Canada's doctors assail pharmacist prescribing

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From allowing pharmacists to prescribe, to allowing other health professionals to head collaborative team practices, reforms have been introduced that physicians believe are slowly eroding their leadership.

Delegates to the Canadian Medical Association (CMA) 140th General Council in Vancouver on Aug. 21, 2007, struck back with a series of resolutions demanding that they lead all collaborative care teams and that pharmacists be precluded from all manner of "independent" prescribing.

Canadian Pharmacists Association Executive Director Jeff Poston later wondered whether doctors might feel slighted if pharmacists had the temerity, at their annual general meeting, to define the suitable duties of doctors.

Delegates approved 12 desired principles of a patient-centred collaborative care model, based on a CMA discussion paper. At the core of the model lies the proposition that doctors should always be the clinical leader of a collaborative team, that is, "the individual who, based on his or her training, competencies and experience, is best able to synthesize and interpret the evidence and data provided by the patient and the team, make a differential diagnosis and deliver comprehensive care for the patient. The clinical leader is ultimately accountable to the patient for making definitive clinical decisions."

The physician is the health care provider who is ultimately accountable and liable, stated the discussion paper, crafted by the 13-member CMA working group on collaborative care, co-chaired by board members Dr. Don Pugsley and Dr. Susan Fair.

"Collaborative care," Pugsley told delegates, "should not be seen as an opportunity for governments and must not be permitted to substitute one care provider for another simply because [one] is more plentiful or less costly than the other."

Both the delegates and the discussion paper contended that within any

Mark Holleran

Then-CMA President Dr. Colin McMillan says the goal is enhanced patient care.

collaborative team, there's a need for clear lines of authority and clearly defined roles for all members.

Nowhere was that expressed more forcefully than during a discussion of the role of pharmacists. In a series of resolutions, delegates unequivocally took the stance that the role of pharmacists must be limited. One resolution stated, point-blank, that the CMA "recommends that pharmacists not be given independent prescribing authority."

Poston of the Canadian Pharmacists Association says, "Medicine has still got a long way to go in terms of accepting the roles of other health care professionals." There is "overwhelming evidence," he says, that collaborative care improves patient outcomes and is cost effective.

Poston noted that CMA's defensive attitude is out of step with realities across the country. Alberta legislation allows pharmacists to initiate or modify prescriptions; New Brunswick and Nova Scotia allow pharmacists to extend a prescription for 30 days if a patient is unable to see a doctor; while, in Quebec, pharmacists can "adjust" prescriptions. Manitoba legislation gives pharmacists broad prescriptive authority, although specifics have yet to be announced. "Pharmacists already prescribe independently on a regular basis," Poston says.

Then-CMA President Dr. Colin McMillan later told reporters the goal is enhanced patient care. "Collaborative care must not be about shuffling work

from one set of hands to other busy hands. And collaborative care must not be about protecting or enhancing a profession's scope of practice. It must be about patients."

A final formulation of the collaborative care policy will be presented to CMA's Board of Directors in September. — Wayne Kondro, *CMAJ*

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CMA urges national equivalent of medicare for extended health services

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The Canadian Medical Association (CMA) has thrown its weight behind developing and passing national legislation to cover the pharmaceutical, long-term, extended and home care costs of Canadians.

Delegates at CMA General Council in Vancouver adopted a resolution on Aug. 20 calling on the CMA to develop a "policy framework and design principles" for a Canada Extended Health Services Act that could then be pitched to all levels of government as a politically palatable alternative to revising the Canada Health Act.

Delegates also urged CMA to lobby governments to redress other gaps in the health care system, including providing mental health programs for Canadian soldiers returning from Afghanistan, creating a national program to pay for ultra-expensive drugs needed to treat rare diseases and immediately establishing a national fund to cover the cost of providing drugs and vaccines for children under the age of 5.

Details of the envisioned Canada Extended Health Services Act remain unresolved, as does the source of funding.

CMA was asked to analyze alternative methods of funding, including such options as "compulsory contributions" like those under the Canada Pension Plan, an RRSP-like program or direct government funding.

The following day (Aug. 21) delegates narrowly defeated a motion (49% v. 50%) to revamp the Canada Health Act to allow co-payment and health savings accounts.

Dr. Larry Erlick of Scarborough, Ont., said he initiated the controversial motion because budget restraints on items such as new medications mean that “my patients continue to suffer.” He said he supports publicly funded universal health care based on patient need, not ability to pay, and argued that the current act limits innovative solutions.

Several opponents, including former CMA president Dr. Hugh Scully, responded by citing research suggesting that such plans don’t work. — Wayne Kondro, *CMAJ*

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Health Minister Clement promises crackdown on illicit drug use

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Federal Minister of Health Tony Clement promised a bevy of new health-related federal initiatives in an address to the Canadian Medical Association (CMA) annual General Council in Vancouver Aug. 20, including a crackdown on illicit drug use, a renewed tobacco-control strategy aimed at reducing national smoking rates to 12% from 19% by 2011 and more stringent regulations to prevent the import of counterfeit or contaminated food, drugs and consumer products.

Clement was most emphatic about the need for a tough new national strategy to prevent illicit drug use, indicating that the government is determined to redress the long-standing absence of a “significant anti-drug campaign,” a condition that he asserted has led to Canada having the highest percentage of marijuana users (16.8%) in the industrial world.

Canada’s current marijuana policies have spawned “an entire generation

that is confused about whether pot is legal,” he added.

Clement later told reporters the scientific evidence of the efficacy of safe injection sites is entirely equivocal. He welcomes the public and academic debate, which will help government make an informed decision.

Clement also indicated the recent spate of recalls on products manufactured abroad, including toothpaste (South Africa) and children’s toys (China), have led to a Health Canada review of standards and regulations related to foreign goods.

Clement was conciliatory on matters of systemic reform of the health care system, repeatedly stressing that although the Conservative government defends the principles of the Canada Health Act, it believes that there is plenty of room for “innovation” within the system, particularly with respect to the private delivery of services to “meet demands on the system in the future.”

Mark Holleran

Federal Health Minister Tony Clement (left) meets with CMA’s new President Dr. Brian Day.

Even staunch proponents of public health care were reassured. “It’s really important that people not fall into the trap of believing that innovation means privatization. Those 2 things should not be equated in our minds. Quite the contrary, actually,” said Dr. Danielle Martin, chair of the board of Canadian Doctors for Medicare. — Wayne Kondro, *CMAJ*

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CMA considers election and structural reforms

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Potential changes to the practice of rotating the Canadian Medical Association (CMA) presidency through provincial associations and the process for electing the president are among reforms being examined by the CMA’s recently appointed Governance Review Task Force.

Although proposed changes to these procedures have been previously dismissed, CMA Chair, Dr. Louise Clouthier, and task force Chair, Dr. Dan O’Brien say there’s now a need to review all facets of CMA’s structure, which has essentially remained unchanged since it was formed in 1909. The 2 made the case for reforms during an information and consultation session Aug 19, prior to the CMA General Council in Vancouver.

Other elements of the review include the process for selecting representatives to the annual General Council and for appointing members to CMA’s board of directors.

“Essentially, what we’ve asked the task force to do is look at how the organization is structured and how it functions, to make sure it meets the needs of the physician members,” Clouthier said in an interview.

The presidency is now determined on a complex, rotational basis among provincial associations, based on such factors as geographic location and the number of physicians within a province. Essentially, the provincial association that is next hosting CMA General Council elects the new president from among its members, and his or her appointment is ratified at the CMA annual meeting.

O’Brien said all facets of CMA’s structure and operations are on the task force’s table. It will make its recommendations for change at the CMA’s 2008 annual meeting in Montréal. — Wayne Kondro, *CMAJ*

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