

## Albertans overestimate MDs' fees

An recent Angus Reid survey found that 90% of Albertans grossly overestimate the fee doctors are paid for a simple office visit. The survey found that the average estimate was \$112, while the actual fee is \$22.60.

"We were truly astounded," said Dr. Clayne Steed, president of the Alberta Medical Association, which sponsored the survey. "The number [\$112] is so extreme it takes your breath away."

The survey questioned 800 Albertans about how much doctors earn for providing various services. The AMA is responding to misconceptions uncovered in the survey by producing a brochure listing the 50 most common medical procedures and the amount doctors are paid for each of them. The pamphlet will be distributed to Alberta doctors and made available to their patients as part of a province-wide education program. Specialists have also asked for posters outlining common procedures and fees.

Steed said the survey results indicate that Albertans don't blame doctors for high health care costs. "They are assuming we are in step with [lawyers' and dentists' fees] and we're not. [Physician fees] have been the area where health care costs relative to services delivered have not gone up." — *Richard Cairney*, Edmonton

## New needlestick law for US

A law passed recently by the US Senate means that only "safety-engineered" needles can be used in American health care facilities. These devices have been "designed to automatically eliminate needles or to retract, cover or blunt them after use." The bill also requires that a detailed log of needlestick injuries be maintained. According to *JAMA* (2000;284:2585), there are 600 000 to 800 000 needlestick injuries in the US each year, and there have been 55 documented cases of occupational HIV transmission involving US health care workers since 1985.

## CF Medical Branch seeks new colonel commandant

Past and present members of the Canadian Forces Medical Branch are being asked to nominate physicians to serve as the branch's colonel commandant. Although this is a ceremonial position, the colonel commandant is expected to act as "ambassador" between the branch and the medical community at large. The position usually is filled by a former senior medical officer, but consideration will be given to physicians who are "particularly prominent and well respected within the world of civilian medicine." Nominations should be sent to Colonel Scott Cameron, CF Medical Group, 1745 Alta Vista Dr., Ottawa ON K1A 0K6; (fax)613 990-1345; the final date for receipt of nominations is Feb. 28.

## CONFERENCE REPORT

### Cardiovascular congress wrap-up

Patients with lipodystrophy run a risk of early coronary disease that is several times greater than the risk in the general population, physicians attending the recent Canadian Cardiovascular Society Congress were told. Dr. Robert Hegele, from the Robarts Institute at the University of Western Ontario, observed that in familial partial lipodystrophy there is absence of fat in the buttocks and arms, with central obesity. He noted a common ancestry among afflicted Canadians and discovered that the causative gene on chromosome 1q21 encoded nuclear lamin. The results indicate that defects in the nuclear envelope can have metabolic and, ultimately, cardiovascular consequences.

Hegele has also been studying why there is an extraordinary 40% incidence of type 2 diabetes among some First Nations adults in Northern Ontario, versus the overall Canadian incidence of 8%. It appears that this is caused by an abnormality at a single residue in the amino acid sequence of hepatic nuclear factor-1 a, which appears unique to this population. Hegele then linked the emergence of diabetes to radical alterations in diet and lifestyle. Although this genetic trait was unimportant 50 years ago, it has now emerged as a key determinant of diabetes risk and a likely explanation of the increase in diabetes and coronary disease within the Aboriginal population of Northern Ontario.

Dr. Simon Pimstone, from the Department of Medical Genetics at the University of British Columbia, addressed the role of pharmacogenomics in the treatment of cardiovascular disease. He suggested that the extensive genetic variability

seen among humans has influenced interindividual variation in response to drugs. He said this variation has modulated, at least in part, the fatal adverse drug reactions that in 1999 accounted for more than 100 000 deaths in the US and were estimated to be the fifth leading cause of in-hospital death. Perhaps even more important is the strong likelihood that genetic factors will modulate the susceptibility to the beneficial effects of medications. For instance, for a particular pharmacogenetic marker, 49% of the population were low responders, 35% high responders and 16% nonresponders. At present, the only way for a clinician to tell which category a patient falls into would be empirical: try the medication, wait for the response and then make adjustments to dose or try another medication. However, if a patient's response — high, low or nonresponsive — could be predicted by a simple genetic screen, there would be less need for such empirical treatment and monitoring. In this way, the most appropriate treatment could be determined much sooner. Thus, the mass-marketing approach for drugs indicated for common conditions, such as hypertension, is unlikely to be the way of the future. Instead, genetic typing has the potential to "microsegment" the market in a boutique fashion. As a result, this may rescue some failed drugs and lead to changes in indications or even expand indications and appropriate patient populations for others. — **This article was written by Dr. Paul Armstrong, an Edmonton cardiologist. Physicians interested in submitting similar reports should contact John Hoey, 800 663-7336 x2118; hoeyj@cma.ca.**