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STANDARDS, ACCREDITATION AND PROFICIENCY TESTING IN THE MANAGEMENT OF BLOOD AND BLOOD PRODUCTS IN HOSPITALS

There is a very wide range in the quality of programs for standards, accreditation and proficiency testing in the management of blood and blood products in Canadian hospitals, and there is no standardization among provinces. To examine the programs available and to stimulate interest in resolving the lack of standardization, the Canadian Blood Agency sponsored a meeting in June 1995, which was attended by interested parties from across Canada.

Representatives from Alberta, British Columbia, Manitoba and Ontario outlined their approaches. It was noted that expertise in inspection and accreditation is available across the country.

There are problems, however. Standards developed by the Canadian Society of Transfusion Medicine and the American Association of Blood Banks are readily available to all laboratories but are not always followed and are not agreed upon across the country. There has been a lack of accepted practice guidelines for most blood-product use. Rapid changes are occurring in transfusion knowledge, but training opportunities may be insufficient. Databases are scant. Only 20 large and medium-sized hospitals participate voluntarily in the Canadian Blood Agency's annual collection of records concerning the use of blood products. The only other good source of information on transfusion practice is the database maintained by the Association of Hemophilia Clinic Directors of Canada. Communication among organizations and jurisdictions is poorly developed, and there is a great deal of concern about safety and continuing surveillance of adverse reactions.

Representatives at the meeting agreed that standards require regular updating and that inspection must be performed by objective, outside reviewers. Serologic proficiency testing in the laboratory can no longer be the sole focus of evaluation. Utilization management, guidelines for the use of blood products, and risk management, including follow up of transfusion and evidence of education for all staff involved in transfusion, should now be mandatory issues in quality performance.

Although no definite solutions were found, a follow-up meeting was held in October 1995. At that time it was revealed that Health Canada is reviewing its role in licensing certain practices within hospitals and that the Canadian Council of Health Services Accreditation may help design a specific module for transfusion-laboratory accreditation. An Interprovincial Working Group on Transfusion has been started, and the Intersociety Council of Laboratory Medicine has expressed an interest in becoming involved. At a meeting of the Canadian Society of Transfusion Medicine, to be held in May 1996, all of the parties will have an opportunity to table proposals. These meetings have generated a considerable amount of momentum toward addressing deficiencies.

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SELLING GUIDELINES DOOR TO DOOR

Steven Lewis writes on the role of organizations in clinical practice

← For prescribing information see page 946

guidelines, and on the subsequent acceptance of guidelines by their users, in the article "Paradox, process and perception: the role of organizations in clinical practice guidelines development" (*Can Med Assoc J* 1995; 153: 1073–1077).

We have long been struck that those who educate, supervise and pay for the ultimate quantum of medicine (the physician–patient encounter), who should be interested in its efficiency, validity and appropriateness, have not been tempted to follow the lead of the pharmaceutical industry.

Our capitalist (not a pejorative term, by the way) partners in health care have long sent representatives door to door to "promote" new developments in drug therapy. The fact that the practice has persisted over the decades suggests that there is profit in it. Would it be too outrageous to imagine a roving group of paid "health care" representatives going door to door, and, in 15 minutes, with the aid of handy hand-outs, explaining scientifically the health benefits of whichever clinical practice guidelines were chosen as the product of the month?

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Received via e-mail

[The author responds:]

Drs. Brock and Gurekas advocate a best-practice-oriented effort that would parallel drug-industry detailing. There is evidence that such "academic detailing" can influence behaviour. Two large problems remain: detailing is expensive and time-consuming, and it is a case of treating the symptom instead of the cause.

Pharmaceutical companies spend about 20% of their revenues on marketing. In Canada this translates to more than $2 billion annually spent on marketing drugs to physicians, pharmacists and the public. By contrast, total Canadian expenditures on all forms of medical research — including pharmaceutical research — are about $1.4 billion. Ideally, we would market all good evidence-based research to the appropriate audiences. Of course, it is better to drain the swamp (i.e., to promote practice based on the best available research), but the immediate challenge is to fight off the alligators unleashed by the relentless drug-industry marketing juggernaut.

Given the stakes — the battle is for the concept and practice of medicine — it may be rational and even wise to spend huge sums counter-detailing, but this would be costly levelling. Drug companies spend more than $2 billion digging the hole, and public agencies spend another enormous sum to fill it in. The losers in this heroicly unconstructive battle are the citizens who ultimately pay for both.

There are, then, two objectives: developing a culture in which practitioners and at least some consumers seek out and assimilate valid knowledge, and equipping the targets of advertising with the tools to filter out the junk. Several medical groups and academic health science centres have taken prophylactic steps: they do not see the detailers, do not read their propaganda, control their access to students and instil critical appraisal skills in future practitioners. This still leaves thousands of physicians and the public vulnerable to sales pitches of varying quality and honesty.

The policy solution, which is heavy handed but effective, is to ban pharmaceutical and related advertising, just as we ban cigarette advertising from television. That will not happen; from a public-interest perspective, let us say that it should not. What is to be done?

One option is to set up an organization of high-quality, disinterested scientists and public representatives to vet drug advertising. The organization would certify that the advertisements meet standards of accuracy and balance and otherwise contribute to understanding without distortion. In time, providers and the public would learn to recognize the stamp of approval (say, a prominent logo), creating an incentive for the industry to clean up its act. Who knows — in time the good information may become recommended reading.

Alternatively, the industry could self-regulate and cease digging the figurative hole. Then, whatever funds we have to spend on marketing good evidence could achieve the admirable purposes Brock and Gurekas no doubt have in mind.

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VIOLENCE SELLS

The inside of *CMAJ*'s front cover and back cover are presumably the choice advertising spaces for the pharmaceutical industry and the most lucrative for the journal. In the July 1, 1995, issue, advertisements by Merck Frosst and Abbott demonstrate the value of images of violence in selling products, whether these products are movies or medicines. The first, for an antihypercholesterolemic agent, which also appeared in the Sept. 1 issue of *CMAJ* and in other publications, depicts a scorpion poised to strike. The message is: "An effective killer moves fast, gives no warning, and strikes before the victim expects it." "Killer" and "victim" are words that should be applied with caution, if at all, to animals and the food chain. The second advertisement consists mainly of a photograph of notorious US bank robbers Bonnie Parker and Clyde Barrow,

For prescribing information see page 958 →