Ainsi, un écart important se dessine entre le site http://penuriesdemedicaments.ca, qui recense en moyenne 81 % à 87 % du nombre total des interruptions d'approvisionnement, et la veille électronique du grossiste, qui ne mentionne sur www.vendredipm.ca que 42 % à 48 % des ruptures de stock totales.

En septembre 2012, Bhat et coll.[3] ont calculé, dans une unité de soins intensifs d'un centre hospitalier universitaire de la région de Boston, un délai médian de huit mois entre la publication d'une rupture de stock d'un médicament sur le site de l'American Society of Health-System Pharmacists et la diminution de plus de 50 % de la disponibilité mensuelle habituelle des doses, la période d'observation avait débuté six mois avant la déclaration et a été poursuivie durant les douze mois qui ont suivi la déclaration. Les auteurs soulignent qu'il existe plusieurs facteurs pouvant expliquer les délais entre l'annonce d'une rupture de la continuité des livraisons et l'apparition du manque dans un établissement donné ou encore les différences entre le nombre de ruptures de stocks déclarées par différentes sources de données, l'un de ces facteurs étant les réserves dont disposent les grossistes ainsi que chaque établissement. De plus, dans une enquête menée auprès des professionnels de la santé des cinq centres hospitaliers universitaires du Québec[4], 64 % des pharmaciens (88/137) ont considéré que « la pénurie de médicaments a été vécue plus facilement grâce à la mise en ligne de l'état de la situation sur le site de vendredipm.ca ».

Nous pensons qu'un site unique canadien (p. ex. http://penuriesdemedicaments.ca) serait utile au soutien des cliniciens, comme le souligne le rapport du comité permanent sur la santé de la Chambre des communes et du groupe de travail de l'Ordre des pharmaciens du Québec[5-7]. Pour être utile, le site devrait également être complet, c'est-à-dire recenser un nombre maximal de ruptures d'approvisionnement et intégrer certaines des fonctionnalités retrouvées sur www.vendredipm.ca, telles que la dénomination commune, le nombre de produits similaires disponibles au Canada et le lien vers des fiches de soutien clinique.

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A Year in the Life of a Resident

One of my favourite quotations about change is a statement by Harold Wilson, former prime minister of the United Kingdom: "He who rejects change is the architect of decay." Change is frightening and uncomfortable, but it is a necessity of life. Without change, we experience very little; we don't learn and we don't grow.

As fourth-year pharmacy students, my classmates and I were thrown into non-negotiable change—we were graduating. I knew I wanted to work in the hospital setting, but I didn't know where I wanted to practise. Thus, I opted to do a residency with the Winnipeg Regional Health Authority Pharmacy Program. I assumed that the program would be easy. It would involve work, of course, but I had just spent 4 years in an intense university program, so I was sure I could handle it. School had equipped me with the knowledge and skills a pharmacist needs to practise. After all, I passed the PEBCs,* didn't I?

Within 2 weeks of starting my residency, however, I felt that university had let me down. Methods for time management, research, and patient care that I had successfully relied on in school failed me miserably in the "real world". I needed to develop my practical skills and to learn how to cope with the emotional side of patient care:

> I did not use an appropriate systematic approach [to the drug info question] and found myself buried in information.—June monthly residency reflection

> I was overwhelmed not only by the challenge of caring for a patient with [leukemia] but also by the fact that he was only 2 years older than I am … I did not have the right to be his care provider.—July monthly reflection

As the year went on, I began to change. It wasn't long before I was referring to myself as a "pharmacist" rather than a "resident", and I found that I was contributing more to bedside rounds. Yet it was still challenging to change patient care teams each month, constantly having to establish credibility in a short period of time. On occasion, I also witnessed disregard for patients' privacy and emotions, as well as dysfunctional teams

*PEBCs = examinations of the Pharmacy Examining Board of Canada.

whose members fought more often than they worked together. These experiences strengthened my resolve to build my practice the way I wanted it to be. They also reminded me that my patients are people and my interactions with them are more than just tasks to be completed before the end of the day.

My exposure to numerous preceptors was influential on how I viewed not only my personal practice but also pharmacy practice as a whole. They prepared me to be a leader, regardless of my work environment or position:

> Leadership … is being confident in your abilities, knowledge and skills to shape your practice and the practice of the profession. It is about … being proactive in your approach to patient care … [and] setting the practice expectations that will have the best impact on patients.—April monthly reflection

As a whole, a residency program is best described by the cliché of the roller coaster ride: you're thrown forward into new practice areas at breakneck speeds, twisted and pulled in every direction with the multiple projects, discussions, presentations, and forms that must be completed, on top of patient care. You're flipped upside down when you realize that processes that worked for you as a student aren't good enough in real-life practice, and life flashes before your eyes while you have very little sense of what is going on in the world around you. Yet, like every good amusement park ride, no matter how terrifying it is, the residency year always ends too quickly and you realize after it's over that you just want to hop back on. Was my year challenging? Yes. But was it worth it? More than words can say.

I've now been in my workplace for 7 months and have seen the positive effect that my residency training has had on me. Naturally, I still experienced the culture shock of working in a new area, and the learning curve has been steep. But I knew my residency training had been worth it when, on the second day of my clinical training, I felt completely at ease on the ward and on rounds despite being new to the service area.

Would I have had such an easy transition without a residency? I don't think so. It would have taken me much longer to find my professional identity without the exposure I had during the residency year. I'm very grateful for the residency experience and for all of the preceptors who gave up their time to coach and guide me. All I can say now is, "Change: Bring it on!"

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Competing interests: Ashley Walus is the Manitoba representative on the CSHP 2015 Branch Champions subcommittee.

Optimal Warfarin Management Can Be Achieved in All Practice Settings

We read with interest the Point Counterpoint column in the September–October 2012 issue of the *Canadian Journal of Hospital Pharmacy*. Kertland[1] and Tejani[2] highlighted many important issues in their debate about whether new oral anticoagulants should replace warfarin for prophylaxis of thromboembolism in Canadians with atrial fibrillation.

We would like to clarify one point regarding the review by the Canadian Agency for Drugs and Technologies in Health (CADTH) on the optimal use of warfarin. CADTH did recommend a well-coordinated, structured approach to warfarin management,[3] but it did not recommend that care be "dedicated to anticoagulation therapy", as stated by Kertland.[1]

The best available evidence is unclear as to whether specialized anticoagulation clinics result in improved outcomes for patients. What does matter is a structured approach, including a clear plan for patient follow-up, use of a validated dosing tool, ongoing patient education, and involvement of caregivers and other health professionals. This type of care can take place in a specialized anticoagulation clinic, a family doctor's or specialist's office, or other care settings.

CADTH continues to focus on prevention of stroke among patients with atrial fibrillation. A systematic review and network meta-analysis, comparing the new oral anticoagulants with warfarin, was completed in April 2012.[4] The best available evidence to date suggests that the benefit of the new oral anticoagulants is small, their long-term safety is unknown, and the new drugs are more expensive even when warfarin monitoring is taken into account.

Expert recommendations based on the review were made in June 2012, with warfarin being recommended as first-line therapy for patients with nonvalvular atrial fibrillation.[5]

An extension of this review, which will include antiplatelet agents such as acetylsalicylic acid and clopidogrel, will be available in spring 2013. All CADTH reports are freely available at the organization's website (www.cadth.ca/anticoagulants), which readers may visit for additional information.

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