Currently, NB medical students studying in French and enrolled in the Sherbrooke program split their 4-year degree between Sherbrooke and the University of Moncton and do their residencies at Dumont and other hospitals around the province.— Christine Morris, Fredericton

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Phase 2: Benchmarks to accountability

Setting wait times is not an end in itself, but a step toward a sustainable health care system, says the federal Wait Times Advisor.

Dr. Brian Postl said that instead of setting "hundreds and hundreds of benchmarks" we need to look at ways to make the first 5 benchmarks (*CMAJ* 2005;174:299), set in December, work. Postl addressed attendees at a Jan. 16 conference sponsored by the Canadian Health Coalition (CHC), a non-profit group that promotes medicare.

Sustainability depends on innovative operational improvements that will ensure appropriateness of care and consistent management, said Postl, president and CEO of the Winnipeg Regional Health Authority. Physician buy-in is also essential.

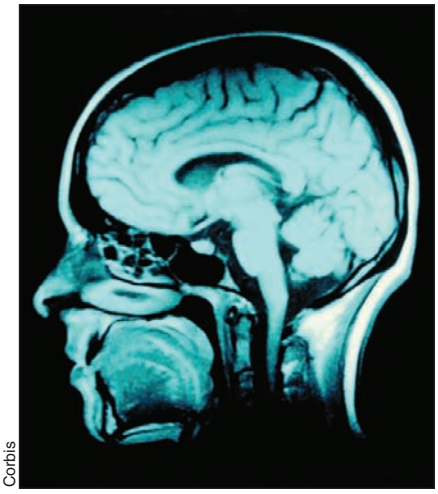
Postl's report on phase 2 of the federal wait times project, which will stipulate elements of system transformation, is due this spring.

In broad terms, Phase 2 will include engaging researchers to tie evidence to benchmarks, adopting new business practices, such as common wait lists for provinces or regions, employing wait-time coordinators so patients "know where they are," wait-time management training for health care professionals, and transparent waiting lists.

It will also outline the use of information technologies, including integration across health care systems and developing a registry.

Postl said physicians must also "take responsibility and change how they do business" by moving from a physician-based model to a program service-based culture. In the former, physicians "feel ownership of their patients" and refer them to, for example, a specific neurologist. Postl advocates a system where patients are assigned to a neurological service.

"We need to establish professional responsibility and accountability if this is going to work," said Postl. "We need physicians as part of it; we can't do it without them."



Corbis

Using our head to reduce wait lists: about 5% of radiology imaging is unnecessary.

"One of the key issues around benchmarks and wait times, which we've done a very poor job of in this country, is the area of appropriateness," added Postl. There are some "remarkable inconsistencies across the country in how that's managed."

A case in point is the use of radiology services. A pilot study by the Canadian Association of Radiologists (CAR) found that 86% of radiology requests were appropriate, but in 9% of cases a more appropriate test should have been ordered and in 5% of cases no imaging was necessary for diagnosis or treatment.

This means that 4 million exams per year could be eliminated, saving about $500 million or twice the annual equipment purchasing budget. This saving would mean the "elimination of wait times" and "the elimination of the need for private services," CAR's CEO Normand Laberge, told the conference. "We need to make sure we only do tests that will have a benefit."

Although these strategies are obviously needed, the problem is one of public perception, CHC Chair Kathleen Connors said at the conference. "The care guarantee has become the Trojan horse for for-profit health care." In an attempt to meet care guarantees, provinces will allow more privately delivered care, she maintained. — Barbara Sibbald, *CMAJ*

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Quebec strain of *C. difficile* in 7 provinces

The same strain of *Clostridium difficile* that has caused close to 1400 deaths in Quebec since 2003 is present in 7 provinces, the Public Health Agency of Canada is reporting.

The NAP 1 strain of *C. difficile* was found in hospitals in Ontario, Quebec, Nova Scotia, Newfoundland and Labrador, Alberta, Saskatchewan and British Columbia. The Canadian Nosocomial Surveillance Program participated in a 6-month study conducted by the Canadian Hospital Epidemiology Association and the Public Health Agency, and involving 34 hospitals that belong to the program (Fig. 1).

From Nov. 1, 2004, to Apr. 30, 2005, the National Microbiology Laboratory in Winnipeg collected more than 2000 stool samples and epidemiological data from patients at these institutions. The Public Health Agency has so far analyzed 615 of those samples and identified 1847 cases of NAP 1. Although they have not yet found the strain in New Brunswick and Manitoba, that may be because they still have more samples to investigate, says Denise Gravel, manager of the Nosocomial and Occupational Infections section of the Public Health Agency.

Compared to Agency data from a similar 1997 study, the incidence rate of *C. difficile* is essentially unchanged; 5.8% per 1000 hospital admissions in 1997, and 6% in the new study. But the

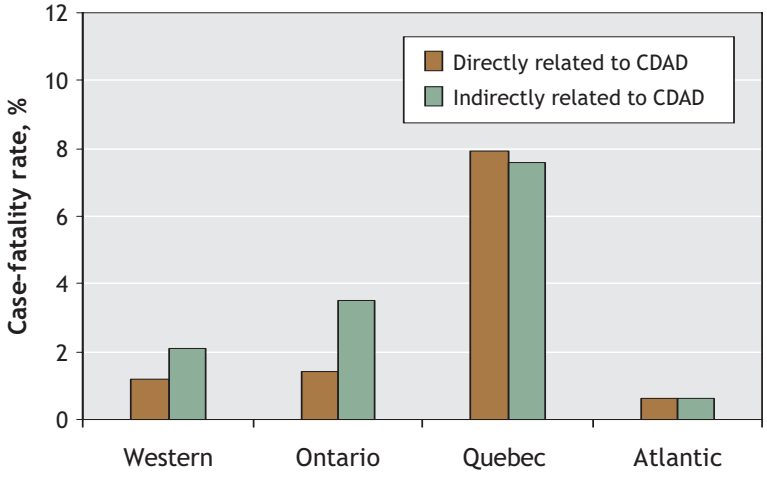

Fig. 1: Case-fatality rates among patients with Clostridium difficile–associated disease (CDAD) from Nov. 1, 2004, to Apr. 30, 2005, by province or region. The mean rate was 5.7% overall (2.2% directly related to CDAD, 3.5% indirectly related to CDAD). Source: Public Health Agency of Canada

mortality rate has jumped by 400%. In 1997, *C. difficile* contributed, either directly or indirectly, to the deaths of 1.5% of patients with the infection; the new study indicates the mortality rate is 5.8%, "which of course is highly significant," Gravel says.

She says morbidity has also jumped. "We did find that those who had the NAP 1 strain are 2.3 times more likely to have a serious outcome." The study defined "serious outcome" as death, colectomy or ICU admission.

Quebec has the highest incidence rate, 13 per 1000 admissions compared with 7 per 1000 in Ontario, 3 per 1000 in Western Canada and 6 per 1000 in Atlantic Canada. There are no baseline data to allow a comparison with provincial rates in each province.

In separate data released by the Quebec government in December 2005, *C. difficile* is listed as the direct cause of death for 354 people in 2003 and 686 in 2004, for a total of 1040 deaths.

These official figures appear to support the estimates of Dr. Jacques Pépin, an infectious disease specialist in Sherbrooke, Que. Pépin published a paper last year (*CMAJ* 2005;173:1037-42) estimating that as many as 2000 people died, directly and indirectly, from *C. difficile* in 2003–2004.

C. difficile directly caused another 341 deaths in the first 6 months of 2005, according to the province. In total, Quebec has attributed 1381 deaths directly to *C. difficile* from 2003 through the first half of 2005. — Laura Eggertson, *CMAJ*

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News @ a glance

TB test: A new blood test for tuberculosis has been approved for use by the US Centers for Disease Control and Prevention. The QuantiFERON-TB Gold test is made by an Australian company and will be used instead of the 100-year-old tuberculin skin test. The new test detects interferon-gamma (IFN-γ) in the blood of sensitized people when it is mixed with two antigens specific to *Mycobacterium tuberculosis*. QuantiFERON-TB Gold will be used to test contacts of patients with tuberculosis, new immigrants and health care workers. — Sally Murray, *CMAJ*

No Bextra: Following a review of safety information, Health Canada has decided that valdecoxib (Bextra), a COX-2 selective inhibitor used to treat arthritis and pain, will not return to the market. Pfizer pulled the drug in April 2005 (*CMAJ* 2005:172;1299) becaue of a potential increased risk of cardiovascular events (including myocardial infarction and stroke) in patients taking valdecoxib for short-term pain relief after high-risk heart surgery. There is also an associated risk of rare but severe skin reactions (e.g., toxic epidermal necrolysis, Stevens–Johnson syndrome, erythema multiforme). Health Canada set up an expert advisory panel to review all COX-2 selective inhibitors after rofecoxib (Vioxx) was voluntary pulled from the market in September 2004. The panel found that the "overall risk versus benefit profile for Bextra does not support the marketing of this drug in Canada under its current conditions of use."

Luck of the draw: The 8000 residents of Yarmouth, NS, who don't currently have a family physician are eligible to enter a draw that may gain them admittance to a new clinic. When it opens this spring, the Ocean View Family Practice, consisting of 4 family physicians and 1 resident, will accept 1500 patients. Each applicant is assigned a number, and a computer program will randomly select the winners in April. It's an experiment to solve a "very long-standing" physician shortage that's "growing progressively worse as our current population of physicians begin to retire," said Blaise MacNeil, CEO of the local health authority.

Malaria therapy problem: WHO asked 17 drug companies in January to stop selling artemisinin as a stand-alone therapy for malaria because of the potentially huge increase in drug-resistant strains. The use of artemisinin as a monotherapy weakens but does not kill the parasite. When used correctly in combination with other antimalarial drugs in artemisinin combination therapies (ACTs), artemisinin is nearly 95% effective in curing malaria, and the parasite is highly unlikely to become drug resistant. ACTs are currently the most effective medicine available to treat malaria. Dr. Arata Kochi, head of the WHO malaria department, said he is trying to prevent the emergence of rare strains that are resistant to all drugs. The "potential risk is tremendous," he said. — Compiled by Barbara Sibbald, *CMAJ*

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