

Cord blood for the vast majority of the transplants done in Canadian hospitals has, to date, been purchased from foreign public banks at a cost of about \$25 000 a unit. Indeed, all of the 50 cord blood units obtained from public banks through Canada's Unrelated Bone Marrow Registry in 2005 (up from just 6 in 2002) came from outside Canada.

The Alberta Public Cord Blood Bank was established in 1996, but its funding has been patchy and many donated units have not been human leukocyte antigen-typed. The proposed national bank might take over the inventory in the Alberta public bank, depending on the integrity and quality of those cord blood units, says Dr. Graham Sher, chief executive officer of Canadian Blood Services.

Héna-Québec, that province's counterpart to the Canadian Blood Services, established a public cord blood bank several years ago and has been slowly building inventory, while the Canadian surgeon with the most experience in cord blood transplants is Dr. Martin Champagne of Montréal.

The plan is to complete the national cord blood bank by early next year, but preliminary work puts the price tag for establishing it at about \$4.5 million, with operating costs are estimated at \$2.5 million annually, says Sher. The goal is to store between 10 000 and 30 000 units. Currently, most cord blood is simply discarded.

Couban says Canada is "behind where we would like to be, by a year or 2," in setting up a public bank, attributing some of that lag to the fact that until recently, surgeons had not pushed the idea because clinical practice is "innately conservative in Canada" and has not changed as quickly as in the United States and Europe.

Sher, meanwhile, says that since its creation in 1998, the focus of the Canadian Blood Services has been to rebuild trust in the safety and adequacy of the blood service in the wake of the tainted blood scandal that led to the 1997 Commission of Inquiry on the Blood System in Canada. "We knew about new programs like cord blood ... but we did not have the capacity to take them on, so we did not push for them."

The proposed bank would build in-

ventory through the targeted collection of cord blood to ensure that cords are representative of the human leukocyte antigen types found in Canada. Human leukocyte antigen "tissue types are distinctly inherent across ethnic lines and it will be a lot of work to collect from the right demographic mix," says Sher. Canadian Blood Services would work with health cultural groups to understand how best to approach culturally diverse groups.

A shift to targeted collection was also initiated for the bone marrow registry 2 years ago, he noted. About 220 000 Canadians are registered, but 80% are of white, north European extraction, so the registry does not reflect the genetic diversity of today's Canada.

Private banks have "developed a lot of expertise" in collecting and storing blood, Couban says, and 1 scenario for a public bank would see the storage of cord blood contracted out to private banks. However, Sher stressed that a public bank would be fully publicly funded.

Cord blood collection would likely take place in the community as opposed to teaching hospitals, since the latter have more high-risk births and also more competition from stem cell and other researchers.

As not all cord blood samples collected are deemed ineligible for public storage, "there would be a large spillover to benefit researchers," he said. The expert group discussed the need for a scientific and ethics board to consider researcher requests. — Ann Silversides, Toronto

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New editor to increase systematic reviews and transfer knowledge

The *CMAJ*'s newly minted Section Editor, Reviews, Dr. Sharon Straus will develop tools to move research from the journal's pages into physicians' practices.

Straus, a geriatrician and general internist, holds a Canada Research Chair

in Knowledge Translation. She is also cross-appointed at the University of Calgary and the University of Toronto.

"Sharon is not only an exceptional general internist and geriatrician, she is one of Canada's leading researchers in implementation research," says *CMAJ* Editor-in-Chief Dr. Paul Hébert. "She is very creative and thoughtful, as well as being a wonderful writer — all skills that will serve her well in her new role."



Barbara Sibbald

Section Editor, Reviews, Dr. Sharon Straus will examine how *CMAJ* can present scientific information in more physician-friendly and useful formats.

Straus will work at *CMAJ* 1 day a week developing a strategy around knowledge translation. She'll also expand and enhance the journal's systematic and clinical narrative reviews.

Despite the myriad information available from randomized clinical trials, new knowledge often stays between the covers of the journal once published. Straus has analyzed the barriers to transferring that knowledge and will work with *CMAJ* editors to eliminate them.

"It really stems from my own interest as a clinician," she says in explaining her focus. "I want to be the best physician I can be for my patients and the best teacher I can be for my residents, so I want to enhance the quality of care I deliver."

From her own practice at Calgary's Foothills Hospital, Straus knows physicians are overloaded with information and struggle to implement research results, even if they could improve the quality of lives of their patients. At least 50 randomized trials get published every day, she says. "When you wake up, you're already behind, so there's no way we can keep abreast."

Most of those studies also present barriers to knowledge transfer because they are not presented in a user-friendly format, Straus adds. Finally, neither clinicians nor patients have access to many of the journals that assess all of the studies and resources to determine which ones are valid and clinically important.

Straus plans to work with authors of clinical practice guidelines published in *CMAJ* to create tools to help physicians implement those guidelines and will later evaluate the success of those tools.

In addition to these practical measures, Straus will examine how *CMAJ* presents systematic reviews, to see if different formats can enhance the way people apply the content. She will also encourage senior clinicians and authors to work with residents and fellows on more reviews.

In her spare time, Straus enjoys travelling and spending time with her extended family and with friends. She intends to continue her practice at Foothills.

"That's where my research questions come from," she says. "I love interacting with the residents and medical students as well. It's what keeps me stimulated and on my toes."

Straus' new job follows naturally from her previous position as the director of the knowledge transfer program for the Calgary Health Region. She moved to Calgary from Toronto, where she completed residencies in internal medicine and geriatric medicine. Straus also has a master's degree in clinical epidemiology from the University of Toronto and attended the physician leadership course at the Harvard School of Public Health. — Laura Eggertson, Ottawa

Presidential musings: prescriptions for the nation

This article combines 2 previously published at www.cmaj.ca on Aug. 22 and Aug. 23, 2007.

Wait time programming is a poor "surrogate" for a proper health human resources strategy.

The use of private clinics to alleviate wait lists will eventually eliminate any possible need for private clinics.

Harsh truths, anomalies and seeming paradoxes marked the passing of the presidential torch at the Aug. 22 closing session of the Canadian Medical Association (CMA) 140th General Council in Vancouver as outgoing President Dr. Colin McMillan and incoming President Dr. Brian Day weighed in with their prescriptions for the nation's health care woes.

Day elicited a prolonged standing ovation from the 250 physician delegates after delivering a blunt inaugural address in which he accused opponents of private health care of shameless hypocrisy, dismissed the entire public-private health care debate as "largely irrelevant and counterproductive" and repeated earlier calls for a sys-

tem in which hospitals receive funding directly proportional to the number of patients they treat, rather than through block grants (*CMAJ* 2007;177[4]:333-4).

McMillan, meanwhile, wrapped up his tenure at the CMA helm by telling reporters that Canadians are now paying the price, and the health care system is moving into crisis, because of the short-sightedness of politicians who have failed to implement a comprehensive health human resources strategy that would have ensured there are enough doctors and other health professionals to meet the system's needs.

Asked if he believed the failure to implement a pan-Canadian strategy is a function of inertia, cost, lack of political will or jurisdictional wrangling between the federal and provincial governments, McMillan candidly replied, "some or all of the above."

"I think the basic template, however, is that the decisions that were made ... a generation ago are starting to reap the repercussions today," McMillan added. "The attention to wait times and wait lists is a surrogate to the lack of capacity and the chief lack of capacity is human resources."

There is a desperate need for a "made in Canada, pan-Canadian approach to



Wayne Kondro

Incoming CMA President Dr. Brian Day and outgoing President Dr. Colin McMillan exchange pleasantries shortly before their ceremonial march into the 140th annual General Council session at which the Vancouver-based orthopedic surgeon was installed at the association's helm. Day drew a prolonged standing ovation from delegates after an installation address in which he pitched for more private delivery of health care services.