Briefly

No chimps please: The United States National Institutes of Health has suspended all new grants for biomedical and behavioural research involving chimpanzees. While chimpanzees have been useful in advancing science and human health, "new methods and technologies developed by the biomedical community have provided alternatives to the use of chimpanzees," Dr. Francis Collins, director of the NIH, said in a press release (www.nih.gov/news/health/dec2011/od-15.htm). The NIH will convene a working group to develop new criteria for research that utilizes chimpanzees and is consistent with three principles: "1. That the knowledge gained must be necessary to advance the public's health; 2. There must be no other research model by which the knowledge could be obtained, and the research cannot be ethically performed on human subjects; [and] 3. The animals used in the proposed research must be maintained either in ethologically appropriate physical and social environments (i.e., as would occur in their natural environment) or in natural habitats." — Wayne Kondro, *CMAJ*

Gouging penalties: Price gouging on prescription drugs in short supply would become a federal crime in the United States under new legislation proposed by Senator Charles Schumer (Democrat-New York). "Forcing hospitals to buy life-saving medications at outrageously inflated prices is unquestionably unethical, and with this legislation it would be illegal too," Schumer said in a press release (www.schumer.senate.gov/Newsroom/record.cfm?id=335049). Many US hospitals face drug shortages, and sometimes resort to purchasing drugs from third party drug distributors outside the normal pharmaceutical system, the release adds. Schumer's proposed law would allow penalties of up to US$500 million per instance of price gouging. — Julia Sisler, Ottawa, Ont.

More docs, better pay: The national physician pool grew by 2.3% to 69 700 doctors in 2010, the largest in history, according to the Canada Institute for Health Information (CIHI). Meanwhile, clinical payments for physicians reached nearly $19 billion in fiscal 2009/10, CIHI says its report, *Supply, Distribution and Migration of Canadian Physicians, 2010* (http://secure.cihi.ca/cihiweb/products/smdb_2010_en.zip). The report also indicates that between 2005 and 2010, average payments to doctors increased by 21.5%, or about 4% a year on average. In 2010, the average gross fee-for-service income for a family physician was $239 000, while for a specialist it was $341 000. "Expenditures for physicians' services continue to represent the fastest-growing category of health spending," Geoff Ballinger, CIHI's manager of health human resources, added in a press release (www.cihi.ca/cihi-ext-portal/internet/en/document/spending+and+health+workforce/workforce/physicians/release_15dec11). "Although part of this growth is related to the large number of new physicians Canada has trained and gained over the past decade, part is also due to increases in physicians' average earnings." — Wayne Kondro, *CMAJ*

Open data strategy: The European Commission has unveiled a three-pronged open data strategy to more research and wider public use of the vast pools of government data to create new economic products and services. The strategy will also involve the establishment of European Union standards for ensuring that data are available in commonly used machine readable formats, as well as the dispensing of roughly €100 million over the next two years to fund new research aimed at the development of new technologies for handling data. "Opening up governmental data for re-use can have major benefits for citizens, businesses, and society and for the governments themselves: New businesses can be built on the back of this data: Data is an essential raw material for a wide range of new information products and services which build on new possibilities to analyse and visualise data from different sources. Facilitating re-use of this raw data will create jobs and thus stimulate growth; More Transparency: Open data is a powerful instrument to increase transparency in public administration, improving the visibility of previously inaccessible information, informing citizens and business about policies, public spending and outcomes; [and] Evidence-based policy making and administrative efficiency: the availability of solid EU-wide public data will lead to better evidence-based policy making at all levels of government, resulting in better public services," the European Commission stated in a press release (http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/11/891&format=HTML&aged=0&language=en&guiLanguage=en). — Wayne Kondro, *CMAJ*

Executive compensation: A "standardized hospital executive compensation framework," with pay levels at the 25th percentile of total cash compensation received by the chief executive officers of private sector organizations with similar revenues, should be used to determine salaries from the top administrators of Ontario's hospitals, an Ontario Hospital Association appointed panel recommends. "The Framework should be developed by the OHA in consultation with its members based on the following underlying principles: 1. Ontarians have a right to expect that hospitals will be run effectively and efficiently, and that common standards of care and performance will be achieved. 2. Each hospital's strategic priorities should be supported by goals and clear accountabilities of the Board, CEO, Chief of Staff and other senior executives right through to the front line. 3. Executive compensation should be aligned with hospital priorities

and objectives and reflect actual performance measured against these objectives. Failure to meet performance standards should have consequences for hospital executive pay. 4. The public has the right to full disclosure of hospital performance and executive pay. 5. Total compensation for hospital executives should stand the test of reasonableness taking into account factors such as market competition, hospital size and complexity, while recognizing the public nature of the healthcare system. 6. The Framework should be sensitive to differences among hospitals, and provide hospital boards with the latitude to govern," states the *Report of the Independent Expert Panel on Executive Compensation in the Hospital Sector* (www.oha.com/CurrentIssues/Issues/Documents/Report%20of%20the%20Independent%20Expert%20Panel%20on%20Executive%20Compensation%20in%20the%20Hospital%20Sector.pdf). — Wayne Kondro, *CMAJ*

Deal of a decade: While signalling its intent to maintain a hands-off approach to health care, the federal government has announced that transfer payments to the provinces for health will grow by 6% through fiscal 2016. They will then be pegged to a "three-year moving average of nominal gross domestic product," with a minimum 3% increase, through 2024, Finance Minister Jim Flaherty said in a statement (www.fin.gc.ca/n11/data/11-141_1-eng.asp). The investment will allow the provinces to be more innovative in delivering health care, Health Minister Leona Aglukkaq argued. "This investment is balanced and sustainable, and provides a solid foundation for further progress on health system renewal to ensure the health care system will be there when Canadians need it. This investment also provides the opportunity to put the divisive issue of funding behind us to allow us all to focus on the real issue — how to improve the system so you can ensure timely access to health care when needed," she wrote in a letter to provincial and territorial health ministers. — Wayne Kondro, *CMAJ*

Concussion protocol: The wunderkind of the National Basketball Association returned to the hardwood over the Christmas holidays after a protracted lockout and labour dispute with a recently minted league concussion protocol in place to determine when players can be allowed back on the floor after suffering a head injury. "If a player is diagnosed with a concussion, he will have to complete a series of steps to confirm that he's healthy enough for competition. Once he is free of symptoms, the player must make it through increasing stages of exertion — from a stationary bike, to jogging, to agility work, to non-contact team drills — while ensuring the symptoms don't return after each one. Then the neurologist hired to lead the NBA's concussion program needs to be consulted before the player is cleared," the NBA stated in a release (www.nba.com/2011/news/12/12/nba-concussions.ap/index.html). At the start of each season, players will undergo baseline testing to aid in the diagnosis of concussions and sign agreements indicating that they will report symptoms. The concussion program will be overseen by Dr. Jeffrey Kutcher, an associate professor of neurology at the University of Michigan. — Wayne Kondro, CMAJ

The widening gap: The 100 highest paid CEOs of Canadian companies listed on the Toronto stock exchange earned an average $8.38 million apiece in 2010, as compared with the $44 366 earned by the average Canadian and the $19 798 earned by those earning minimum wage. The executive pay levels of the 100 CEOs represented a whopping 27% increase in pay levels for the 100 CEOs over 2009, according to a study, *Canada's CEO Elite 100: The 0.01%*, conducted by the Canadian Centre for Policy Alternatives. "The conclusion from these data is inescapable. Soaring executive salaries have played a significant role in driving the growth in income inequality in Canada," states the study (www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2012/01/Canadas%20CEO%20Elite%20100FINAL.pdf). "At this rate, the average of Canada's CEO Elite 100 make 189 times more than Canadians earning the average wage. If you think that's the way it has always been, it's not. As recently as 1998, the highest paid 100 Canadian CEOs earned 105 times more than the average wage," the study adds. — Wayne Kondro, *CMAJ*

Delayed diagnosis: Canadians often fail to receive what treatment is available to manage the symptoms of Alzheimer disease and other forms of dementia because they do not consult their physicians about early warning signs such as memory loss, disorientation and personality changes, according to an online survey of 958 Canadians who either have dementia or have a family member with dementia conducted by Alzheimer Society Canada. The survey indicated that 44% of Canadians wait at least one year to consult their physicians and 16% of those waited more than two years, largely because they believed the symptoms were either episodic or merely a function of aging. In a bid to promote earlier diagnosis, the society has launched a "Let's face it!" campaign featuring a dementia fact sheet (http://alzheimerletsfaceit.ca/wp-content/uploads/2011/12/AW12_Fact-sheets_EN_FINAL.pdf). — Wayne Kondro, *CMAJ*

Five steps: In a bid to "help physicians earn Medicare and Medicaid bonus payments for Meaningful Use of EHRs [Electronic health records], and ultimately deliver higher-quality care," the United States Department of Health and Human Services has produced an online guide to help doctors to get wired. The "How to Get Started" guide advises physicians on a five-step process to implement EHRs (www.healthit.gov/providers-professionals/ehr-implementation-steps). The five steps? "Assess your Practice Readiness; Plan Your Approach; Select or Upgrade to a Certified EHR; Conduct Training & Implement an EHR System; [and] Achieve Meaningful Use & Quality Improvement." — Wayne Kondro, *CMAJ*

Medical miscue reporting: Medical errors are vastly under-reported by American hospitals, according to a report by the Office of the Inspector General of the United States Department of Health and Human Services. A survey of 189

American hospitals indicated that "staff did not report 86 percent of events to incident reporting systems, partly because of staff misperceptions about what constitutes patient harm," Daniel R. Levinson states in a report, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm* (http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf). "Of the events experienced by Medicare beneficiaries discharged in October 2008, hospital incident reporting systems captured only an estimated 14 percent. In the absence of clear event reporting requirements, administrators classified 86 percent of unreported events as either events that staff did not perceive as reportable (62 percent of all events) or that staff commonly reported but did not report in this case (25 percent)." Levinson urged that "a list of potentially reportable events" be crafted to educate health care providers and that guidelines be developed for overseers to "assess the adequacy of hospital event collection efforts, including incident reporting systems." — Wayne Kondro, *CMAJ*

Face transplants: The United States Health Resources and Services Administration is proposing that face, hand and other body part transplants be regulated and distributed in the same manner as other human organs, using a waiting list system overseen by the United Network for Organ Sharing. The proposal to add "vascularized composite allografts" to the definition of organs covered by Organ Procurement and Transplantation Network operations, is open to public comment through February 14 prior to publication of final regulations (www.federalregister.gov/articles/2011/12/16/2011-32204/organ-procurement-and-transplantation- network#p-3). The agency noted that there are over a dozen vascularized composite allograft centres now operating in the US and that government agencies are now undertaking extensive research transplant programs aimed at treating soldiers returning from duty in Iraq and Afghanistan. "Although the current activity level is less than a dozen transplants a year in the U.S., the VCA transplant community has begun to encounter the expansion problems faced in the early days of organ transplantation with ensuring equitable access for patients to VCA, uniform allocation policies across the U.S., coordination of procurement efforts, consistent application of recovery and logistics processes, and monitoring patient safety with appropriate outcomes reporting and oversight of transplant programs." — Wayne Kondro, *CMAJ*

Cancer death rates decline: The death rates for cancer in the United States dropped by 1.8% per year for men, and 1.6% per year for women, between 2004 and 2008, according to the American Cancer Society's latest report. The decline is attributable to lower smoking rates, earlier detection and removal of colorectal and cervical lesions, an increase in prostate screening, reduced use of hormone replacement therapy by women and decreased incidence of *Heliobacter pylori* infections, the society says in its annual report, *Cancer Facts & Figures 2012* (www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf). But the incidence of some cancers is increasing, including: "human papillomavirus (HPV)-related oropharyngeal cancer; esophageal adenocarcinoma; melanoma of the skin; and cancers of the pancreas, liver and intrahepatic bile duct, thyroid, and kidney and renal pelvis," the report adds. "The causes of these increasing incidence trends are unclear, but may reflect the combined effects of changes in cancer risk factors and detection practices. Notably, as the US population continues to shift to older age groups where cancer risk is highest, if rates of other more common cancers remain unchanged or decline, cancers with increasing trends will account for a greater proportion of all cancer cases over time." — Wayne Kondro, *CMAJ*

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