

A letter from CMAJ's Editorial Advisory Board

The *CMAJ* Editorial Advisory Board is concerned by the simultaneous dismissal of Dr. John Fletcher and the Journal Oversight Committee (JOC).¹

Following the dismissal of a previous editor-in-chief, Dr. John Hoey, the *CMAJ* Governance Review Panel's final report ("the Pound report")² recommended a new governance structure that had worked until 2011, when changes were suggested by the Canadian Medical Association (CMA).

Despite attempts to implement a collaborative model between the various parties, it appears that unresolvable tensions between the CMA, Joule, the JOC and the editor-in-chief culminated in the current distressing situation.

It is not clear to us why Dr. Fletcher and the JOC were dismissed so abruptly. We are concerned that the dismissals themselves and the process used have reduced the trust of CMA members in the future independence of the journal; CMA's poor track record in retaining *CMAJ* editors-in-chief contributes to this loss of trust.

This lack of governance structure and the instability it creates means that *CMAJ* cannot effectively interview for the post of editor-in-chief. Although the CMA has created a task force to make recommendations on how *CMAJ* can remain competitive in the current climate, we do not have any assurances that its recommendations will endure the next time there is a major disagreement between *CMAJ*, CMA and Joule (or its next iteration).

We respectfully suggest that, for *CMAJ* to have the most viable future, the report and recommendations from the task force should be seen as having the same credibility as the Pound report. To facilitate this, the *CMAJ* Editorial Advisory Board advises:

1. that the task force have independent, third-party oversight on the process and content of the task force report

2. that there be a timetable for the task force, its deliverables and the engagement undertaken posted on *CMAJ*'s website
3. that there be a deadline for a governance structure for *CMAJ* to include clarity on how future disagreements will be resolved.

The members of the Editorial Advisory Board are committed to ensuring that *CMAJ*'s editorial and staffing issues are managed predictably and professionally. We wish to help the task force succeed, but we need assurance that our concerns will be addressed.

CMAJ Editorial Advisory Board

See www.cmaj.ca/site/misc/edboard.xhtml

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CMA Board of Directors responds

The CMA Board of Directors is very pleased that the members of the *CMAJ* Editorial Advisory Board continue to work toward helping secure a sound future for *CMAJ*.¹ Its involvement in the work of the CMA Task Force on *CMAJ* has been most welcome and will continue to be an integral part of this continuing process.

The CMA board has the utmost confidence and respect for the work of the task force, which is being led by Dr. Chris Simpson, past president. Work is underway on the comprehensive consultation exercise that will begin soon. This consultation will identify best practices and result in recommendations on a new mission statement, goals and objectives for *CMAJ*.

Based on this process, the CMA will build a strong foundation, identifying the strategy and direction required for CMA publications. Regardless of the advances and changes that are proposed, *CMAJ*'s editorial independence will remain sacrosanct.

On behalf of the CMA board, I commend and thank the members of *CMAJ*'s Editorial Advisory Board for their continuing commitment to Canada's premier peer-reviewed medical journal. Their knowledge and expertise are invaluable to the work underway to strengthen *CMAJ* for the future.

Brian Brodie MD

Chair, CMA Board of Directors

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Lyme Disease guidelines

I was interested to read Zubek's letter in *CMAJ*.¹ Most doctors in Canada are aware of the National Guideline Clearinghouse (NGC), a federal agency of the United States Department of Health and Human Services responsible for providing the most up-to-date clinical guidelines to physicians.

The NGC also removes clinical guidelines that are no longer relevant, that do not meet the Institute of Medicine's standards for clinical practice guidelines, including a systematic review of the evidence, or that have not been revised in the past five years.²

In January 2016, the NGC removed the Infectious Diseases Society of America (IDSA) guidelines on Lyme disease for these reasons.³ In a scathing report on the standard of clinical guidelines in North America, the Institute of Medicine specifically referenced the IDSA guidelines on Lyme disease as a prime example of what not to do.⁴

Now, the only evidence-based, peer-reviewed guidelines on Lyme disease that conform to (and exceed) the Institute of Medicine's clinical guideline standards and are available on the NGC website, are the International Lyme and Associated Diseases Society guidelines for Lyme disease.⁵

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Prevention better than harm reduction

Though I appreciate that harm-reduction strategies may be the best option for established smokers who are unable to overcome their nicotine addiction, surely prevention is an even better goal?¹

About 80% of adult smokers started smoking before they were 20 years of age.² At that age, human brains are not fully developed, and we are more prone to develop a nicotine addiction. Teenage smokers think that they will be able to quit before they suffer permanent health damage, but one-third of them will die early from smoking-related diseases.³

In the United States, many people understand that 18 or 19 years is too young to allow legal access to a known carcinogen, an addictive substance that can never be used safely. In 2005, in Needham, Massachusetts, the minimum legal age for buying tobacco began to increase, to 21 years.⁴ The rate of smoking among high school students then dropped from 12.9% to 6.7%, a percentage decline that was nearly triple that of its neighbours.⁴ The state of Hawaii and 118 cities in nine US states, including New York, Boston and Cleveland, have now increased the minimum legal age for buying tobacco to 21.⁵

The Institute of Medicine calculated that increasing the smoking age to 21 years in the US would result in a 25% decrease in smoking initiation among young people and a 12% drop in overall smoking rates.⁶ It would

avert 16 000 cases of preterm birth and low-birth-weight infants in the first five years of the policy and prevent 4.2 million years of life lost to smoking in kids who are alive today.⁶

In Tasmania,⁷ a proposal is being presented to increase the smoking age by one year every year to create a smoke-free generation. People born after a specific year would never become old enough to buy tobacco legally.

In some parts of Canada, the legal age for buying tobacco is 19 years, and the average smoking prevalence is 17.3%.⁸ In provinces and territories with an age limit of 18 years, the prevalence is 19.3%. There is nowhere in Canada where one has to be over 19 years to buy tobacco.⁸

Tobacco 21 needs to come to Canada.

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Resting heart rate and wearable technology

Zhang and colleagues have reported a well-conducted meta-analysis describing the association between resting heart rate and all-cause and cardiovascular mortality in the general population.¹ They found an increased risk of mortality in patients with a resting heart rate even within the normal range (60 to 100 beats/

min). Although there is little clinical data on the benefits of heart rate reduction in otherwise healthy patients free of cardiovascular risk factors or disease, this study may provide valuable information to engage and empower patients.

There is a clear increase in the popularity of wireless heart rate monitors, fitness trackers and wearable body sensors.² Patients are using these devices for a variety of reasons, such as to track the number of steps taken per day and sleep quality, but they also use them to monitor heart rate. Physicians are being asked by patients to interpret the heart rate data logged by their wearable technology. Because these devices are not medical grade, questions about their data are often dismissed by clinicians. We believe this is a missed opportunity to engage and collaborate with the patient.

Patients who use a wearable device have taken a voluntary step toward improving their health. Dismissing questions about the heart rate data tracked by their device may deter patients from taking these initiatives. Although resting heart rate is influenced by various factors, long-term physical fitness, especially endurance training, is associated with a lower resting heart rate.³ Zhang and colleagues' study findings may be informative to patients and open the dialogue to discuss safe and appropriate fitness goals, counsel on other lifestyle changes and provide overall encouragement and support. Physicians should still confirm resting heart rates with medical grade equipment and inform patients that heart rate reductions in otherwise healthy patients have not been proven to lower risk. But for now, it appears that the lower the resting heart rate the better.

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