PROFESSIONAL DEVELOPMENT

Lifelong medical licences may end in 5 years

Mandatory revalidation of medical licences will likely be introduced across Canada within 5 years in response to the demands for improved patient safety, regulatory officials say.

"It's coming. It's just a question of how it's going to be done and when. There's a tremendous will to do it," says Dr. Bernard Marlow, director of CPD/CME (continuing professional development / continuing medical education) at the College of Family Physicians of Canada (CFPC).

About a dozen nations and 37 US states have already moved to implement revalidation. It's clear there's an increased societal "expectation" that doctors regularly demonstrate fitness to practice, says Dr. Bob Burns, president of the Federation of Medical Regulatory Authorities of Canada (FMRAC). "And as a self-regulating profession, we have a professional obligation to demonstrate continuing competence."

It's equally apparent that if professional organizations fail to step up to the plate, provincial governments will fill the void, says Royal College of Physicians and Surgeons of Canada (RCPSC) Director of Professional Development, Dr. Craig Campbell.

A revalidation bill has already been introduced in Manitoba but died on the order paper, while several other provinces, including Ontario, Saskatchewan and BC are contemplating regulation.

Revalidation is expected to be high on the agenda of this summer's intergovernmental health ministers meeting, fuelled by the 2004 *CMAJ* study by Ross Baker, Peter Norton, et al. (170[11]: 1678-86) and the *Health Care in Canada 2004* report by the Canadian Institute for Health Information. The latter indicated as many as 23 750 deaths, 1.1 million added days in hospital and $750 million in spending could be annually attributable to medical errors by doctors, hospitals and pharmacists.

The validity of linking revalidation to ongoing CME was the focus of a special educational session of the annual FMRAC meeting in Saskatoon. Although no consensus was reached, "we have to begin to connect the dots," Burns says.

Most models of revalidation propose some measure of ongoing CME, as well as some means of periodic practice review, such as the Physician Achievement Review (PAR) program adopted in Alberta and Nova Scotia, wherein all doctors are assessed every 5 years.

But PAR is aimed at quality assessment rather than summative measurement of whether a physician is competent, Burns adds. "That requires a different sort of tool, like testing."

It's arguable whether CPD/CME alone provides a basis for revalidation, Burns notes. "The link between CME and actual performance is tenuous at best."

"It's a bit of stretch" to assert that CME necessarily changes performance and practice, Campbell adds.

Nevertheless, the colleges want their maintenance of certification programs (for continued membership) to be including in any revalidation schemes. About 50% of FPs belong to the CFPC, while an estimated 80% of specialists belong to the RCPSC.

Implementing revalidation will also require overcoming several systemic barriers, argues CMA President Dr. Sunil Patel. Those include providing the money to conduct physician reviews, bolster CPD/CME and providing remedial training for doctors who fail to make the grade.

Art Explosion

"It makes sense that in a rapidly evolving world, where standards have to be maintained, certain types of revalidation are necessary [for example, for immigrating physicians]," Patel says. "But a wholesale revalidation process would require a tremendous amount of resources, both from the federal and provincial governments, and from the universities and the licensing author-

DOI:10.1503/cmaj.1041145

ities. It could cause a serious problem in the delivery of health care because you already are stretched to the limit in terms of human resources."

Another unresolved issue centres around portability. With each province having jurisdiction over licensing, 10 different systems may emerge, making it difficult for doctors to move between provinces, Burns notes. "Yet, the ideal, and the desire, is to have something that's consistent through all the provinces."

Marlow says achieving that objective will be altogether problematic.. "From the looks of it, we could have 10 different ways of re-licensure, and with different fees. It doesn't look like they're all going to embrace the same method." — *Wayne Kondro*, Ottawa

MEDICARE POLITICS

New "point man" for federal health negotiations

Newly appointed Health Minister Ujjal Dosanjh will be the behind-the-scenes point man for tough health care negotiations this summer before Prime Minister Paul Martin meets provincial premiers Sept. 13 to achieve what he calls "a fix for a generation."

Martin named Dosanjh to the Health portfolio July 20, when he unveiled his new cabinet following the June 28 election that reduced the Liberals to a minority government. Dosanjh, the former NDP premier of BC, is a lawyer and former human rights advocate who immigrated to Canada in 1968.

Immediately after being sworn in at Rideau Hall, Dosanjh sent a signal distancing himself from former health minister Pierre Pettigrew, who had appeared to favour opening the door to private delivery of health care services.

"We will work together to make sure we have a better health care system in Canada," Dosanjh told reporters. "I can tell you what we need to do is stem the tide of privatization in Canada and expand public delivery of health care."

As a former New Democrat, Dosanjh's appointment may have been intended to appease that party, which holds a critical 19 seats in the House of Commons. To pass legislation, the Liberals will need to build coalitions within the House.

Dosanjh's appointment "signifies that the federal government is if anything going to tilt left on the medicare issue," says Dr. Michael Rachlis, a Toronto-based health policy analyst and author of *Prescription for Excellence: How Innovation is Saving Canada's Health Care System*.

Canapress

Health Minister Ujjal Dosanjh: "We need to stem the tide of privatization."

That tilt is likely to send Dosanjh into direct conflict with at least a few of the premiers, scheduled to meet Martin in a televised meeting beginning Sept. 13. Martin's election promises — $3 billion over 2 years in unconditional health transfers, $4 billion over 5 years to cut waiting times, and $2 billion for a national home care program — are expected to rank high on the premiers' agenda.

Dosanjh is saddled with the role of carving out common ground before the September meeting. Already, he faces entrenched positions. Alberta Premier Ralph Klein has mused publicly about giving healthy people a tax break over those who are a drain on the health care system, of imposing changes in Alberta that may violate the Canada Health Act, or of opting out of any agreement the other provinces reach in September.

Many of the other premiers, notably Quebec's Jean Charest, are opposed to having any conditions attached to federal health dollars.

Fulfilling the Liberal election promises, especially on wait times, will be difficult within the limited time frame of a minority government, says Rachlis. "It's a challenge for Dosanjh, because I do not think the information about how to fix these problems is widespread enough for it to be implemented quickly."

Dosanjh has also echoed Martin's commitments to not only improve the medicare services that already exist, but to expand them — a jurisdictional challenge, since health care is delivered largely by the provinces.

The new minister pledged not to take a combative approach, hoping that his previous experience as a premier will help bridge differences.

"By getting tough you won't get anywhere," Dosanjh said after his first cabinet meeting. "You'll get somewhere by being cooperative, and our approach is to make sure that we work with the provinces." — *Laura Eggertson*, CMAJ

Minority government: Liberals won 135 of 308 federal seats, the Conservatives 99 seats, the Bloc Québécois 54, the NDP 19 and an independent candidate 1.

DOI:10.1503/cmaj.1041190