com), the world's youngest contemporary graduate of a medical school is Balamurali Ambati of Hollis Hills, NY, who graduated from the Mount Sinai School of Medicine in 1995 at the age of 17 years.