Clinical trial registry initiative

Editor – The news item in the January 2006 issue of the *Bulletin* announcing a new WHO clinical trial initiative,[1] inappropriately and inaccurately refers to Merck, a company that has always been committed to the highest standards of scientific integrity and patient safety. Merck promptly and appropriately disclosed the results of Vioxx clinical trials — positive and negative — including VIGOR and APPROVe. Merck's behaviour over Vioxx is not that of a company "withholding negative research findings," as your article inaccurately suggests.

We also wish to clarify the timing of certain events. The editorial by the International Committee of Medical Journal Editors (ICMJE) calling for registration of clinical trials as a condition of publication, which you cite in your news item, appeared online at www.nejm.org on 8 September 2004, and on 16 September 2004 in the print version of the *New England Journal of Medicine*, as well as in other ICMJE journals. This was several weeks **prior** to Merck's voluntary withdrawal of Vioxx on 30 September 2004,[2] i.e. not in response to the withdrawal as the *Bulletin* news item implies. Additional information can be found on our Vioxx information page at: http://www.merck.com/newsroom/vioxx_withdrawal/.

Merck has been an active participant in the WHO International Clinical Trials Registry Platform, taking part in meetings when invited, and commenting on proposals. Merck's commitment to registering all Phase II, Phase III, and post-marketing controlled clinical trials that we conduct anywhere in the world goes well beyond both the current US law that mandates registration of clinical trials designed to test the efficacy of products for life-threatening or otherwise serious illnesses and the industry commitment to register all "confirmatory" trials. Our policy on the registration and publication of clinical trials is posted at: http://www.merck.com/mrl/swf/Merck_Position_on_Clinical_Trials_Registries.swf.

We look forward to continued dialogue with WHO and other stakeholders to promote transparency and allow patients and their health-care providers access to clinical trial information, while preserving protection of intellectual property. ■

Competing interests: none declared.

Laurence J Hirsch[a]

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2. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. *N Engl J Med* 2004;352:1250-1.

Dual job holding by public-sector health professionals may be beneficial to patients

Editor – The paper recently published in the *Bulletin* by Jan et al. on dual job holding (in the public and private sectors) by health professionals in developing countries makes an important contribution to the debate on human resources for health.[1] Dual job holding can provide continuity of care to those patients who can move between the two sectors. For example, patients attending a private facility would have the opportunity of obtaining services they cannot afford to pay for but which might be available in the public sector.

Jan et al. appear to be suggesting that the flow of patients from the public to the private sector is a bad thing per se. In the case of Malawi, however, the flow of patients from the predominantly free public health sector to the private sector may even be desirable as it reduces pressures on the public sector. Also, patients who demand services that are not available within the public sector, but which are available in the private sector, can be offered them against payment by dually employed physicians.

Dual job holding can also increase health professionals' status, as patients can witness that those working in state facilities are equally competent to work in private facilities, whose infrastructure may support first-world medicine.

Dual job holding also increases the productivity of health professionals as they can be employed after "normal working hours". Such health professionals may be able to inject new ideas from the private into the public sector, where in some cases the quality of care may be better than that in the public health system. Clearly, it would be unethical for health professionals to treat private patients during the time they are employed by the public sector and to use its resources for individual income generation. But if health professionals bear this in mind, and refrain from abusing public resources, there should be no problem.

The migration of health professionals from Africa to developed countries is bad enough[2] and all attempts to retain them in developing countries should be investigated. But doing it in an ethical way that does not jeopardize patients' wellbeing is a difficult challenge. Finally, although the phenomenon of public health sector professionals who also hold jobs in the private sector has been described,[3] there is a need to study their private-sector counterparts who also work in the public sector. ■

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2. Muula AS. Is there a solution to the "brain drain" of health professionals and knowledge from Africa? *Croat Med J* 2005;46:219.
3. Ferrinho P, Van Lerbeghe W, Fronteira I, Hipolito F, Biscaia A. *Hum Resour Health* 2004;2:14.

Corrigendum

In Vol. 84, issue number 3, 2006, page 181, the correct affiliations for the sixth author of this paper, Yohannes Kinfu, should be "Australian National University, Canberra, Australia, and ACDIS, Africa Centre, University of KwaZulu-Natal, Durban, South Africa". The name of the eleventh author was incorrectly spelled; it should read "Kubaje Adazu".

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