FOR THE RECORD

Spanish campaign endorsing independent medical education and training gains momentum

Spanish doctors and medical students have joined together to launch a campaign to reduce industry involvement in the financing of continuing medical education and research. There's a need for more transparent relationships between doctors and industry, say No Gracias, a group formed by the Federation of Associations for the Defence of Public Health, and Farmacriticxs, a group created by the Spanish branch of International Federation of Medical Students' Associations.

"Many doctors are starting to get tired of the pharmaceutical, food and technology industries' aggressive marketing, and are aware of the techniques that pave the way to the medicalization of society, with the invention of diseases, disease mongering, and its harmful effects on health. This makes many doctors and students highly critical of the activities sponsored by industries/corporations, which sometimes are obscene in its double intention of 'selling' scientific 'no-truths' and promoting excessively 'intimate' relationships," writes Dr Juan Gérvas, a Spanish general practitioner and promoter of the movement, in an email.

The campaign also hopes to promote sponsorship-free activities under a common label, in a similar manner to the European sustainable development movement (www.blueflag.org). Included in their platform are such plans as ones to promote "industrial smoke-free" spaces like primary health care centres, hospitals and medical schools.

"As future professionals, to plan and build real alternatives is for us the only way to work towards education, research and professional performance that is independent, free and has quality. Showing a coherent opposition within our group is undoubtedly the first step of many," says June Udaondo, one of the coordinators of the medical student arm of the campaign.

More than 60% of financial support for continuing medical education and continuous professional development programs in Europe comes from industry, according to a presentation by Bernard Maillet, secretary general of the European Union of Medical Specialists (www.europeancmeforum.eu). But Maillet writes in an email that the actual amount is unclear. "There are no clear data on this issue but it is assumed that the amounts are similar to the US [United States]," he writes.

Measuring industry's financial support for continuing medical education is a complex task, explains Eugene Pozniak, programme director of the European CME Forum, in an email. "While in the USA and Canada the lines of demarcation between education and promotion is very clear, in Europe it is not. At one end of the spectrum we have 'pure' CME, and at the other, Pharma-driven medical education. ... I estimate that about 5% of accredited European CME programmes are supported by Pharma."

"What needs to be agreed and clarified is a definitive distinction between promotion and (independent) education, the permitted role of each type of organisation, and who controls and regulates each bit — with rules and sanctions in place," Pozniak adds. — Tiago Villanueva MD, Lisbon, Portugal

Transforming care for chronic health conditions

Canadians with chronic health conditions (such as cardiovascular conditions, cancer, respiratory conditions and type 2 diabetes), or infectious diseases (such as hepatitis and HIV/AIDS) that require long-term treatment should be provided care using a patient-centred approach that integrates physician, specialty, acute care and community-based services, the Canadian Academy of Health Sciences says.

In a report urging the transformation of treatment for Canadians with chronic health condition, the academy argues that health professionals now act too independently and are too often disconnected from the specific needs, unique conditions and special circumstances of chronic care patients.

The report, *Transforming Care for Canadians with Chronic Health Conditions: Put People First, Expect the Best, Manage for Results*, urges that people with chronic conditions "have access to healthcare that recognizes and treats them as people with specific needs; where their unique conditions and circumstances are known and accommodated by all of their healthcare providers; and where they are able to act as partners in their own care" (www.cahs-acss.ca/e/pdfs/cdm%20final%20English.pdf).

To that end, the academy urges that the health care system be transformed by:

- "aligning system funding and provider remuneration with desired health outcomes" through such measures as the provision of sufficient funding for homecare and chronic care services; equal access to essential medications; and less fee-for-service funding of physicians.
- "ensuring that quality drives system performance" through such measures as the creation of a pan-Canadian quality improvement strategy and the development of "regional structures and processes to engage specialty physician and primary care practices in examining their performance to improve health outcomes."
- "creating a culture of lifelong education and learning for healthcare providers" through such measures as improved prelicensure education and

training of health professionals to ensure they have the "core competencies" to treat chronic conditions
- "supporting self-management as part of everyone's care"
- "using health information effectively and efficiently" through such measures as national unified standards for electronic health records
- and "conducting research that supports optimal care and improved outcomes."

The academy said the health care system is now too focused on acute care and treatment of single health issues, making it ill-suited for efficiently treating the 16 million Canadians who it estimates suffer from multiple chronic conditions.

Person-focused care can result in appropriate preventative care, fewer diagnostic tests and prescriptions, lower treatment costs, as well as reduced emergency department and hospital use, the report stated.

Poor management of people with chronic conditions can negatively impact the sufferer's quality of life and that of family and friends. Caregivers often take leave from work, quit their jobs and have lowered immune system functioning as a result of the demands placed on them, the report said. — Timothy Legault, Ottawa, Ont.

Unnecessary surgeries and Hospital Standardized Mortality Ratios

Thousands of unnecessary therapeutic knee arthroscopies and vertebroplasties continue to be performed in Canada despite evidence that the procedures are essentially ineffective, according to a Canadian Institute for Health Information (CIHI) report.

The report, *Health Care in Canada 2010*, also indicates that in 2008/09, there continued to be significant regional variations in the number of cesarean sections and hysterectomies performed across the country, while many patients occupy hospital beds although they do not need acute care services (http://secure.cihi.ca/cihiweb/products/HCIC_2010_Web_e.pdf).

In a separate release, CIHI also issued its Hospital Standardized Mortality Ratio 2010 results, which indicate that "40% of publicly reportable facilities significantly decreased their HSMRs when 2009–2010 results are compared with those from 2004–2005" (www.cihi.ca/CIHI-ext-portal/internet/en/applicationleft/health+system+performance/quality+of+care+and+outcomes/hsmr/cihi006769).

More than 3600 therapeutic knee arthroscopies and approximately 1050 vertebroplasties were performed in Canada in 2008–2009 even though "research evidence from randomized controlled trials has called into question the effectiveness of the interventions," the report states. Those studies have shown that therapeutic knee arthroscopies do little to reduce pain and many patients subsequently required knee replacement surgery within a year, CIHI adds. The report states that the number of therapeutic knee arthroscopies performed in 2006/07 and 2008/09 declined from 4781 to 3600, while the volume of vertebroplasties rose to 1050 from about 600.

The report also indicates that the number of Cesarean deliveries in Canada has been unchanged, at about 19%, since 2004/05. But the costly procedure (twice that of vaginal deliveries), continues to be used more often in some provinces and territories than others. Rates ranged from 23% (Newfoundland and Labrador) to 5% (Nunavut). "While there are currently no agreed-upon benchmarks for the appropriate use of these procedures, significant variations in surgical rates among Canadian jurisdictions suggest that some of these procedures may not be appropriate or necessary," CIHI states in a news release (www.cihi.ca/CIHI-ext-portal/internet/en/Document/health+system+performance/indicators/performance/RELEASE_16DEC10).

There is similar regional variation in hysterectomy rates, the report states. "In 2008–2009, age-standardized hysterectomy rates varied almost threefold across the provinces and territories, ranging from a high of 512 per 100,000 women (age 20 or older) in Prince Edward Island to a low of 185 per 100,000 in Nunavut. British Columbia had the lowest rate among the provinces, at 311 per 100,000 women. Variations in hysterectomy rates may point to differences within and between jurisdictions in care provider culture, practice and approaches to this surgery. If all provinces achieved British Columbia's hysterectomy rate, the difference would be an estimated 11% (3,700) fewer hysterectomies performed annually — with a cost savings of more than $19 million."

In regard to the number of patients unnecessarily occupying acute care beds, the report notes that "in 2008–2009, there were more than 92,000 hospitalizations and more than 2.4 million hospital days involving ALC [alternative level of care] stays in Canada. This represented 5% of all hospitalizations and 13% of all hospital days." About 8% of such patients were admitted to acute care even though they didn't need acute care services, primarily because they were waiting for palliative care, admission to another facility or physical therapy.

CIHI also indicated that the 2010 hospital standardized mortality ratio results indicate that over the past five years, roughly 81% of reportable hospitals have demonstrated a decrease in the number of actual to expected deaths, while 40% experienced "significant decreases."

"Improvements in both cardiac care and hospital processes and policies in reaction to HSMR results are examples of what is possible when targeted efforts to improve the health of Canadians meet head on with targeted efforts to improve quality of care," states the report. — Timothy Legault, Ottawa, Ont.

Drug supply chain needs oversight, pharmacists say

Canada needs some form of government or third-party oversight of the drug supply chain to prevent the sort of widespread drug shortages that are now being experienced, the Canadian Pharmacists Association says.

"What is missing in the drug supply chain is any organization or party that holds accountability for the supply chain from a system-wide perspective," the association says in its report on a survey of 427 pharmacists across the country about drug shortages in the system (http

://www.pharmacists.ca/content/About_CPHA/Whats_Happening/CPhA_in_the_News/CPhADrugShortagesReport_Dec2010.pdf). "Neither government nor any third party has an oversight function for the drug distribution system, and therefore drug supply is dictated in large measure by the market. Due to the reluctance of individual manufacturers to share information on supply and manufacturing problems, it is difficult to predict when shortages will occur, for how long, and affecting which drugs. Canada does not possess any system or mechanism that provides information about which drugs are facing supply constraints. The Center for Drug Evaluation and Research's Drug Shortage Program within the Food and Drug Administration in the United States does have such a Web-based information system in place which could potentially serve as a model for Canada."

The *Canadian Drug Shortages Survey Final Report* also notes that exact causes of various drug shortages are difficult to pinpoint but the reasons include:

- "Shortages of raw materials used in drug manufacturing
- More stringent regulatory requirements that delay production
- Problems with manufacturing processes in specific plants that have delayed delivery of supply
- The introduction of new pricing regimes in provinces that act as a disincentive to production of particular drugs
- An increase in product recalls in Canada or elsewhere, possibly as a result of more stringent enforcement efforts or new regulatory requirements
- Monopolization of production of a particular drug by 1–2 manufacturers; when production problems occur, shortages are the immediate result; and
- Shortage of proper container materials."

It identifies amitriptyline as the drug for which there is the greatest nation-wide shortage, followed by cephalexin, metoclopramide, clonidine, methotrimeprazine, diltiazem, tetracycline, amoxicillin + clavulanate, hydralazine and metronidazole.

The survey, conducted in October 2010, also indicated that:

- 81.2% of pharmacists had trouble locating medications to fill a prescription in their last shift (up from 63% in 2004)
- 93.7% said they had trouble locating medications to fill a prescription in the last week (up from 80% in 2004)
- 29.8% said they never receive advance notices of drug shortages
- 89% said drug shortages have greatly increased over the past 12 months
- 69.8% said they thought their patients' health outcomes have been adversely affected as a result of drug shortages
- 91.3% said their patients have been inconvenienced in some way by drug shortages, and
- the median number of minutes pharmacists said they spent dealing with drug shortages in one shift was 30 (up from 17 minutes in 2004).

Some 73% of pharmacists also indicated that the time spent addressing drug shortage problems precluded them from conducting medication reviews to determine the appropriateness of drug therapy.

"This report should serve as a wake up call to everyone involved in the drug distribution system that shortages are a serious concern, and that solutions need to be developed," Jeff Poston, executive director of the association said in a news release (www.pharmacists.ca/content/about_cpha/whats_happening/news_releases/release_detail.cfm?release_id=193). "One immediate step that needs to be taken is for governments to regulate a greater scope of practice for pharmacists, so that pharmacists can use their specialized skills and training to help patients deal with a shortage when it arises."

The report also recommended better communication lines in the drug supply chain, giving pharmacists more responsibilities, and implementing government policies that promote drug production. — Timothy Legault, Ottawa, Ont.

The main hazards of health technology

Radiation overdoses and other dosing errors during therapy top Plymouth Meeting, Pennsylvania-based nonprofit organization ECRI Institute's 2011 list of health technology hazards.

Errors with radiation administration — whether wrong dose, wrong site or wrong patient — can cause tissue and organ damage leading to morbidity, death, or the creation of "an avenue for disease recurrence through improper or incomplete treatment of a tumor," says the report, *Top 10 Health Technology Hazards for 2011* (www.ecri.org/Forms/Documents/Top_10_Health_Tech_Hazards_2011.pdf).

"The consequences of radiation dose errors are rarely immediately apparent, meaning that certain errors — such as those resulting from improper device setup or an inappropriate treatment plan — could lead to a patient being repeatedly exposed to an inappropriate dose before the error is noticed in a clinical review. And by that time, the damage has already been done (and can't be undone). For another, to increase the chances for success, treatment plans are becoming more complex, leaving a very narrow margin for error; thus, even a small setup error can have serious effects."

The list is crafted annually based on "the prevalence and severity of incidents reported to ECRI Institute by healthcare facilities nationwide; information found in the Institute's medical device problem reporting databases; and the judgment, analysis, and expertise of the organization's multidisciplinary staff," the Institute states in a press release (www.ecri.org/Press/Pages/Top-10-Health-Technology-Hazards-List-2011.aspx). It is intended as "a tool that healthcare facilities can use to prioritize their patient safety efforts."

The remainder of the top 10:

2. **Alarm hazards:** The modification of settings for physiologic monitoring systems and ventilators in an attempt to reduce "alarm overload"; staff desensitization to alarms; and improper relays to "ancillary notification systems (e.g., paging system, wireless phones), potentially leading to a failure to notify relevant staff," are identified as the primary causes of alarm-related mishaps. Among solutions are established protocols for alarm-system settings.
3. **Cross-contamination from flexible endoscopes:** Infections are typically caused by "failure to follow estab-

lished cleaning and disinfection/sterilization guidelines and instructions or with the use of damaged or malfunctioning equipment." The solution? Develop, follow and periodically review reprocessing protocols.

4. **The high radiation dose of CT scans:** Such doses are estimated to cause 29 000 cases of cancer in the United States annually, the report states. Among recommendations to reduce the risk to patients is a call to "educate referring physicians regarding ordering the most appropriate diagnostic studies. Unnecessary imaging means unnecessary radiation dose, so it is important that the potential benefits of a CT study (or any radiology study) outweigh the radiation risk." The report urges facilities to "monitor and audit radiation levels used in routine CT exams. Seek expert assistance (e.g., from a medical physicist) in determining appropriate parameters to monitor."
5. **Data loss, system incompatibilities, and other health IT complications:** Ineffective convergence can adversely affect patient care in a wide variety of ways. It can, for example, lead to data being lost (e.g., overwritten, unsuccessfully transmitted) or being associated with the wrong patient, which in turn can lead to misdiagnosis, inappropriate treatment, or the need for repeat testing," the report states, urging better planning and management of health information technology initiatives.
6. **Luer misconnections:** The continuing incidence of tubing and catheter misconnections to the wrong medical device indicate a need for such policies as the periodic training of staff, a prohibition on the use of adapters within a hospital and purchasing policies that favour products that incorporate misconnection safeguards.
7. **Oversedation during use of PCA infusion pumps:** Less frequent use of patient-controlled analgesic pumps, improved monitoring and regular clinician review of patients on pumps is recommended to reduce the incidence of oversedation.
8. **Needlesticks and other sharps injuries:** The frequency with which clinicians continue to suffer injuries despite sharps programs "are a signal that additional attention is needed; it could be that clinicians are using poor technique, that the safety devices being used should be replaced with more effective models, or that gaps exist in the facility's sharps safety program."
9. **Surgical fires:** Noting that approximately 600 surgical fires occur inside or on a patient in the US annually, largely as a consequence of errors associated with oxygen administration and accumulation, the report urges the development of institutional surgical fire prevention and management programs and greater familiarity with clinical recommendations on oxygen delivery.
10. **Defibrillator failures in emergency resuscitation attempts:** Most often a function of battery failures, the report urges that clinicians check devices daily and follow recommended maintenance guidelines.

— Timothy Legault, Ottawa, Ont.

New association hopes to become the voice of Canadian patients

Although patient-centred care is becoming all the rage in Canadian health care, there's nothing in the way of a national voice for patients.

But after nearly four formative years, a Toronto-based group hopes to fill that void by officially launching itself as The Patients' Association of Canada, a patient-led and patient-governed charitable organization that can advocate on behalf of patients on a level with that of existing national associations of doctors and nurses.

The planned Feb. 15 official launch is the prelude to the development of a national platform that presents patient's concerns and needs to the country's decision-makers, says Sholom Glouberman, cofounder of the association and philosopher in residence at the Baycrest Centre for Geriatric Care in Toronto, Ontario.

The organization hopes to evolve into a broad umbrella organization that speaks for patients and bring systemic change to Canadian health care, Glouberman adds. "We not interested in getting resources for particular diseases. We're interested more in the structure of the system and ways in which the patient voice can be stronger." To that end, the association hopes to develop educational programs aimed at helping health care administrators find means of assimilating the patient voice into their decision-making processes, such as including patients on governing boards and committees.

The embryonic organization has received a grant from the Canadian Health Research Foundation and has applied for another from the Ontario Trillium Foundation. Outside of that, it's funded entirely from donations and pledges, and currently has no paid staff but that may change as a result of a membership drive and a marketing push slated to coincide with the February launch. "We're not getting any money from drug companies," Glouberman stresses.

The association currently has a membership of about 130 and hopes to expand that tally to 3000 by year's end.

— Timothy Legault, Ottawa, Ont.

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