Government prescribing errors

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In the past few years, governments across Canada have tried desperately to remedy errors made in the 1990s when they prescribed inadequate numbers of training positions for physicians. Unfortunately, the support these governments are finally providing to increase medical school enrolments will take several years to take effect, leaving millions of Canadians without timely access to services they need today. To address this challenge some provinces have decided that medical regulatory and licensing authorities must offer faster tracks to licensure for international medical graduates (IMGs). They are also legislating expanded scopes of practice for other health professionals, hoping these individuals will provide services traditionally offered by physicians. These high-risk decisions could compromise patients in ways that would make past government errors seem trivial.

Physicians from other countries should be welcomed as part of the practising physician community in Canada. But governments and regulatory authorities must also ensure that the standards required to practise medicine in Canada are being maintained across the board. Canadian medical graduates must complete rigorous training and frequent evaluation of their clinical competencies before they are licensed and certified; IMGs should be expected to provide evidence of similar training and evaluation. Canada's medical schools, regulatory and licensing authorities, and certifying Colleges must do everything possible to accelerate processes for training, evaluating, licensing, and certifying IMGs. It might make sense for physicians who have completed accredited medical school and residency programs similar to Canada's to be approved more quickly than physicians from countries where the education, training, and health systems are quite different from ours, but it is vitally important to maintain standards for patient safety. To overly accelerate this process because of a current shortage of doctors might trade what appear to be short-term gains for longer-term problems.

Prescribing roles

Health professionals such as nurses and pharmacists are now being given the right to provide services that cross over with physicians' scope of practice. While research by Starfield and others has shown the value of interprofessional teams, the most important factor in better population health outcomes is access to personal family physicians—skilled medical doctors to provide and coordinate medical care on an ongoing basis.[1] While others on the team can and should participate in providing the full spectrum of health care services for patients, it would be a serious error if our system were to support them as substitutes for family doctors.

Almost all definitions of the term *prescribing* in health care recognize it as an order by a physician authorizing a pharmacist to supply a specific medication for a patient. Today, increasing numbers of nonphysicians, in particular nurses and pharmacists, are being granted the right to "prescribe." This will be of value only if those given this right have successfully completed specific accredited training and if the situations and types of medications they may recommend are limited and clearly defined. Prescribing requires the ability to make a medical diagnosis. Like many activities carried out by highly trained individuals, formulating medical diagnoses and prescribing treatments can seem to be relatively simple tasks. In fact, these are the most complex and important competencies that physicians develop, requiring every bit of the 6 to 10 years of medical education and training each doctor must complete. There is no shortcut to developing these skills.

Balancing act

In Canada, Schedule I medications require prescriptions, which, until recently, has meant that the expertise of a medical doctor is needed for such medications to be dispensed. Canadian pharmacy professors Dobson, Taylor, and Lynd[2] recommend that pharmacists should focus on being responsible for Schedule II drugs (available in pharmacy dispensaries without prescriptions) and leave the prescribing of Schedule I medicines to physicians who are educated and trained to deal with this level of patient care. Improving protocols to allow timely prescription renewals by pharmacists and increasing the numbers of medications available on Schedule II would be preferable to opening up the more complex prescribing of Schedule I drugs to nonphysicians.

While it is appropriate for governments to do all they can to ensure timely access to care for the people they serve, it is an error for them to be overly prescriptive with how physicians are licensed or who should carry out physicians' roles. Canadians deserve better treatment.

Cet article se trouve aussi en français à la **page 1343.**

References

1. Starfield B. Is primary care essential? *Lancet* 1994;344(8930):1129-33.
2. Dobson R, Taylor JG, Lynd LD. Are we ready for prescriptive authority? Lessons from the self-care example. *Can Pharm J* 2004;137(9):38-9.