CMA's Presentation to the Senate Standing Committee on Social Affairs, Science and Technology

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Study on Canada's pandemic preparedness

Presented by:

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ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

Check against delivery

A healthy population and a vibrant medical profession
Une population en santé et une profession médicale dynamique

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 73,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 51 national medical organizations.

ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

Good morning.

We are very pleased to appear on behalf of the Canadian Medical Association before this Senate committee as part of your study of pandemic preparedness and the H1N1 experience in Canada.

Earlier this year, the CMA collaborated with the College of Family Physicians of Canada and the National Specialty Society of Community Medicine to present a picture of lessons learned from the frontlines of the pandemic.

Together we represent over 80,000 physicians engaged in all aspects of Canada's health care and public health systems.

The report includes recommendations that, if acted upon, would help ensure that a strong foundation is in place to protect Canadians from future health threats.

As President of the CMA and a practising physician, I am here to present my association's point of view.

Physicians have a unique and critical role to play during public health emergencies. Many people turn to their physician first for information and counseling. Physicians are the first line of defence.

This was certainly the case during the H1N1 pandemic. This role was intensified by the confusion created by the great variation in mass vaccination programs across the country.

Many physicians felt that their urgent need for clinically relevant information was not well recognized by the Public Health Agency of Canada, the Public Health Network and, in some cases, provincial, territorial, regional or local levels.

The lack of national leadership on clinical guidance led to delays and the proliferation of differing guidelines across the country.

Standard clinical guidance, adaptable to local circumstances, is the norm in medical practice. Nationally disseminated clinical practice guidelines on vaccine sequencing, use of anti-virals and hospital treatment would have created consistent clinical responses across the country.

We recommend that the Public Health Network seek advanced pan-Canadian commitment to a harmonized and singular national response to clinical practice guidelines, including mass vaccination programs, during times of potential public health crisis.

The CMA also recommends that the Public Health Agency of Canada work closely with the medical specialty societies, as it did successfully with Society for Obstetrics and Gynecology in the development of clinical guidance for the care and treatment of pregnant women.

Many physicians and public health workers have complained that multiple levels of government provided similar, but not identical, advice. The differences led to skepticism among both physicians and the public and the inundation of messages led to overload.

In situations where scientific evidence is rapidly changing, as was the case during the H1N1 pandemic, we need a national communication strategy, targeted to physicians that can build on communication processes already in place.

It is especially important during a health emergency to build on existing systems that work well and can minimize the chances of conflicting messages.

It is also important that two-way lines of communication between public health and primary care are established. Embedding primary care expertise into public health planning at all levels would help us avoid problems and improve our response.

We believe that the H1N1 immunization process did not adequately engage physicians in planning and delivery.

A number of difficulties, such as the impact of bulk packaging, the sequencing of patients and the logistics of inventory management, led to friction between front-line public health practitioners and family physicians.

These could have been avoided with strengthened consultation, interdependence and mutual understanding before the crisis.

A number of witnesses have noted the importance of surveillance. There is no doubt that greater use of electronic medical records – or EMRs – in primary care could have facilitated surveillance and communications.

Family practice clinics with EMRs were able to quickly identify high-risk patients, communicate with them to schedule vaccination appointments, and collect the required data for public health.

Another aspect of pandemic planning that cannot be ignored is the possibility that physicians themselves might fall ill.

Physicians have never hesitated to provide care to patients during times of crisis, but this obligation must be balanced by a reciprocal obligation of society to physicians.

Following the SARS outbreak, the CMA prepared *Caring in a Crisis*, a policy paper that addresses the need to take into account and plan for what would happen when health care providers become part of the statistics of those infected.

We urge the committee to consider this challenge in your deliberations.

My last point addresses the lack of surge capacity in Canada's health system.

To mount a response to H1N1, public health units pulled human resources from other programs and many critical services were delayed, suspended or cancelled altogether.

The resources of our critical care infrastructure were stretched to their limits in many hospitals and frontline health care providers were inundated with telephone calls and visits from the worried well and an increase in visits from those with flu symptoms.

If H1N1 had been the severe pandemic that was expected and for which Canada had been preparing, our health system would have been brought to its knees.

The CMA has been warning of the lack of surge capacity in our health system for over a decade.

Canada remains vulnerable to the risks presented by epidemics and pandemics. If we are to be prepared for the next emergency, a long-range plan to build our public health capacity and workforce and to address the lack of surge capacity in our health system must become a priority.

We therefore very much appreciate the review to Canada's response to the H1N1 pandemic that has been undertaken by this Committee, and we look forward to your report.

Thank you.