Access-to-care issue to dominate CMA annual meeting

The CMA's 131st annual meeting, which takes place in Whitehorse Sept. 6–9, will consider a medicare mystery: How long a wait is too long when it comes to health care?

The trade-off Canadians have always made in exchange for universal coverage is delayed access to some services. However, the CMA thinks that some patients are now waiting too long to receive care. That is why delegates attending the first CMA annual meeting ever held "north of 60" will debate and help establish principles for health care access. In turn, these will help form the backbone of the CMA's Access to Quality Health Care Project (*CMAJ* 1998;158:1261), which will develop national guidelines for funding and appropriate access.

At last year's annual meeting, federal Health Minister Allan Rock said he recognized the "very real anxiety being felt by Canadians" concerning the health care system. When he returns to this year's meeting, the greetings from physicians will likely be muted. "The 1998 federal budget did nothing to bolster Canadians' confidence that the system will be there when they need it," says Dr. Victor Dirnfeld, the CMA president.

Is HIV treatment becoming too complex for nonspecialists?

The treatment of patients infected with HIV is becoming so complex many primary care physicians will have to refer them to specialists, a Montreal-based expert says.

"I see this disease as getting very, very complex," says Dr. Chris Tsoukas, director of the Immune Deficiency Treatment Centre at the Montreal General Hospital. Increasingly, he said, the treatment of HIV infection will follow the "oncology model," with treatments becoming so specialized they can only be provided through dedicated clinics.

Tsoukas said there are already roughly 20 drugs available to fight HIV infection, with more arriving all the time, "so it's important that patients get appropriate care and be seen by people who know what they're doing."

Growing numbers of HIV-infected patients now take antiretroviral cocktails of from 20 to 25 pills per day, as well as prophylactic drugs to ward off opportunistic infections. Failure to adhere to precise dosing and timing schedules for these multidrug regimens can lead to drug resistance, significant adverse effects, patient noncompliance and treatment failure.

Tsoukas said FPs who have taken the time to learn about the myriad treatments for HIV are "perfectly capable" of managing the disease, but problems may arise when doctors have only 1 or 2 infected patients and see them irregularly. "Then it becomes a real issue for us," he said.

Tsoukas said there is demand for family doctors to see newly infected patients whose disease is following a simple clinical course, but noted that this accounts for fewer than 50% of all HIV patients.

Dr. Brian Cornelson, a Toronto family physician who treats a large number of HIV-infected patients, doesn't "know how FPs who have just a few HIV patients are able to stay abreast of the latest developments to provide their patients with optimal care when it comes to managing antiretrovirals. I'm not saying they can't, but it has become a lot more difficult in recent years."

The push to have treatment provided by specialists is not being driven by the specialists themselves, Cornelson said. In fact, they are genuinely worried that FPs will give up their roles in this field because of the growing complexity.

Dr. Donald Zarowny, one of the principal authors of recently released guidelines on the use of antiretroviral therapy in Canada (*CMAJ* 1998;158:496-505), said the Canadian HIV Trials Network, which drew up the guidelines, was aware of the FP–specialist issue. However, he said decisions about who should be treating these patients was not within the mandate of the working group. —

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