Alberta Physician Achievement Review

We thank Geoff Norman and John Cunnington for their interest in the Physician Achievement Review program of the College of Physicians and Surgeons of Alberta.[1] At the request of *CMAJ*'s editors, we condensed our 2 original submissions, one describing the purpose and operational aspects of the program and the other providing statistical results, into a composite report.[2] Space limitations precluded inclusion of extensive technical results, but we would be pleased to correspond with interested readers directly and provide additional technical data.

Norman and Cunnington asked about concurrent validity and inter-rater reliability. Concurrent validity, which is the extent to which there are correlations between self, patient, peer, consultant and co-worker assessments, was investigated using confirmatory factor analysis. The factors identified for the patient surveys were positively and significantly correlated with the factors identified for the peer surveys ($r = 0.25$, $p < 0.05$), the patient factors were positively and significantly correlated with the co-worker factors ($r = 0.20$, $p < 0.05$) and the co-worker factors were positively and significantly correlated with the peer factors ($r = 0.31$, $p < 0.05$). In other words, different groups of raters tended to rate a physician in the same way.

Inter-rater reliability addresses the issue of whether different raters of the same physician tend to rate the physician the same way. Our results indicated that when a physician's performance was rated very high or very low, most of the raters assessed the physician the same way. For example, when a physician was rated low in the "clinical competency" category he or she was rated low by most peers. For this particular category there was up to 100% agreement among peers in placing physicians in the lowest group.

The Physician Achievement Review program has now been implemented as described[2-4] and the survey results provide a basis for further assessment by practice visits for some physicians. Our operational experience will be reported in due course.

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References

1. Norman G, Cunnington J. Show us the evidence [letter]. *CMAJ* 2000;162(4):489.
2. Hall W, Violato C, Lewkonia R, Lockyer J, Fidler H, Toews J, et al. Assessment of physician performance in Alberta: the Physician Achievement Review. *CMAJ* 1999;161(1):52-7.
3. Violato C, Marini A, Toews J, Lockyer J, Fidler H. Using peers, self, patients and co-workers to assess physician performance. *Acad Med* 1997;72:582-4.
4. Fidler H, Lockyer J, Toews J, Violato C. Changing physician practice: the effect of individual feedback. *Acad Med* 1999;74:77-89.

Drug approval times

According to Nigel Rawson's figures, Canada and Australia are much slower in approving new drugs than Sweden, the United Kingdom and the United States.[1] Rawson acknowledges the difference in resources available in Canada and the United States but then dismisses this difference as not being significant. Is it reasonable to assume that the Therapeutic Products Program, with a budget of just under Can$50 million, will be able to review drugs as quickly as the US Food and Drug Administration (FDA), which spends about Can$745 million in approving roughly the same number of new drugs?

Canada takes the same amount of time to approve new drugs as Australia, a country with roughly the same level of resources in terms of population size and level of development. It is true that Sweden, a country with roughly 25% of Canada's population, approves new drugs more rapidly, but some of the drugs on the Swedish market have been approved through the centralized European procedure, which could have skewed the figures.

There are 2 additional questions that Rawson did not consider: Is safety compromised by quicker approvals? How important are new drugs to the health of Canadians?

A study of postapproval risks for drugs approved by the FDA between 1976 and 1985 found that 102 of the 198 drugs for which data were available had serious postapproval risks that could lead to hospitalization, increases in the length of hospitalization, severe or permanent disability, or death. Among drugs approved in fewer than 4 years, those that had serious postapproval risks had generally been approved in a shorter time than those without such risks.[2] In a 1998 survey, 12 FDA reviewers identified 25 new drugs in the previous 3 years that they felt had been approved too quickly.[3]

The Patented Medicine Prices Review Board categorizes new drugs according to their expected therapeutic benefit. Between 1994 and 1998, 408 patented medicines were introduced into Canada. Discounting the 171 that were not new chemical entities, only 24 of 237 or just over 10% were classified as "breakthrough" drugs or major therapeutic advances.[4] Between April 1996 and 1998, the British Columbia Therapeutics Initiative assessed 60 new drugs for the BC Ministry of Health. For 46 of the drugs (77%), it found no evidence of a therapeutic advantage over existing therapies.[5,6]

Rawson states, "Physicians want to be able to prescribe the most effective drugs for their patients, and patients want access to these drugs to get well quickly."[1] The implication is that more rapid drug approvals will lead to better health. New drugs do not need to show any advantage over existing therapies to be approved; they merely have to be better than placebo. Until the new drugs that the industry produces represent better value and until we are sure