FOR THE RECORD

Published at www.cmaj.ca between Aug. 12 and Aug. 26

Ontario probe finds concern in hundreds of Windsor pathology cases

A provincial probe into cases of mistaken mastectomy at three Windsor, Ontario-area hospitals has found “significant concerns” with the work of a pathologist.

Medical experts had “moderate or major disagreements” with the original diagnosis of Dr. Olive Williams in 221 of more than 6000 pathology cases reviewed, according to a report by investigators, (www.health.gov.on.ca/en/public/publications/ministry_report_surgical_pathology_issues/docs/surgical_pathology_issues.pdf). Among those cases of concern, 45 warranted “further investigation, treatment or patient follow-up.”

The four-month investigation was launched earlier this year after two women reported their breasts had been removed under the mistaken belief they had cancer.

Williams is no longer practising in Ontario, but investigators urged the College of Physicians and Surgeons of Ontario to reassess her clinical competency, should she resume her practice in the future. The report also called for Ontario’s Ministry of Health to set province-wide pathology standards and guidelines by March 2011.

The college is already investigating Williams, as well as Dr. Barbara Heartwell, the surgeon who performed the accidental surgeries. In one of the cases, Heartwell admitted to the hospital she had misread the results of a needle biopsy.

The provincial probe cleared Heartwell, concluding she “generally performed safe surgery and provided safe care,” despite expressing concerns that she wasn’t up-to-date with surgical advances and techniques.

The report called upon Hôtel-Dieu Grace Hospital in Windsor to lift restrictions on Heartwell’s practice, but recommended she participate in quality and continuing professional development initiatives. Hôtel-Dieu Grace suspended Williams’ privileges in January.

The report found an “alarming lack of respect” between the hospital’s medical leaders, senior management, and board of directors. Investigators said an “unhealthy” culture had been allowed to fester for more than a decade, and called upon Hôtel-Dieu Grace to consolidate its pathology services at Windsor Regional Hospital, where working relationships were less toxic. It was also recommended that a facilitator be hired to help the hospitals implement all recommendations.

“This has been a difficult time for all concerned, but most of all for the affected patients and their families. We were profoundly saddened by the errors that gave rise to the investigation and we are sorry that these errors occurred,” Egidio Sovran, chair of Hôtel-Dieu Grace’s board of directors, said in a press release (www.hdgh.org/Assets/Media-Release-OfficialStatement-FinalCombined_000.pdf). “We look forward to working with the facilitator in implementing the recommendations.” — Lauren Vogel, *CMAJ*

UK wait times rise due to cap on junior surgeons’ hours

Rules limiting junior physicians in the United Kingdom to a maximum 48-hour workweek have dramatically increased wait times for surgeries, according to the Royal College of Surgeons.

The percentage of patients waiting at least 18 weeks for nonemergency surgeries has doubled in the last 18 months, increasing from 1.5% to 3%. In 2006, wait times in the UK had reached a record low, thanks to National Health

Service efforts to increase efficiency. But a restriction on hours in the European Working Time Regulations (www.cmaj.ca/cgi/doi/10.1503/cmaj.109-3111) has reversed that trend.

The European Union directive to restrict the hours of junior surgeons has “failed spectacularly,” Dr. John Black, president of the college, said in a press release. “Despite previous denial by the Department of Health that there was a problem, surgeons at all levels are telling us that not only is patient safety worse than it was before the directive, but their work and home lives are poorer for it” (www.rcseng.ac.uk/news/impact-of-doctor-working-time-cap-on-patient-safety-and-training-getting-worse-says-new-survey).

Surgeons have been very critical of the directive, claiming it has harmed not only patients but also the quality of education for doctors. According a survey of 980 UK surgeons and surgical trainees, released by the college on Aug. 1, 80% of surgeons and 66% of surgical trainees say that patient care has deteriorated since the European Union directive to cut junior doctors’ weekly hours from 56 to 48 was implemented on Aug. 1, 2009 (www.rcseng.ac.uk/news/docs/rcs_ewtd_survey_results_jul_2010.pdf).

The survey also revealed that two-thirds of surgical trainees say their training time has decreased, though 72% claim they still work more hours than is permitted under the directive. One respondent said that the “The European Working Time Directive has been a training disaster. We are raising a generation of demotivated, demoralised and poorly trained surgeons. The UK will pay for this and regret it for at least 30 years.”

The Royal College of Surgeons, the Association Surgeons in Training and the British Orthopaedic Trainees Association have all suggested that a 65-hour workweek would be better for ensuring surgical trainees gain enough experience and patients receive timely care. — Roger Collier, *CMAJ*

Canada slow on uptake of new cancer drugs

Canada is one of the lowest users of new cancer drugs and a mid-range user of many other pharmaceutical therapies, according to a comparison of international drug usage in 16 therapeutic areas within 14 developed nations conducted by the United Kingdom.

The study ranked Canada seventh overall in drug usage among the 14 nations, behind the United States, Spain, France, Denmark, Australia and Switzerland. Its highest ranking was fourth, in three therapeutic areas: antipsychotics, dementia and statins. Canada received an intermediate (5th–9th) rank in three therapeutic areas, and a lower rank (10th–14th) in eight.

Canada's lowest ranking was 13th, in the use of rheumatoid arthritis biologics, cancer drugs developed within the last five years and cancer drugs developed in the last six to 10 years, according to the study, *Extent and causes of international variations in drug usage*.

Conducted by Professor Sir Mike Richards, MD, on behalf of the UK Secretary of State for Health, the study surmises that there are a variety of reasons which might explain the international variations in drug usage, including such systemic factors as the level of health expenditure, prescription restrictions and the nature of pharmaceutical marketing (www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117977.pdf).

Reimbursement factors such drug prices and health technology assessment processes also play a role, as do capacity factors such as “the extent of national prioritisation for a disease factor”; cultural factors such as clinical attitudes toward risk and the level of research activity; and epidemiological factors such as stage of diagnosis.

But the report also notes that there is little in the way of evidence to support the proposition that the level of a country's outlays, or the structure of its health delivery system, has an impact on drug usage levels. “It is not clear that system characteristics such as

health expenditure, sources of system funding or coverage exert a strong determinative effect on levels of drug usage observed,” it states.

Richards, the UK's national cancer director, noted in his covering letter to the study that “it is important to stress that there is not always a consensus about what the optimum level of drug usage in different disease areas would be and that the appropriate level of usage may vary because of different factors at work in different health economies. For some disease areas, high usage may be a sign of weaknesses at other points in the care pathway and low usage a sign of effective disease prevention. Equally, for others, low usage may imply that patients' needs are not being met effectively and high usage may imply that patients are receiving the best treatment. This report does not seek to identify a correct level of utilisation, but rather to identify where variations exist and to provide potential explanations for them.”

“Although some countries emerge as generally high or low users, there is no uniform pattern across disease areas and categories of drugs. France, Spain, the USA and Denmark have high levels of usage generally, but not across all disease areas. Low levels of usage are also observed for all four countries in some categories. Generally lower than average levels of usage were observed in Norway and Sweden. New Zealand had the lowest ranking (14th) in nine out of the 14 groupings,” he added. — Wayne Kondro, *CMAJ*

Educating Canadians on the dangers of transplant tourism

Canadian health care providers are responsible for educating their patients on the mortality risk and ethical concerns surrounding transplant tourism, according to a policy statement released by the Canadian Society of Transplantation and the Canadian Society of Nephrology (http://journals.lww.com/transplantjournal/Citation/publishahead/Policy_Statement_of_Canadian_Society_of.99745.aspx).

The policy statement, published Aug. 13, is targeted at Canadian health care providers involved with candidates for solid organ transplantation or recipients of a solid organ transplant. It is intended to provide “a framework to approach the subject of transplant tourism and organ trafficking with patients.”

All patients with end-stage organ failure should receive information about the dangers of transplant tourism, the paper states. Patients who purchase organs overseas are at increased risk of organ failure, infection and death. Upon returning to Canada, these patients may receive suboptimal care due to poor documentation and communication about their transplants, and because they may have been transferred out of hospital before they were stable. The statement also says that Canadian doctors are not obliged to speculate on the relative safety of commercial transplantation in different countries. Physicians opposed to transplant tourism should, however, inform patients that their personal values may influence the care they provide.

If, despite these warnings, patients decide to travel overseas for organ transplants, their physicians are not obliged to prescribe medications that will be used during the procedure, according to the policy statement. “Prescribing medications for treatment that the prescriber is not supervising contravenes current Canadian medical standards of care.”

Physicians may also choose not to provide patients with their medical records, the paper states, if they believe “the information will be used in support of an illegal transplant performed in an unregulated system and that there is a significant risk of harm to the patient or organ vendor.”

When transplant tourists return to Canada, their doctors must still provide care during emergencies, the paper states, but, in other situations, doctors have a right to defer care to other physicians.

The policy statement was inspired by the “Declaration of Istanbul on Organ Trafficking and Transplant Tourism,” a 2008 paper that claims transplant tourism and organ trafficking

violates the principles of equity, justice and respect for human dignity (www.asn-online.org/press/pdf/2008-Media/Declaration%20of%20Istanbul%20Study.pdf).

"The Canadian Society of Transplantation and the Canadian Society of Nephrology endorse the Declaration of Istanbul," states the Canadian policy statement, "and condemn the practices of transplant tourism, organ trafficking, and commercialization of organs that lead to the exploitation of the poor and the vulnerable both within Canada and throughout the world." — Roger Collier, *CMAJ*

Outgoing CMA president urges united front

A "united voice for change" will be essential to achieve transformation of the health care system, outgoing President Dr. Anne Doig said in her valedictory address to the 143rd annual general meeting of the Canadian Medical Association in Niagara Falls, Ontario.

Physicians must be front-and-centre in breaking the "trajectory of decline" that characterizes the Canadian health care system, Doig said. "It is fundamentally our responsibility to lead the change that is necessary, and to demonstrate the willingness to change our own behaviour before and while expecting others to change. We will be the catalyst for system change."

Doig later told reporters that such a unified voice will also need to be strongly supported by the public. "We've developed a good unified voice, where it's fairly clear now to the Canadian public that we, the profession, are engaging them as our best allies in advocating for change for them."

Canadian Healthcare Association President and CEO Pamela Fralick says the unified voice must also include other health professionals and associations if it is to carry the requisite weight needed to actually affect change.

"There has to be a larger voice," Fralick says. "Physicians are hugely influential in our system. We want them to be. But they don't represent the entire system. So if we can bring that voice, together with the systems pieces that I represent, and that other groups and associations represent, how strong would that be? Then we've got a far greater chance of succeeding in transforming the system."

Doig also said in her valedictory address that Canada's doctors must be resolute in pursuing health care reform. "Our fundamental duty as physicians is to do our best for our patients, individually and collectively. We know that there is a crisis looming in our system of health care delivery. As professionals, we owe Canadians the duty to identify the crisis and to work towards its resolution."

Doig assumed the CMA helm in August 2009, advocating for "efficiency, effectiveness and effecting change." (www.cmaj.ca/cgi/doi/10.1503/cmaj.109-3025). — Wayne Kondro, *CMAJ*

Ontario doctors to get break in liability fees

Medical liability insurance fees for all doctors in Canada, except those in Ontario, will increase in 2011, delegates to the Canadian Medical Protection Association's (CMPA) annual meeting were told in Niagara Falls, Ontario.

Average fees for doctors in Ontario will drop for the second consecutive

year, to \$2422 from \$3845, a 37% reduction after an 8% reduction in 2010.

But fees for doctors in all other parts of the country will continue to rise.

Average charges for doctors in Quebec will rise 11.1% to \$4332, while charges for doctors in the rest of Canada will rise 11% to \$2670.

The differential fees are largely the product of CMPA's operation of essentially three different liability systems in the country, with funds for each funnelled into separate accounts. Fee levels are calculated according to an actuarial estimate of current and future liabilities. In cases where claims against a province were lower than anticipated in a given year, doctors are allocated what are called "fee credits," which reduce the average fee they must pay in the following year.

While Ontario doctors will get a substantial 37% break in 2011, Stephen Campbell, CMPA's director of financial services, informed the annual meeting that the windfall is not projected to last. "It is expected that in 2012 and beyond, fees will return to more historic levels," he said.

Delegates were also informed that CMPA's investment portfolio now looks brighter than it did at the end of 2008. The association increased its general reserves to \$391 million in 2008 from \$201 million a year earlier.

The CMPA's annual report indicates that of 891 civil legal actions commenced in 2009, 101 went to trial but only 19 of those saw an outcome favouring a plaintiff. Some 319 actions were settled, while 522 were dismissed, discontinued or abandoned. CMPA membership rose to 78 527 from 75 833. — Wayne Kondro, *CMAJ*

DOI:10.1503/cmaj.109-3347