rating policies from Yale, Stanford, Memorial Sloan Kettering and others.

Further impetus for change will likely be forthcoming if, as expected, the Association of American Medical Colleges' executive-council formally adopts recommendations that its 129 member medical schools and teaching hospitals adopt a zero-tolerance approach to industry handouts (*CMAJ* 2008;178[13]:1651-52).

The pressure on physicians to renounce the goodies is only expected to escalate. Already, the National Physicians Alliance has unveiled an "Unbranded Doctor" campaign, calling on doctors to push back against drug marketing. It offers "Unbranded Doctor" coffee mugs, T-shirts and other items to replace drug company giveaways.

Legislators, meanwhile, are starting to express concern about the effect of drug industry largesse on patient care and costs. Building on disclosure laws in Minnesota, Maine, Vermont and West Virginia, proposed Physician Payments Sunshine Act bills in the House and Senate would require drug makers to publicly disclose gifts and payments to doctors.

Restuccia, who recently received a call from a man worried about receiving a particular pacemaker pushed by his doctor, now wonders about his own mother, who, in her later years, received the artificial Ewald knee, developed by Dr. Frederick Ewald, with the surgery performed by Ewald himself. "At the time, I thought it was great. Now, I wonder, 'Was there a better knee? Why did she get this one?'" As patients become better informed, physicians can expect more such questions, he warns.

SMDC Health System chose to send its branded trinkets, including clipboards and hold patient charts, to the Evangelical Lutheran Church of Cameroon, which operates 3 hospitals and other clinics, because the advertised drugs are largely unavailable there. SMDC has sent supplies to, and exchanged employees with, the church's flagship hospital for more than a decade. "They were putting patient charts up with a thumbtack," said spokesperson Kim Kaiser. "Even though these items seem inconsequen-

tial to us, they are very valued." Two other US health systems are considering similar roundups, said Dr. Kenneth Irons, SMDC's chief of community clinics. — Janet Rae Brooks, Salt Lake City, Utah

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News briefs

MRI study: Great Britain's Health Protection Agency has announced that it will undertake a major epidemiological study on adverse health effects from high static field Magnetic Resonance Imaging machines, particularly with regard to the impact on healthcare workers who operate the machines. "MRI scanning has some undoubted benefits in medicine, especially as an aid to accurate clinical diagnosis. However we need to bear in mind that the magnetic fields produced by the machines are quite substantial and that these fields are increasing in order to achieve improved clarity of image," stated agency Chairman Sir William Stewart.

Diagnostically elusive: The US National Institutes of Health has unveiled a pilot clinical research project aimed at improved disease management for patients with "mysterious conditions that have long eluded diagnosis." The pilot will take 100 patients per year (rare-diseases.info.nih.gov). "A small number of patients suffer from symptoms that do not corresponded to known conditions, making their care and treatment extraordinarily difficult," said NIH Director Dr. Elias A. Zerhouni.

Second look: The Alberta Cancer Board says it will re-examine its 2006 study which concluded there isn't a higher incidence of blood, colon, bile-duct and liver cancers in Fort Chipewyan, a small community downstream from Alberta's oilsands projects, than in other parts of the province. Residents and physician Dr. John O'Connor (*CMAJ* 2008;178[12]:1529) have long postulated a link between higher rates of cancer and the development of the tar sands.

Play the odds: A 37-member task force initiated by the American College of Chest Physicians has recommended an algorithm for rationing care in the event of a flu pandemic or natural disaster (*Chest* 2008;133:1S-7S). It urges that in cases where medical need exceeds supply, patients with a greater than 80% chance of dying in hospital should be denied ventilators, using the

Sequential Organ Failure Assessment score, measuring levels of such factors as oxygenation, platelets, bilirubin and consciousness. Application of the algorithm would essentially preclude such groups as the elderly, the demented, the badly burned and severe trauma victims from receiving care. A pair of Canadian physicians, Dr. Michael Christian and Dr. Randy Wax, sat on the task force and earlier helped craft a similar algorithm for flu pandemics in Canada (*CMAJ* 2006;175:1377-81).

Website launch: Médecins Sans Frontières has launched a free website compiling research based on the work of its volunteer physicians. The website (www.fieldresearch.msf.org) has more than 350 articles, many previously published in peer-reviewed medical journals, on topics such as malaria, tuberculosis, refugee health and emergency medical care.

Recruiting: The Global Health Workforce Alliance has unveiled guidelines for providing incentives for the retention and recruitment of health professionals (www.who.int). The wide-ranging guidelines cover such financial incentives as tax waivers, insurance and allowances (housing, clothing, daycare, etc.), as well as non-financial incentives, such as flexible hours and career development programs. Largely a com-

pendium of practices around the world, the guidelines often provide examples of novel initiatives, such as split patient loads for family physicians over 60 years of age.

Home wanted: The New Brunswick government is hoping a private sector donor will step forward to fund a build-

ing for the medical school the province has pledged to establish. The launch of the new medical program, originally scheduled for 2007, has been delayed until 2010, and the government now says a temporary home may be necessary for the first 2 years of operation. Premier Shawn Graham says a proper site will cost about \$20 million. "We're

prepared to fund the operational side of a medical school, but the infrastructure has to have participation from the community." To date, the search for a permanent home has put the start date at risk. — Roger Collier, Ann Silversides and Wayne Kondro, *CMAJ*

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DISPATCH FROM THE MEDICAL FRONT

Six days in the delta

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It is 5 am, Tuesday, May 7, 2008. We are approaching Heyngyi, our destination in the Delta region, struck 3 days earlier by a deadly cyclone. It is slowly getting light and along the banks we see looming skeletons. Tree skeletons. They are bent over and have broken branches that are shorn of any leaves. There are skeletons of buildings too, all lacking roofs and walls. As we dock in Heyngyi, I see the first people. I notice that many of them have a faraway look in their eyes. It seems as if they are looking right through me and don't actually see me standing there.

We start working in a half-destroyed building owned by a women's group. The local people help me to sweep all the mud out of the building and a few men repair the roof with plastic sheeting. As soon as that is done, the first patients start to arrive. I see more than 200 patients that day.

On Wednesday, hours later than planned, I get into a boat with 4 teams, medicine and supplies, heading for more remote villages along the coast.

The girl is 7 years old. She has a big, ugly head wound from a palm tree that fell upon her. Using unhygienic material, someone gave her emergency stitches. The wound is now terribly infected and she needs more medical help than our mobile team can offer.

Her father is a fisherman and they lived in a house by the sea. When the palm tree hit their house, the family fled inland. That saved their lives. The water

The United Nations has estimated that the death toll from Cyclone Nargis in Myanmar will top 100 000.

washed away their house and most of their neighbours drowned. I arrange transportation by motorbike and boat and send the girl with her mother to a hospital even further inland.

Four days later, our sixth in the delta, and everyone on our team has been seeing an average of more than 200 patients a day and many people are in shock or are experiencing trauma. There are confused people still searching for their families, children who have lost their parents, parents who have watched their children drown.

In the evenings, I sit with my colleagues and everyone tells what they've heard and seen during the day. It is difficult for everyone.

We are all tired and we sleep poorly. "I can't get the stench of the dead bodies out of my nose," says one of the

doctors. She spent a few hours sitting in a boat going through an area where there were many dead bodies and animal carcasses. The smells, the images and the people's stories together form an overwhelming picture. I feel myself blocking it out.

Tonight, I went outside for a moment. I didn't want to hear anything anymore. — Khine Myae, Yangon, Myanmar

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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