CMAJ welcomes new senior editor

Winter dumped a near-record amount of snow on Ottawa, Ontario, and by late February 2008 most residents would have sooner donned a Toronto Maple Leafs jersey than seen another flake. But as far as Dr. Rajendra Kale was concerned, the more snow there was on the ground, the better. Of course, he had an excuse for his enthusiasm — it was his first Canadian winter.

"For me, there's a big novelty factor," says Kale, a native of Mumbai, India, who joined *CMAJ* as Senior Deputy Editor on Feb. 28, 2008.

Kale is a former senior editor at the *BMJ*, one of the world's most widely read medical journals. He will contribute to all parts of *CMAJ* and hopes to increase the publication's international standing.

"*CMAJ* is a very good journal but doesn't get the exposure it deserves outside of Canada."

Kale wore many hats during his years at the *BMJ*, overseeing various sections, including editorial, clinical review and practice. His experience will prove valuable to *CMAJ*, says Editor-in-Chief Dr. Paul Hébert.

"He's adding a truly experienced voice to the journal," says Hébert. "We're really looking forward to working with him in making this a major international journal."

After graduating from Grant Medical College in Mumbai, where he specialized in neurology, Kale completed a research fellowship in Dublin, Ireland. After returning to India, he practised as a neurologist in the city of Pune, located 150 kilometres east of Mumbai.

"I practised for several years, and somewhere along the line I became interested in medical journals," says Kale.

In January 1994 he began a 1-year term as editorial registrar at the *BMJ*. His duties included writing articles, editing the letters section and providing critical appraisal of scientific papers. He returned to his Pune practice the following year, maintaining ties with the *BMJ* as a visiting editor. During his days off from practising, Kale contributed to publications for The International Bureau for Epilepsy and the International League Against Epilepsy. In 2001 he returned to the *BMJ*, as a senior clinical editor, where he remained until joining *CMAJ* this year. "The difficult part of this job will be to make a good journal better." — Roger Collier, *CMAJ*

Wayne Kondro

After arriving in Ottawa, Senior Deputy Editor Dr. Rajendra Kale was jokingly asked to pitch in to clear the *CMAJ* parking lot. Kale forwarded this photo to former colleagues at *BMJ*, where it was posted in the servery and comments invited, prompting one wit to inquire: "Have they demoted you already?"

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From bedside to lab and back again

Canada must persuade more physicians to become more involved in research to ensure that bench science is being transferred to the bedside and that research protocols are properly informed by health needs, says the incoming President of the Canadian Institutes of Health Research (CIHR).

Decreased physician involvement in research, typically because of clinical demands, teaching loads or other administrative and financial pressures, is counterproductive to the health of the research enterprise because doctors are "key in the whole knowledge transfer system," argues Dr. Alain Beaudet, who will step aside from his current duties as Fonds de la recherche en santé du Québec president to assume the CIHR helm on July 1.

The problem has been particularly acute in Quebec, where a regime governing distribution of physicians known as "regional general medicine manpower plans" has essentially punished university hospitals who allowed clinicians to become involved in research, Beaudet says.

In hopes of resolving that, the agency recently negotiated an agreement with the province to allow hospitals to calculate clinician-researchers differently in manpower plans. It also helped develop an agreement to financially compensate medical specialists for research activities and is now working on a similar arrangement for general practitioners.

As well, it will soon establish a new 5-year program aimed at encouraging and training more residents to become involved in research, Beaudet adds. "It's going to fund the first years of research during the residency, then an additional 2 years of fellowship abroad and then the first year back into an academic setting to encourage our universities to hire them back and support for a first year until they get CIHR or FRSQ [Fonds de la recherche en santé du Québec] stipends and salary support." The financial elements of the program, including exact level of support and the number of residents to be supported, have not yet been determined.

The affable neuroscientist (*CMAJ* 2008;178[9]:1128) stressed that it would be presumptuous, if not downright "incendiary," to presuppose what sort of changes might be required at CIHR without first launching extensive consultations with the academic community and political decision-makers, including provincial health ministers, which he plans to undertake this fall.

But measures to make research more attractive to clinicians and to make CIHR collaborative programming more responsive to both provincial and national health needs appear to be personal priorities.

All too often, CIHR partnership programs take the "Canadian way of doing

things," Beaudet says. "So when CIHR partners, it's 'we partner, so we decide. We decide on the program. We organize everything and you guys come in and part with your money.'"

Instead, Beaudet would like CIHR partnership programs to be more responsive to local needs. "I'd like to see individual provinces come up with a health problem specific to that province and this is how they would like to tackle it and how could CIHR help to tackle that problem in that their province. ... Let some of the research questions come up from the clinical observations and the clinical results."

Beaudet declined comment on many of the contentious issues that have bedeviled the council in recent years, including whether the current division of the pie between the the 4 so-called pillars (biomedical, clinical, population health, and health services and systems research) is suitable; whether there's an excessive amount of strategic, multidisciplinary, interdisciplinary and collaborative programming; and whether the CIHR's 13 so-called "virtual" institutes have appropriate roles and functions (*CMAJ* 2006;175[8]:857-8).

"I want to be very prudent now to really understand what's going on before I start making any statements that could be seen or perceived as being incendiary," Beaudet said.

"It's clear that we have to bring the individual institutes into the fray. They have a critical role to play. They've got boards that are full of really creative energy, very bright people. Let's use these people more than perhaps they've been used so far. But I really want to be prudent here. Let me first get acquainted with the beast and then I'll tell you how to tame it," Beaudet later added.

Asked point-blank whether he's concerned that the recent devolution of financial decision-making authority from the CIHR's governing council to a Research and Knowledge Translation Committee comprised primarily of the scientific directors of the 13 institutes might severely limit the ability to affect change, Beaudet replied, "No, I don't think so. If there's good will, it's going to work and when there's a will, there's a way. What you have with the institutions, is a federation and what you want is a federation that works. We're familiar with that problem in this country, aren't we?"

Provincial counterparts describe Beaudet as extremely collegial and receptive to argument but a "bit of a bulldog" once he decides upon a course of action. — Wayne Kondro, *CMAJ*

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Dispatch from the medical front

Eye contact

He was my first patient in East Timor: 12 years old, with a 5-day history of delirium and fever.

I'd just finished my first year of medical school, but what I lacked in clinical experience, I hoped to make up for in enthusiasm, supplemented by frequent consultations of the *Oxford Handbook of Clinical Medicine*. I had never seen or managed a delirious patient before, but, in well-trained medical student fashion, I started by taking a history from his mother.

I followed all the communication "rules." Introduce yourself. Set an agenda. Signpost. Summarize. Make eye contact.

They never prepared me for what I saw. I'd expected fear, pleading, maybe even desperation in his mother's eyes. I was shocked to see only emptiness and resignation.

He was the first patient to die in my care. When I arrived for morning rounds, the nurses had drawn a black cross next to his name in the register. His mother had taken his body to the church and I waited all day for her return. I never found out what had killed him, whether it had been cerebral malaria, typhoid or any of a host of diseases, which we didn't have the means to diagnose. We treated him as well as we could given that we had run out of most of the commonly used antibiotics and painkillers. (When I asked for ibuprofen, the pharmacist wryly offered me ketamine.)

Liana Hwang

Parents are often reluctant to take children to hospitals in East Timor.

I never saw his mother again, but I have seen that look many times in the years since. Sometimes I think about how easy it would be to close my eyes.

And yet, in East Timor, I saw why some villagers are reluctant to bring their children into the hospital: a lifetime of suffering has taught them to expect the worst. For a poor villager, the death of a child is an emotional and financial catastrophe since the grieving family is often unable to afford the expense of bringing the body home for traditional funeral arrangements. Eventually, our mobile clinics agreed to cover that cost. A small difference, to be sure, but one that has saved lives.

It's been 3 years since I travelled to East Timor. Outwardly, I'm just another family medicine resident and yet when I look at my reflection in the mirror, I see how I've been changed by the simple act of having made eye contact. — Liana Hwang MD, Calgary, Alta.

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CMAJ invites contributions to Dispatches from the medical front, in which physicians and other health care providers offer eyewitness glimpses of medical frontiers, whether defined by location or intervention. Submissions, which must run a maximum 400 words, should be forwarded to: wayne.kondro@cma.ca