

FOR THE RECORD

Parliament adopts

Jordan's principle

In an altogether rare demonstration of legislative unanimity, Parliament voted to adopt what has come to be called "Jordan's Principle" in resolving healthcare disputes involving First Nations children.

Although not legally binding, the principle advocated by the First Nations Child and Family Caring Society of Canada and 400 other organizations, and embodied in New Democrat Member of Parliament Jean Crowder's (Nanaimo-Cowichan) private member's motion calls on governments to adopt a "child first" approach to resolving jurisdictional disputes involving the care of children like 4-year-old Jordan River Anderson. As governments squabbled over who was financially responsible for Jordan's care, he languished and eventually died of a rare neuromuscular disorder while living in a Winnipeg hospital, far removed from his family and home on the Norway House Cree Nation reserve.

CMAJ threw its weight behind the legislation last August in an editorial urging that the medical needs of First Nations' children be the prime consideration in such intergovernmental disputes. If governments "ignore Jordan's Principle and entangle themselves in financial or jurisdictional battles first, the governments deserve to be sued," stated the editorial (*CMAJ* 2007;177[4]: 321).

A recent study indicated that as many as 400 Aboriginal children annually are caught in similar disputes.

The final vote in Parliament? 262-0.

Ontario fails to adequately monitor public drug provision

Overbilling by pharmacies and lax medication practices at long-term care facilities were among findings in the annual report of Ontario's spending watchdog.

Ontario fails to adequately monitor pharmacies in their provision of drugs for seniors, welfare recipients, the dis-

abled and others eligible for assistance under various programs, Auditor-General Jim McCarter stated in his 2007 report on government spending.

McCarter's review found that more than 30% of claims exceeded Ontario Drug Formulary prices by more than 100%. In 1 case, a pharmacy's claim exceeded the formulary price by 12 500%, so the Ministry of Health and Long-Term Care paid nearly \$2400 for a claim that should have cost less than \$20. In another instance, a pharmacy made 300 claims in 5 months for 1 ineligible individual. Less than 3% of pharmacies are inspected. Selecting 1 for review, McCarter found that it claimed \$270 000 in overpayments, including

\$240 000 for invalid dispensing fees.

The report also raised major concerns about medication management practices at long-term-care homes, including failure to obtain informed consent from patients for the use of new medications, inadequate reporting of medication errors and inadequate processes to ensure that medications that approach their expiry date are removed.

Among the findings was that "91% of the 18 000 level-1 alerts (which warn of a drug combination that is clearly contraindicated and should not be dispensed or administered) generated by pharmacy computer were overridden and the drugs dispensed to residents of 421 long-term-care homes."

Parliament's remarkable isotope fiasco

It is difficult to imagine how Parliament, when it resumes this week, could possibly top the level of spectacle that characterized its final week of pre-Christmas sittings. It featured the mudslinging antics of former prime minister Brian Mulroney and Karlheinz Schreiber, as well as government passage of emergency legislation to override the safety concerns of Canada's nuclear watchdog and reopen the nuclear reactor that produces isotopes for medical imaging.

In the latter instance, there was absolutely no shortage of grandstanding: Prime Minister Stephen Harper accused Canadian Nuclear Safety Commission President Linda Keen of being little more than a Liberal Party shill determined to compromise the health of Canadian patients by denying them access to radioisotopes used in diagnostic tests.

Meanwhile, the crown corporation Atomic Energy of Canada, which operates the Chalk River, Ontario, reactor, was revealed as a manager that flat out ignored the conditions of its licence by essentially refusing to connect 2 coolant pumps to an emergency power backup.

As hospitals struggled to cope with isotope shortages (or at a minimum, were unable or unwilling to invest in more expensive isotopes produced abroad) and patient backlogs began mounting, it also became painfully apparent that the government lacked a national backup plan to obtain isotopes in the event of shutdown or mishap (e.g., fire, earthquake) at Chalk River, which apparently supplies over one-half of the world's technetium.

Almost entirely lost in the brouhaha was any element of discussion of the balance between acceptable levels of nuclear risk and the health risks, and consequences, accruing for Canadians from a shortage of isotopes.



The Chalk River reactor purportedly produces two-thirds of the world's supply of technetium.

WHO speaks out on global health challenges

The following is an excerpt from the 2007 David E. Barmes Global Health Lecture, delivered by Dr. Margaret Chan, director-general of the World Health Organization, in which she advanced the arguments that the world's ability to handle health challenges rests upon the capacity of local health system infrastructure.

"Industrialization of food production, globalization of the food supply and its distribution and marketing channels mean that all of us are in-

creasingly eating similar unhealthy diets. With the massive move to cities, lifestyles are increasingly sedentary. Obesity has gone global.

Chronic diseases, long considered the companions of affluent societies, have changed places. They now impose their heaviest burden on low- and middle-income countries. Here is 1 example. In Cambodia, a least developed country, 1 in 10 adults now has diabetes and 1 in 4 adults has hypertension.

The rise of chronic diseases and the demands of chronic care are placing an almost unbearable strain on health systems. The costs for impoverished households can be catastrophic. In part of rural China, for example, 30%–50%

of poor farmers cite ill health or the costs of chronic care as the root cause for their poverty.

Two conclusions are obvious. If we want better health to work as a poverty reduction strategy, we must reach the poor. If we want health to reduce poverty, we cannot let the costs of health care drive impoverished households even deeper into poverty.

Public health has been given a big push forward, but it is still an uphill climb. Here is the reality. Interventions and money will have only a limited impact in the absence of adequate delivery systems." — Wayne Kondro, *CMAJ*

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DISPATCH FROM THE MEDICAL FRONT

Appropriate applause procedures

It seemed a windfall to our multinational group of 8. Our grand foray to the Great Wall of China was to be interrupted by an unscheduled stop at the world-renowned Imperial Academy of Natural Chinese Medicine.

We were greeted warmly by a pair of attractive young women in freshly starched lab coats, ushered into a classroom, served a hot beverage made from "health giving" plants and treated to a lecture lauding Chinese traditional and natural medicine. We learned about Yin and Yang, the efficacy of acupuncture and the incomparable excellence of hospital staff.

Then, as a special gift, we "Western visitors" received a free personal examination from 2 of the academy's most renowned professors: 'A' and 'B'. They arrived, dapper in suits and lab coats. The 2 attractive women encouraged us to clap. Disappointed by our lack of vigour, A instructed us to clap louder.

He motioned me forward. The translator ordered me to extend my hand, palm up, on a soiled pink satin cushion. My pulse was taken, my tongue scrutinized. A asked my age and gravely inquired about my current medications. A look of disapproval crossed



Traditional Chinese medicine is based on various belief systems.

his face when I told him that I did not take anything.

"Very serious," he intoned. "You have overheated liver, sluggish circulation and thick blood."

I protested that I felt very well.

"Very serious," the interpreter repeated. "No energy, fatigue, dry mouth and sometimes forget things."

A sadly shook his head.

Again I protested: the weather was hot, my energy excellent, my memory good.

"Sometimes," he implored, "the most serious of medical conditions seem like that until it is too late. You need urgent treatment."

I explained that our bus was moving on. He urged that I "look after my health before it was too late. ... Hundreds of my patients come to my hospital from North America before it is too late."

I was clearly not a good patient.

Other tourists were summoned forward. A Mexican physician was diagnosed with "serious womb and period problems." Also of a noncompliant bent, she was swiftly discharged, as was another Canadian physician suffering "sluggish circulation, hypertension, thick blood and developing diabetes." He protested that he felt well and recent lab work was normal.

But a muscular, 35-year-old dental technician proved more responsive. Advised that he was "seriously ill, hypertension, sluggish circulation, and on the verge of getting diabetes," he forked over US\$300 for a football sized bag of dried herbs. He was instructed to return, "without fail," in 3 months. He looked worried! — Donna Stewart, MD, Toronto, Ont.

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CMAJ invites contributions to Dispatches from the medical front, in which physicians and other health care providers offer eyewitness glimpses of medical frontiers, whether defined by location or intervention. The frequency of the section will be conditional on submissions, which must run a maximum 350 words or be subject to our ruthless editorial pencils. Forward submissions to: wayne.kondro@cma.ca