

Five Years of Experience with the Residency Matching Service

In 2003, the Canadian Hospital Pharmacy Residency Board (CHPRB) introduced a national residency matching service in an effort to provide a single process that was efficient, effective, and equitable for all involved. CHPRB-accredited and accreditation-pending residency programs in pharmacy practice are required to participate in the CHPRB Residency Matching Service. Similar matching services are used in other professions, including medicine, dentistry, accounting, and law. In this report I present data for the first 5 years of experience with the CHPRB Residency Matching Service.

In a matching service, applicants apply directly to the residency programs they are interested in, and the applicants and program representatives interview and evaluate each other independent of the matching service. When all of the interviews are complete, each applicant submits a rank-order list, indicating the programs from which he or she is prepared to accept an offer, in order of the applicant's preference. Similarly, each program completes a rank-order list specifying the applicants to whom it is prepared to offer a position, in order of the program's preference. The matching process simulates the making of offers by programs and the acceptance or rejection of offers by applicants based on the rank-order lists submitted.

The CHPRB is responsible for establishing the policies of the Residency Matching Service and for monitoring its implementation. Since 2003, more than 500 candidates have sought residency positions through the matching service (Table 1).

Table 1. Data for Canadian Hospital Pharmacy Matching Service

Variable	2003	2004	2005	2006	2007
Programs registered	28	29	30	31	29
Positions available	61	60	64	71	72
Registered candidates	84	80	92	128	151
Matched candidates	59	51	62	69	72

These data indicate that an increasing number of residency positions are available in Canada; the number of candidates applying for residencies is also increasing.

The CHPRB plans to continue providing an orderly and transparent matching process for residency applicants and programs nationally.

The CHPRB would like to acknowledge the strong support of CSHP, particularly Executive Director Myrella Roy,

who helped in the development of the Residency Matching Service, and Gloria Day, who has assisted in running the service since its inception.

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Bedside Best Bang for Buck!

We read with interest the article by Joan Marshman and others¹ about medication errors in Ontario acute care hospitals. Information like this is useful in increasing awareness of, and advancing, patient safety. As the authors point out, their conclusions are similar to those generated by other data, and the rate of errors that could have caused harm was low (less than 3%). We also note that the data for this trial were collected by pharmacists. Although this might have been necessary for the purposes of the trial, we hope that pharmacists would not be used for ongoing programs.

We also read with interest the article by Barbara Farrell and others² which hints at another and, we would argue, preferable way to improve patient safety: having pharmacists provide direct patient care to reduce unnecessary drug usage. A recent study by Bond and others³ supports this approach. These authors showed that a number of clinical pharmacist activities provided the best evidence for reductions in adverse drug reactions in patients who had been admitted to hospital.

It is important in aligning resources that we assess the causes and the scope of drug-related mortality. As reported by the Audit Commission in the United Kingdom, even if we prevented every death from a medication error, we would reduce drug-related mortality related to adverse reactions and medication errors by less than 10%.⁴ Surveillance programs that simply identify a potential problem (few of which will pose a risk to the patient) would seem to have a lower priority than programs such as those as described by Farrell and Bond and their coauthors.

Technological solutions are important tools in improving patient safety, but pharmacists and pharmacy departments would do well to remember that ultimately human intelligence and care are what is needed on an ongoing basis or, as Dr Luis Gonzales has stated, "We must come out from behind the counters and computer terminals and stand at the bedside of patients, who are dying without our needed expertise".⁵