Title:
Canadian Disaster Preparedness (or the lack thereof).

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Conflicts
I have no financial or other conflicts of interest

It is no secret that Canada is not adequately prepared for a disaster with health care implications. It is also no secret that when disasters occur people go to their overcrowded, under resourced and exhausted Emergency Departments. Since there is no champion in Canada for health care disaster preparedness and given that in a disaster we (the emergency health care system) would have to pick up the pieces it should also be no secret that the topic of disaster preparedness is important, urgent and, ultimately, in the realm of Emergency Medicine.

Our Provincial and Federal governments labour under the illusion that Canadian hospitals, are prepared to handle the load a disaster would incur. Prior to H1N1, CAEP sent a letter to all the Ministers of Health in the Provinces and Territories offering our support in helping them prepare. In return CAEP received almost identical letters from each declining our support and stating that they are all ready. This despite the fact that none of the Federal or Provincial bodies have any real data as to their disaster preparedness in the health care sphere. The only published scientific data that does exist are studies that revealed preparedness deficiencies.[1,2,3,4]

If past experience is any guide, Emergency Departments are most likely going to be the first receivers in a disaster. Should this be a sudden dramatic event such as an explosion or a train crash, then obviously the issue of surge capacity in the emergency department will be sorely tested. It does not take a scientific review for us to know, as front-line emergency practitioners, that the surge capacity in our emergency departments is usually nil. As such,

we already have a tacit recognition that the majority of EDs would likely not be able to cope in the event of a disaster.

Of note the converse is also true. While the lack of surge capacity in the emergency department is in of itself a potential problem when preparing for disaster, it is probable that preparing for disasters, with its inherent breakdown of silos and improving of patient flow, would be useful in helping us to decompress our emergency departments.

The health care impact of a disaster can be mitigated against if proper steps are taken yet many of these steps have not been taken in Canada, particularly at the front lines of disaster response. Why is this? Primarily because health disaster planning is an orphan issue. Disaster planners do not understand health care and health care practitioners are not trained in disaster readiness. Politically, at the Federal level, the agenda of disaster preparedness falls between the Ministries of Public Safety and of Health, neither of them taking full ownership of the topic.

Another obstacle to national readiness is the Federal Provincial divide. The Federal government, sensitive to the Provincial mandate for health care, is wary of mandating any disaster standards but this does not justify the absolute lack of leadership at the Federal level on this topic. Despite a wealth of Canadian resources the Federal Government has been unable or unwilling to disseminate guidelines to Canadian hospitals or to provide common planning resources across the country. As a result each province is planning independently of the other and with unknown interoperability. Even a simple process such

as national cross-licensure of disaster first-receivers, allowing a physician from one province to respond in another during a declared disaster, has not been finalised despite years of bureaucratic effort.

In the absence of Canadian leadership in preparing the health care system for disasters the only question remaining is who should be responsible for this? Disasters, by their nature are a team sport usually requiring a multifaceted response that crosses the silos of specialty and subspecialty and that spans the range from general to intensive care. We, as emergency physicians, are the last of the intensive generalists. We interface with all aspects of the health care system, within and outside the hospital, and deal with all levels of medical acuity. There is no other physician group that has our expertise and is able to prepare cogent plans for a disaster in a health care facility. Public health, trauma care, infrastructure support – each of these and more are important but someone needs to take the lead. That someone is Emergency Medicine and, despite all the other pressing topics we deal with daily, there is urgency for us to address this issue now.

Populations abhor a leadership vacuum. In the absence of our stepping up to the plate other organizations with less understanding, less expertise and, to be frank, less accumulated wisdom over the years, are stepping into this void and the results are worrisome.

The CBRNE Research and Technology Initiative (CRTI), a branch of Defence Research and Development Canada, has already prepared a document- based on a U.S. model-outlining

standards for first receivers, namely us. This is a federal document already circulating in draft format, yet we were not involved in generating any of it. More so, the document is based on an outdated U.S. document and, while it contains some items of value, it refers to a health care system different from ours in structure and dramatically different from ours in capacity. Finally, in the present process of discussing the document with “stakeholders” (a process that initially involved almost no input from emergency medicine who were apparently not considered stakeholders of importance), it has been made eminently clear that the document will not be substantively changed despite concerns raised.

Another federal lead that is grappling with this issue is The Public Health Agency of Canada, which has attempted, at the cost of millions of dollars, to establish health emergency response teams. These “hospitals in a box” have been on the books for years and have even been trialed; however, they have not defined their role clearly, are not functional and pose the risk of giving us a false sense of safety when there is none. Similarly it is also of note that the National Emergency Stockpile System has not been substantively updated for years.

It is in this context that the Disaster Committee of CAEP and its partner organisation, the Centre for Excellence in Emergency Preparedness (CEEP) presented these facts to the previous Minister for Public Safety and were ignored. The Public Health Agency of Canada has been offered comprehensive peer reviewed resources for hospital preparedness and, while stating interest, has been unable to organise itself to disseminate those guidelines in print or in an educational venue. Accreditation Canada was also approached and offered

free tools to assess hospital disaster readiness yet declined to integrate these into their accreditation process. In 2010 the CSA Roundtable White Paper entitled "Voices From the H1N1 Pandemic Front Lines: A White Paper on How Canada Could Do Better Next Time." was released in Toronto at the World Disaster Management Conference. The paper again stressed the need for "a common baseline of preparedness at the grassroots level (e.g., among public health units, front-line healthcare workers and first responders) for training, readiness, processes and inter-operability – to ensure a nation-wide standard of care and an ability to provide mutual support to each other."[5] This paper has been effectively disregarded. (Note: the author of this paper was also a member of the CSA roundtable).

So, in summary, the risk of disasters is significant and our hospitals are unprepared to respond. Such preparedness efforts as are taking place are divorced from the reality of the front lines. Attempts to disseminate Canadian peer reviewed resources through existing channels have met with no success. Finally there is no leadership to provide national guidance on the issue. All this is even more galling in view of the existence of unique Canadian resources, resources that are repeatedly referenced across the world but get no play in Canada.

It is always easy to promote disaster preparedness after the tsunami, the E-coli outbreak or other disaster has occurred, the wisdom is in preparing before the event. CAEP and its partners need to put the issue of disaster preparedness on the front burner for both Provincial and Federal Governments. We need to actively lobby for the dissemination of existing common planning and readiness guidelines to hospitals across Canada. We need to

promote the routine use of objective tools to assess our hospital's (and Emergency Department's) readiness and make sure that those results are public – so as to avoid the possibility of claiming preparedness when none is there. And we need to do it now.

References

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