News @ a glance

Fallout on the rock: George Tilley, the beleaguered president and chief executive officer of Newfoundland and Labrador's Eastern Regional Health Authority, has resigned in the wake of the ongoing controversy over inaccurate hormone receptor tests received by hundreds of patients with breast cancer within the province, which resulted in a class-action lawsuit and a judicial inquiry (*CMAJ* 2007;177:24-5). Tilley has publicly apologized for the rampant "confusion" surrounding his agency's actions.

Travel hazards: The World Health Organization has released a study indicating that plane, train, bus or automobile passengers double their risk of developing venous thromboembolism if they remain seated and immobile on journeys of more than 4 hours.

Jaundice screening: The Canadian Paediatric Society has issued new guidelines for the detection, management and prevention of hyperbilirubinemia which urge that all newborns be screened for jaundice between 3 and 5 days after birth. Elevated bilirubin concentrations in the blood can lead to kernicterus and neurological damage like hearing loss. Jaundice affects 60% of newborns.

Chagas network: The World Health Organization has established a Global Network to combat Chagas disease in hopes of eliminating the tropical disease by the year 2010. The new network will develop a strategy by the end of this year on such issues as strengthening epidemiological surveillance, identifying a suitable diagnostic test and developing consensus on adequate case management.

Butting out: The annual Canadian Tobacco Use Monitoring Survey indicates that smoking rates among youth aged 15–19 declined to 15% in 2006, as compared with 18% in 2005. Health Minister Tony Clement attributed the decline to the efficacy of federal tobacco control strategies.

Personal chitchat: Many doctors waste patients' time by talking about themselves rather than focusing the discussion on information that might aid diagnosis, reveals a new study on the value of physician self-disclosure. "We found that physician self-disclosures were often non sequiturs, unattached to any discussion in the visit and focused more on the physician's than the patients' needs," states the study, led by University of Rochester School of Medicine and Dentistry researcher Dr. Susan McDaniel (*Arch Intern Med* 2007;167:1321-6). The study analyzed recordings of visits to 100 primary care doctors in the Rochester area, discovering that in 34% of instances, the physicians disclosed information about themselves. In 11% of instances, the disclosure was even "disruptive." — Compiled by Wayne Kondro, *CMAJ*

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Dispatch from the medical front

Red in the desert

I never thought that I would celebrate starting a transfusion, and certainly not in Saharan Africa. But life takes strange turns sometimes, and here I am with 3 other expatriates, opening a cheap carton of red wine sent from the Paris head office, mainly to help me stop obsessing about whether I read our patient's blood group correctly. The transfusion has been running for 10 minutes now in our tent hospital next door, and so far no cries of distress can be heard, so we are all in a good mood. We gather under our tarp, rinse out glasses with some murky water, and try to enjoy the wine. The sun is setting. There is nothing like a sunset in a desert, especially if you managed to start a transfusion before dark.

It takes a long time to run all the tests. First, you need to collect an ounce of blood, easier said than done if your patient is a dehydrated baby suffering from hemolytic malaria. The blood comes out thin, like barely-stained iron water, and though you can only guess the hemoglobin, you know that you better hurry to find a donor. Next, you determine blood group by adding little drops of colour. At night, you do this under the glow of an oil lamp and you sometimes test twice to reassure yourself — more of a ritual than a reliable back-up. You then try to convince the parents that their baby cannot last the night. If they refuse or test positive, you give blood yourself.

Sometimes, if the situation is not too urgent, you get sleepy spinning the hand centrifuge in the dark, sweltering laboratory. The constant whir of the centrifuge blends in with the background hum of the generator and the hiss of the stove-top sterilizer. It draws you in. You doze off waiting for the lines to change on the rapid tests for hepatitis and HIV, and when you wake up, your centrifuge lies still.

Then, the first of the morning light breaks through and you realize: it is good to be alive. — David Ponka MD, Ottawa

CMAJ invites contributions to Dispatches from the Medical Front, in which physicians and other health care providers can provide eyewitness glimpses of medical frontiers, whether defined by location or intervention. Without intending to restrict options, the front can be defined as any unique confluence of time and event, whether in developing countries, war zones, inner-city clinics, in the North, or with a novel surgical technique or intervention. The frequency of the section will be conditional on submissions, which must run a maximum 350 words or be subject to our ruthless editorial pencils. Forward submissions to: wayne.kondro@cma.ca

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