Complaints and conundrums: an ombudsman–ethicist for *CMAJ*

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Complaints: (1) A reviewer calls to say he will never review another paper for *CMAJ* because we accepted a paper he had urged us to reject in view of the authors' undisclosed and close relationship with a pharmaceutical company. (2) A letter writer complains that we edited her letter so severely that the main point was utterly lost. (3) An author complains that his paper was rejected even though it was "obvious [we] had not even read it." Another complains that we misplaced his paper for 8 months, only to reject it when we found it.

Conundrums: (1) In their report on a trial of chemotherapy regimens in patients at a community hospital, the authors do not mention obtaining either patient consent or approval from a research ethics board. (2) Another paper, this time from a major university, describes a small study involving outpatients; the participants gave informed consent, but the authors neglected to obtain approval from a research ethics board. (3) An author who was asked during final editing of her paper to provide additional data simply fabricated the numbers; luckily, this was detected before the paper appeared in print. (4) An author calls to say that his institution has refused to allow him to submit a report on a series of deaths that occurred at his institution and which he believes might have been caused by the incorrect prescribing of a commonly used drug.

Each of the above situations has arisen at *CMAJ* in the past 2 years. In the first set of instances our responses were as follows. (1) We felt that including a disclosure of the competing interest with the published article was sufficient. (2) We were sorry, but we had had trouble finding the main point of the letter. (3) We regretted giving the impression of being inattentive, but we still felt that these articles were not suitable for publication in the journal.

In the second set we (1) rejected the paper on scientific grounds but did nothing else, (2) asked the authors to inform their ethics committee and refused publication of the paper (3) did nothing and (4) did some further investigation and asked the caller to send us the report. Saying he would be fired if he submitted the report, he declined.

Our responses to these complaints may or may not have been satisfactory. Journal editors are often viewed by authors as a lesser species of despot, and complaints may seem to fall on ears that, if not deaf, are also not impartial. But, other than complaining to editors, there is no other means to air a grievance. As Richard Horton wrote when he established an ombudsman at *The Lancet*, "there is no-one to whom [the editors] are accountable."[1]

The conundrums raised various issues that might be lumped under the heading "publication ethics," a relatively new field in which there is a small but growing literature.[2] In collaboration with the Canadian Institutes of Health Research and others, *CMAJ* has recently established an ad hoc committee of Canadian health science journal editors in an attempt to cultivate awareness and agree on common standards for publication ethics in the health care disciplines.[3] But, as specific problems arise and demand resolution, editors need the ready advice of an ethicist.

It is with this joint role in mind — ombudsman for *CMAJ* and resident consultant in publication ethics — that we are happy to announce the appointment of Dr. John Dossetor, who has agreed to take on both functions. Dr. Dossetor, emeritus professor in Medicine and Bioethics of the University of Alberta, Edmonton, has had a distinguished career as a nephrologist, researcher (he has published over 250 articles) and medical ethicist with a particular interest in organ transplant issues (see profile in this issue, page 1329). In 1985 he devoted a sabbatical year to studies in bioethics and the following year became director of the Division of Bioethics and of the Bioethics Centre at the University of Alberta. In 1996 he was appointed to the Chair of Bioethics. His outstanding contribution as a leader and mentor was acknowledged with the renaming of the University of Alberta's Bioethics Centre as the John Dossetor Health Ethics Centre in 1998. Dr. Dossetor now lives, in active retirement, in Ottawa.

In his role as ombudsman, Dr. Dossetor will investigate unresolved complaints about our editorial process — for example, a failure to follow the procedures outlined in our information for authors (www.cmaj.ca/misc/ifora.shtml) or prescribed by the International Committee of Medical Journal Editors (www.icmje.org); inappropriate editing; delays; and discourtesy. In his role as the journal's ethicist he will advise us on the questions of conduct we encounter from time to time. In carrying out both duties, he will

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have confidential access to all pertinent files and records and will be able to consult others (while preserving the anonymity of authors and reviewers). As ombudsman he will write an annual report of his findings with regard to complaints (again, preserving anonymity), his recommendations and the resultant changes made at *CMAJ*. The complete report will appear each year in *CMAJ* and on our Web site.

Readers, authors, peer reviewers and indeed anyone who feels that he or she has not been treated fairly by the journal should first correspond with the editors and outline the nature of the complaint. We will respond. If that response is judged unsatisfactory, the complaint (and our reply) should be sent to the ombudsman, c/o *CMAJ*, 1867 Alta Vista Dr., Ottawa ON K1G 3Y6; fax 613 565-5471; email ombudsman@cma.ca.

CMAJ is produced not just by editors and authors, but also by readers, peer reviewers, letter writers, journalists and the public. Dr. Dossetor's help as ombudsman and ethical consultant is a welcome addition to the journal's "constituent assembly."[4]

Dr. Hoey is Editor and Anne Marie Todkill is Senior Deputy Editor of *CMAJ*.

Competing interests: None declared.

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Public health: What is to be done?

Richard Schabas

Two years ago in Walkerton, Ont., drinking water contaminated with bacteria made more than 2300 people ill and caused 7 deaths. The full consequences, from renal damage caused by *Escherichia coli* O157:H7, will not be felt for many years. Canada was shocked to find itself welcoming the 21st century with a problem that belonged in the 19th century.

The Bruce-Grey-Owen Sound Health Unit played a critical role in controlling the outbreak. The local medical officer of health, Dr. Murray McQuigge, acted quickly and decisively.[1] Furthermore, he established himself as a credible independent spokesman. Indeed, public health was virtually the only public service that emerged with some credit from this tragedy.[2]

But the key lesson learned from the Walkerton outbreak is that we cannot take public health for granted. The outbreak happened because institutions vital to the infrastructure of public health were neglected. The incompetence of the operators of the local waterworks and the policy negligence of the Ontario government are the most obvious and most important proximate causes.[2] The problems, however, run much deeper than just one government in one province. They go back many years and can be found, to a greater or lesser degree, in every jurisdiction in the country. My commentary will focus on the public health system in Ontario — the system I know best — but I believe that it has application across Canada.

Ontario's public health system is not broken. It is staffed by dedicated professionals and does many things well. But it is fragile, particularly in some of the small rural areas of the province. Public health could be much better.

A strong public health system requires stable and adequate funding, a sophisticated staff trained in modern methods of surveillance and analysis of health and environmental data and in risk and media communication, and, above all, professional independence from politicians and government bureaucracies.

The current system of funding public health in Ontario is unsupportable. It relies on the willingness of individual municipalities to pay their share. The resulting funding — a little over 1% of all health care expenditures — is inadequate. Per capita funding rates vary almost threefold between health units.

Modern public health requires increasing specialized expertise. Small health units simply lack the resources to accommodate this. They are becoming as anachronistic as the cottage hospital. A population base of at least 200 000, and ideally considerably more, is necessary to support a truly up-to-date public health department.

Public health officials must always be free to speak and act

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