Briefly

Rampant neglect: The United Kingdom's National Health Service does an abysmal job of providing critical care following emergency surgery and often fails to treat postsurgical complications because trusts are more concerned with meeting wait time targets than providing postoperative care, which is often shuffled off to junior staff, according to the UK's Royal College of Surgeons of England. Death rates for the roughly 170 000 patients who undergo major emergency surgery each year are typically 15%–20% within trusts, and as high as 40% for elderly patients, the college states in a report, *The Higher Risk General Surgical Patient: towards improved care for a forgotten group* (www.rcseng.ac.uk/publications/docs/higher-risk-surgical-patient/attachment_download/pdffile). Among other findings were that a patient's chance of survival at a specific trust or hospital even varied depending on the day of the week the emergency surgery occurred, with the risk of death for those admitted on a weekend being 10% higher than those admitted during the week. — Wayne Kondro, *CMAJ*

Blood and goo: The United States Food and Drug Administration has approved the use of a gel to stop blood flow in surgical areas as an alternative to such tools as elastic vessel loops and clamps. The nontoxic gel, LeGoo, forms a plug that stops blood flow within a vessel for up to 15 minutes, after which point it dissolves. More rapid dissolving can be promoted by applying a cold pack. "LeGoo is an innovative device that offers surgeons an additional aid during vascular surgery," Christy Foreman, director of the Office of Device Evaluation in the FDA's Center for Devices and Radiological Health said in a press release (www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm274372.htm). "The gel's unique properties may facilitate surgeries that entail the joining or grafting blood vessels." — Wayne Kondro, *CMAJ*

E-health record misuse: Australian Health Minister Nicola Roxon has unveiled draft legislation that proposes to levy fines of up to A$66 000 on those who inappropriately access an individual's health record. The legislation also allows patients to set differing privacy settings for various health care professionals, for example, by allowing doctors to see more data than dentists (www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/C0E9D70D1051EB80CA25791A007DBDAF/$File/Exposure%20Draft%20-%20Personally%20Controlled%20Electronic%20Health%20Records%20Bill%202011.pdf). "For the first time patients will have control over who has access to their information — and further they will know who has accessed their medical records, and the exact time that record was accessed. This system will be a first for Australia. Patients will not only be able to access their own eHealth record but will also be able to view who has accessed their record," Roxon said in a press release (www.health.gov.au/internet/ministers/publishing.nsf/Content/6F84911B18706FDACA25791A007C1D00/$File/mediarealease-draft%20ehealth%20legislation.pdf). Australia's nationwide ehealth record system is scheduled to become operational on July 1, 2012. — Wayne Kondro, *CMAJ*

Too much care: Patients are receiving too much primary care because of "malpractice concerns" and other factors such as clinical performance measures, according to 42% of primary care physicians in the United States. "Physicians also believe that financial incentives encourage aggressive practice: 62% said diagnostic testing would be reduced if it did not generate revenue for medical subspecialists," states the report, *Too Little? Too Much? Primary Care Physicians' Views on US Health Care* (*Arch Intern Med.* 2011;171:1582-5). "Malpractice reform, realignment of financial incentives, and more time with patients could remove pressure on physicians to do more than they feel is needed," the study concludes. — Wayne Kondro, *CMAJ*

Medical data: Four major United States health insurers — Aetna, Humana, Kaiser Permanente and the UnitedHealth Group — have agreed to relinquish their claims data to a newly minted nonprofit group, the Health Care Cost Institute, as part of a bid to provide researchers and policy makers a more accurate picture about the factors that are driving up health care costs. "Researchers and experts are clamoring for better data and deeper analysis to better understand the factors driving costs and to inform effective policy decisions," Martin Gaynor, chairman of the institute's governing board and E.J. Barone professor of economics and health policy at the Heinz College at Carnegie Mellon University in Pittsburgh, Pennsylvania, said in a press release (www.healthcostinstitute.org/files/hcci-press-release-final.pdf). "Unfortunately, the existing public data derived from Medicare and Medicaid activity aren't enough to form a complete, up-to-date picture of national cost drivers and trends. HCCI [Health Care Cost Institute] will provide, for the first time, researchers access to data that covers all ages and health issues and is national in scope. Perhaps most importantly, for the first time there will be comprehensive data on the privately insured who make up the majority of health consumers in the United States." The institute will issue semiannual "scorecards" on costs and utilization within the health care system. — Wayne Kondro, *CMAJ*

Deferiprone approval: The United States Food and Drug Administration (FDA) has announced that it has

approved the use of deferiprone in the treatment of patients with transfusion-related iron overload. The FDA stated in a press release that the treatment was approved under its "accelerated approval program, designed to provide patients with earlier access to promising new drugs followed by further studies to confirm the drug's clinical benefit" (www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm275814.htm). "The accelerated approval program allows the agency to approve a drug to treat a serious disease based on clinical data showing that the drug has an effect on an endpoint that is reasonably likely to predict a clinical benefit to patients, or on an effect on a clinical endpoint other than survival or irreversible morbidity (illness)." Earlier this year, an FDA advisory panel had recommended that deferiprone be approved as second-line therapy for patients who suffer from transfusion-related iron overload and have already tried other available chelators (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4012). — Wayne Kondro, *CMAJ*

The medical confessional: General practitioners need to provide more holistic care for patients, helping them resolve social problems, as well as treating their biomedical diseases, according to a joint commission struck by the United Kingdom's Royal College of General Practitioners and the charitable organization the Health Foundation. Generalists need to assume responsibilities once fulfilled by local priests, the commission says in a report, *Guiding Patients Through Complexity: Modern Medical Generalism* (www.health.org.uk/public/cms/75/76/4307/2779/COMMISSION%20REPORT%20ON%20MEDICAL%20GENERALISM%20OCTOBER%202011.pdf?realName=fPsru6.pdf). "Making health needs assessments, addressing health inequalities and commissioning services accordingly are key components of this kind of approach," the report states. "But so, too, is being known in the community (whether a physical community or a patient cohort), the obverse of the patient being known to the doctor. In some ways, therefore, the generalist can be seen as fulfilling for many people the type of role that a local priest would have occupied for them in former years: a respected figure who could be turned to for non-judgmental advice on a range of issues including, but not limited to, health care." — Wayne Kondro, *CMAJ*

Hall of fame inductees: Nobel laureate Dr. John James Macleod, Terry Fox, Dr. Armand Frappier, Dr. Peter Macklem, Dr. John Dirks, Dr. F. Clarke Fraser and Dr. Lap-Chee Tsui are the 2012 inductees into the Canadian Medical Hall of Fame. The seven "have truly made a difference in the lives of Canadians, and indeed, people around the world. They have blazed trails, inspired others to follow, and extended the boundaries of medical knowledge and health care," Dr. Cecil Rorabeck, the hall's chair, said in a press release (www.cdnmedhall.org/2012-inductees-named-hall-fame). The seven will be inducted at a ceremony in Toronto, Ontario, on Mar. 21, 2012. — Wayne Kondro, *CMAJ*

Disaster database: Public Safety Minister Vic Toews has unveiled an "enhanced" Canadian Disaster Database to "help business continuity managers assess local disaster threats." Using the database, "Canadians can learn about risks that have historically affected their region, allowing them to prepare for emergencies," Toews said in a press release (http://continuitycentral.com/news05991.html). The database identifies eight epidemics and one infestation, a "mysterious toxic mould" on a reserve in Saskatchewan, as having occurred since the year 1900 (www.publicsafety.gc.ca/prg/em/cdd/srch-eng.aspx). — Wayne Kondro, *CMAJ*

Death bed donations: The United Kingdom's National Health Service should cover the funeral expenses of those who donate organs on their death bed, a medical ethics think-tank says. Such payments would be "ethically justified," states the Nuffield Council on Bioethics in a report, *Human bodies: donation for medicine and research* (www.nuffieldbioethics.org/sites/default/files/Donation_full_report.pdf). "Under such a scheme, donors could not be physically harmed; those close to the donor might benefit directly; and relatives would also clearly have the option of declining the offer of expenses if they preferred not to accept them. While there is no direct evidence as to how effective or popular such an incentive would be, the similar system in place for those who donate their bodies to medical schools for educational purposes appears to be regarded by both professionals and families as an appropriate acknowledgment of the person's gift. This suggests that the extension of such a scheme to organ donors would not be detrimental either to professional values or the common good," the report states. — Wayne Kondro, *CMAJ*

Tobacco use: The United States Food and Drug Administration and US National Institutes of Health will track more than 40 000 tobacco users aged 12 and older under a joint national longitudinal study of tobacco users. The study will "examine what makes people susceptible to tobacco use; evaluate use patterns and resulting health problems; study patterns of tobacco cessation and relapse in the era of tobacco regulation; evaluate the effects of regulatory changes on risk perceptions and other tobacco-related attitudes; and assess differences in attitudes, behaviors and key health outcomes in racial-ethnic, gender, and age subgroups," the agencies said in a press release (www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm274626.htm). "The results will strengthen FDA's ability to fulfill our mission to make tobacco-related death and disease part of America's past and will further guide us in targeting the most effective actions to decrease the huge toll of tobacco use on our nation's health," said FDA Commissioner Margaret A. Hamburg. — Wayne Kondro, *CMAJ*

Cycling inquest: In the wake of the death of 15 to 20 cyclists on Ontario's roads annually, the province's chief coroner has announced that his office will conduct a review of cycling deaths in the province since 2006. The goal is to identify "common factors" in the deaths and make recommendations on how to prevent such incidents in the future, Dr. Andrew McCallum, chief

coroner for Ontario, said in a press release (http://news.ontario.ca/mcscs/en/2011/10/cycling-death-review-announcement—-addendum.html). "Cycling activity is increasing in many parts of the province and like other users of our roadways, cyclists ought to be safe. By examining these deaths, we hope to find ways to increase their safety." The review will be led by Dr. Dan Cass, regional supervising coroner for the Toronto West region. It is expected to completed in spring 2012. — Wayne Kondro, *CMAJ*

Fertility cash: The United Kingdom's Human Fertilisation and Embryology Authority has announced that it will increase the level of compensation paid to those who donate sperm and eggs for infertility treatment. The move, which is expected to make the United Kingdom a popular destination for donors, will increase payments for women who donate eggs to £750 from £250 per cycle. Men will receive £35 per visit to a clinic. "We are convinced that it is right to look at compensation not in terms of crude sums but in terms of the value of donation," Lisa Jardine, chair of the authority, said in a press release (www.hfea.gov.uk/6700.html). "My Authority has set a level of compensation which will not deter those interested in donation but will retain donors already in the system, without attracting those who are merely financially motivated." — Wayne Kondro, *CMAJ*

The view from California: The California Medical Association has become the first state-based association in the United States to call for the legalization of marijuana, so that it can be properly regulated and assessed for its medical value. "There simply isn't the scientific evidence to understand the benefits and risks of medical cannabis," Dr. Paul Phinney, chair of the California association said in a press release (www.cmanet.org/news/detail/?article=cma-urges-legalization-and-regulation-o). "We need to regulate cannabis so that we know what we're recommending to our patients. Currently, medical and recreational cannabis have no mandatory labeling standards of concentration or purity. First, we've got to legalize it so that we can properly study and regulate it." The new policy was based on an association-commissioned study which concluded that the criminalization of marijuana was a "failed public health policy" (www.cmanet.org/files/pdf/news/cma-cannabis-tac-white-paper-101411.pdf). "Cannabis illegality has perpetuated the effective prohibition of clinical research on the properties of cannabis and has prevented the development of state and national standards governing the cultivation, manufacture, and labeling of cannabis products, similar to those governing food, tobacco and alcohol products, most of which are promulgated by federal agencies," the white paper states. "Cannabis is currently not sufficiently regulated. In order to allow for a robust regulatory scheme to be developed, cannabis must be moved out of its current Schedule I status within the DEA's [Drug Enforcement Agency's] official schedule of substances. Rescheduling cannabis will allow for further clinical research to determine the utility and risks of cannabis, which will then shape the national regulatory structure for this substance." — Wayne Kondro, *CMAJ*

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