The College of Physicians and Surgeons of Ontario

January 30, 2017
Physicians and Health Emergencies
Online Survey Report and Analysis

Introduction:

The College's current Physicians and Health Emergencies policy is under review. As part of this review, a public consultation was undertaken on the current policy from September 21 to November 25, 2016. The purpose of this consultation was to obtain stakeholders' feedback to help ensure that any updates made to the policy reflect current practice issues, embody the values and duties of medical professionalism, and are consistent with the College's mandate to protect the public.

Invitations to participate in the consultation were circulated via email to all physician members of the College and key stakeholder organizations, as well as individuals who had previously indicated a desire to be informed of College consultations.

Feedback was collected via regular mail, email, an online discussion forum, and an online survey. In accordance with the College's posting guidelines, all feedback received through the consultation has been posted online.

This report summarizes the stakeholder feedback that was received through the online survey only.

Caveats:

Forty-four respondents started the survey (see *Table 1*). Of these, 2 respondents did not complete the survey but answered at least one substantive question; these are captured as partially complete surveys. The remaining 42 respondents completed the entire survey. The results reproduced in this report capture the responses for both complete and partially complete surveys.

Table 1: Survey Status

Summary of surveys received	N=44
Complete	42
	95%
Partially complete	2
	5%

The purpose of this online survey was to collect feedback from physicians, organizations, and the public regarding the current Physicians and Health Emergencies policy. Participation in the survey was voluntary and one of several ways in which feedback could be provided during the consultation period. As such, no attempt has been made to ensure that the sample is representative of the larger physician, organization or public populations, and no statistical analyses have been conducted.

The *quantitative* data is shown below and the number of respondents who answered each question is provided. The *qualitative* data captured below are a summary of the general themes or ideas conveyed through the open-ended feedback.

Due to rounding, numbers presented throughout this report may not add up precisely to the totals provided and percentages may not precisely reflect the absolute figures.

Respondent Profile:

All respondents indicated that they were completing the survey on behalf of themselves and zero organizations provided feedback through the online survey.

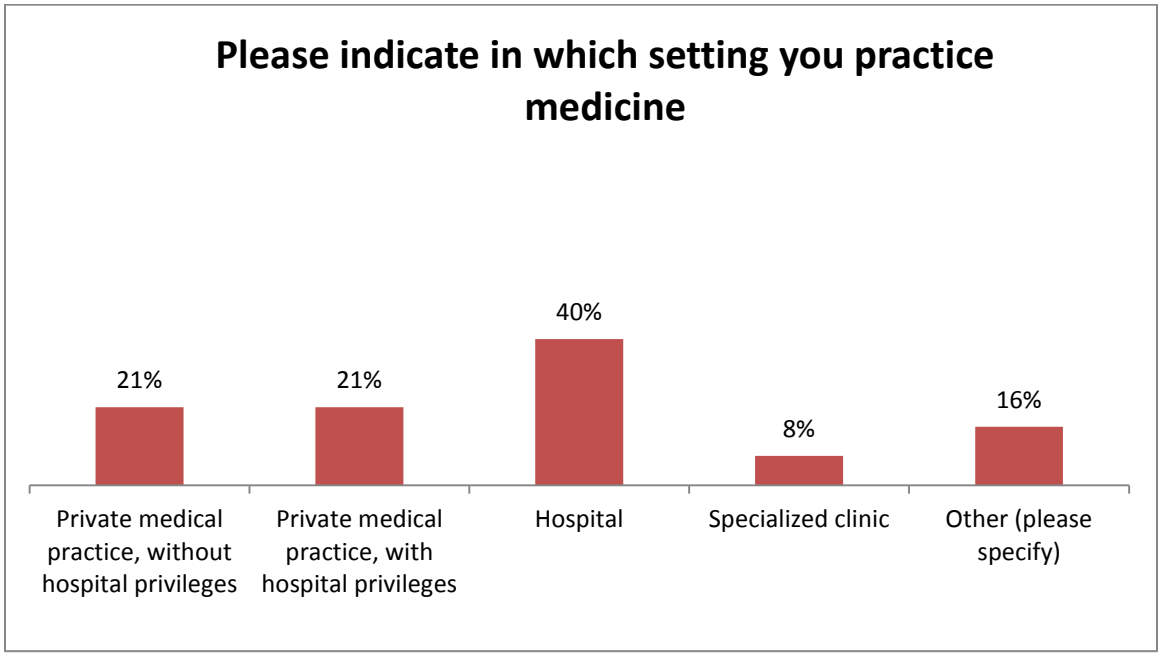
As shown in *Table 2* below, physicians made up the largest segment of respondents (n = 38, or 86%).

Table 2: Respondent Profile

Are you a....?	n=47
Physician	38
	86%
Medical Student	1
	2%
Member of the Public	4
	9%
Prefer not to say	1
	2%

Physician respondents were asked to indicate the setting in which they practiced medicine. Below *Figure 1* shows the distribution of responses received.

Figure 1: Physician Practice Setting



Physicians that responded in the "other" category indicated that they had:

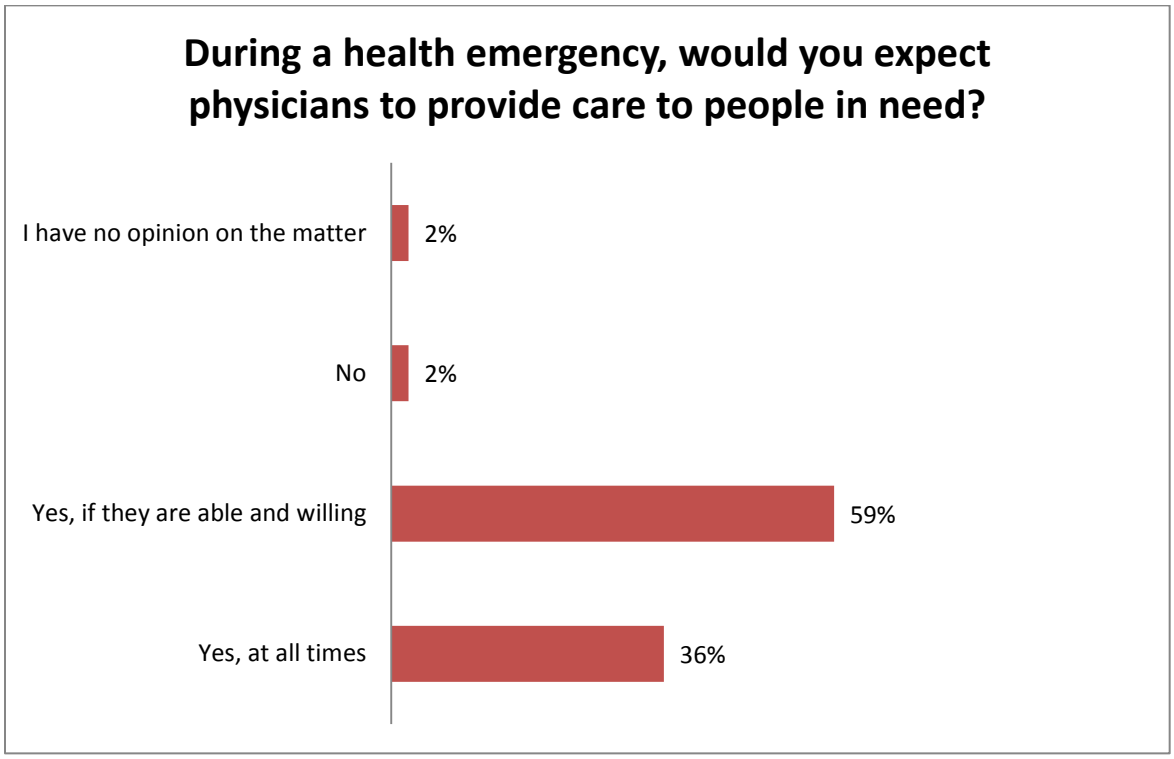
- Retired from private practice
- Practised medicine at a Community Health Centre
- Practised medicine in an Emergency Department

- Practised medicine for a Public Health agency
- Practised medicine as a Coroner

Q6. "During a health emergency, would you expect physicians to provide care to people in need?"

While the overwhelming majority (96%) of respondents indicated that they expect physicians to provide care in a health emergency, there were important differences within this majority. Sixteen respondents (36%) indicated that they expected physicians to provide care to people in need during a health emergency at all times. Twenty-six respondents (59%) indicated they expected physicians to provide care during a health emergency, but only if they are able and willing.

Figure 2: Expectations during a Health Emergency



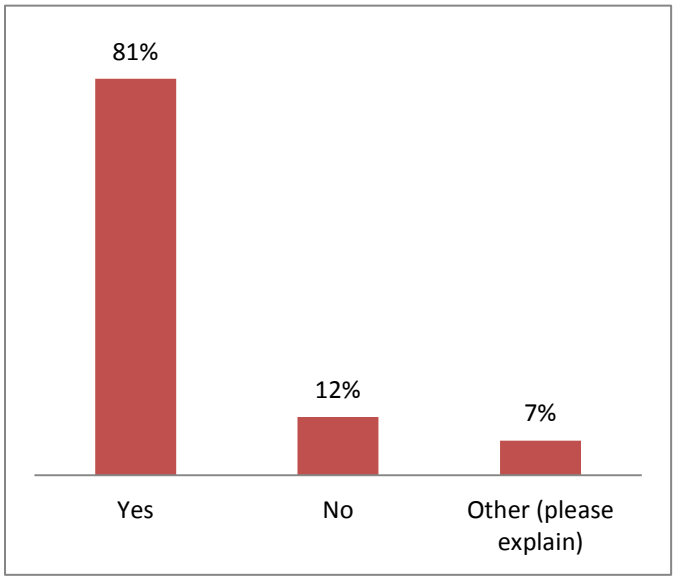
Two respondents added that they would expect physicians to provide care as long as they are not expected to put themselves in a situation of clear and present danger, and if they are suitably protected against infectious risk.

Definition of Health Emergency:

Respondents were asked a series of questions regarding the term 'health emergency'. The current policy does not have a stated definition of the term 'health emergency'. Instead of a stated definition, the current policy points to the following as an example for how 'health emergency' could be described: "an urgent and critical situation of a temporary nature that seriously endangers the lives, health and safety of the population"

Q7. "In your view, is this description of 'health emergency clear?"

Thirty-four respondents (81%) indicated that they thought that the description of 'health emergency' in the current policy is clear. Five respondents (12%) indicated it was not clear.



Base: n=42

The three respondents that indicated "other" noted that:

- It may be unknown at the time a health emergency happens whether the situation will be temporary or longer-term/permanent. This has implications for the use of 'health emergency' in the current policy. This is because the example in the current policy states "an urgent and critical situation of a temporary nature…"

- The description of 'health emergency' in the current policy is okay, but that it needs to be more specific to the type of threats that may be experienced

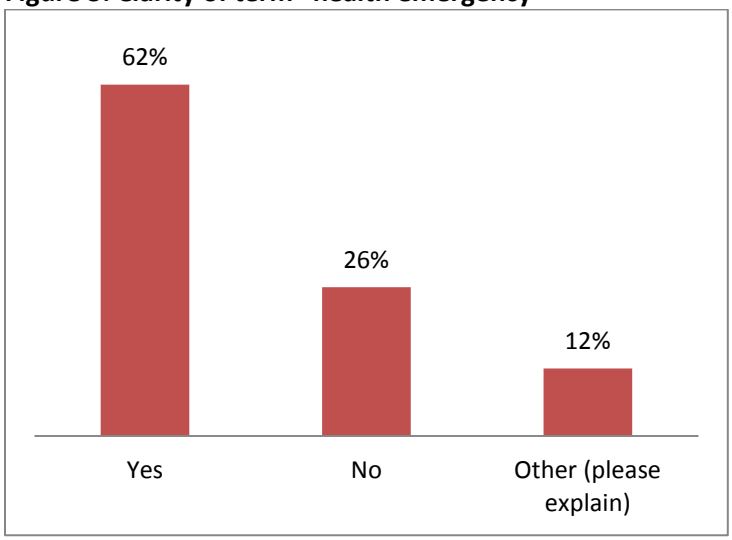
- The determination of whether a health emergency is happening should be made by a committee so that one is not declared for political reasons. Clarity around requirements for physicians to attend would be helpful, especially if the health emergency is located far from where the physician is.

Q8. "In your view, is the current use of the term 'health emergency' clear?"

This question was asked with the intention to gather information on whether the term 'health emergency' was clear without a description or definition in the next iteration of the policy. After analysing the responses gathered, it is clear that respondents were not able to distinguish between the question above and this question. Therefore the responses do not provide insight into whether the term 'health emergency' is clear enough without a stated definition.

Keeping this in mind, twenty-six respondents (62%) indicated that the term 'health emergency' was clear enough, while eleven respondents (26%) did not think it was clear enough.

Figure 3: Clarity of term "health emergency"



Base: n=42

Five respondents (12%) added the following:

- There needs to be clarification as to whether the condition that triggers a health emergency is to be "temporary in nature". There was concern over how physicians are to know at the time whether it is a temporary or permanent situation.
- Specific examples would help clarify what would be considered a 'health emergency' for this policy.
- The term is clear but not meaningful.
- Unsure on the differences between Q7 and Q8
- The policy could include a statement that a health emergency may be declared if community resources are overwhelmed by a situation that has arisen.

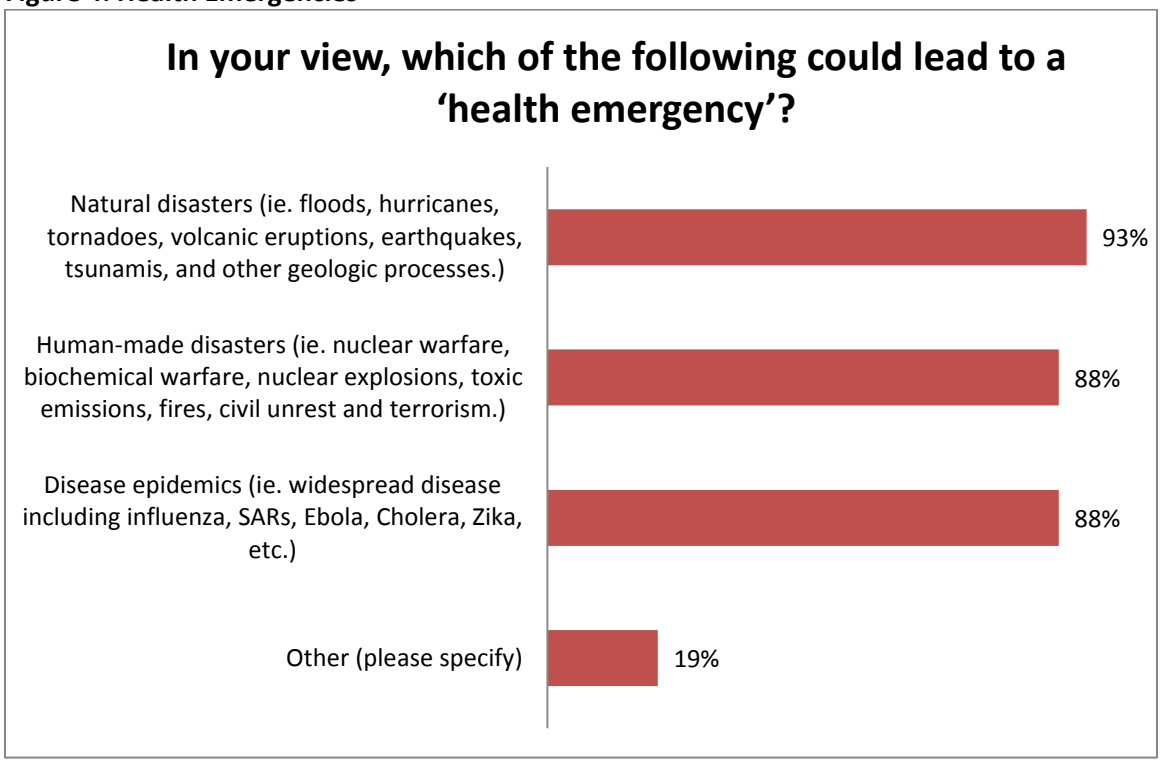
9. "Do you see value in adding a stated definition of 'health emergency' in the next iteration of this policy?"

Twenty-seven respondents (64%) indicated that they saw value in adding a stated definition of 'health emergency' to the next iteration of the policy. Fourteen respondents (33%) did not see value in adding a definition in the next iteration. One respondent noted that more examples in the definition would be valuable.

Q10. "In your view, which of the following could lead to a health emergency?"

Large majority of respondent agreed that natural disasters (n=39), human-made disasters (n=37) and disease epidemics (n=37) all have the potential to lead to a health emergency.

Figure 4: Health Emergencies



Eight respondents provided open-ended feedback. This is summarized below:

- Computer-terrorism which affects immediate access to health records, hospital functions, etc. could be considered a health emergency.
- The deaths currently seen related to fentanyl could be considered a health emergency. There would be a need to consider how to characterize this type of health emergency succinctly.
- All of the above should be included in examples provided with the definition.
- Humanitarian crises as a result of the above name situations. Or it may arise as a result of corrupt and ineffective governments, particularly in developing countries.
- Emerging disease outbreaks that have an element of scientific uncertainty. Examples would include the SARS and ZIKA outbreaks.
- Staff shortages were offered as an example of a health emergency. It is unclear if this would fit in the current use of the term 'health emergency' in the policy.
- Expertise and equipment available in smaller communities is noted to hinder the ability of a health emergency to be contained.

Q11. "Please provide any further comments that may assist us in improving the clarity of this definition."

Additional comments were provided by seven respondents, and are summarised below:

- Providing examples in the definition further conveys the intent of the policy
- There is a need to characterise widespread human behaviours that directly lead to harm (e.g. narcotic deaths, suicide in first nations youth)
- A clear list of situation (similar to what is presented in Question #9) as well as a mandate on who declares that a certain event is, or is not, a health emergency.
- Recognize that a more detailed list of what could be considered a health emergency will not cover emergencies that are not yet known.
- There is a need to separate the typical emergency conditions and their preparedness from the preparedness needed for unexpected health emergencies which cannot be foreseen.

Experience with the Policy:

A strong majority of respondents (n=32 or 86%) indicated that they had read the current *Physicians and Health Emergencies* policy (see *Table* 3).

Table 3: Read Policy

Have you read the current version of the Physicians and Health Emergencies policy?	n=37
Yes	32
	86%
No	5
	13.5%
Skipped	7
	16%

Opinions of the Current Policy:

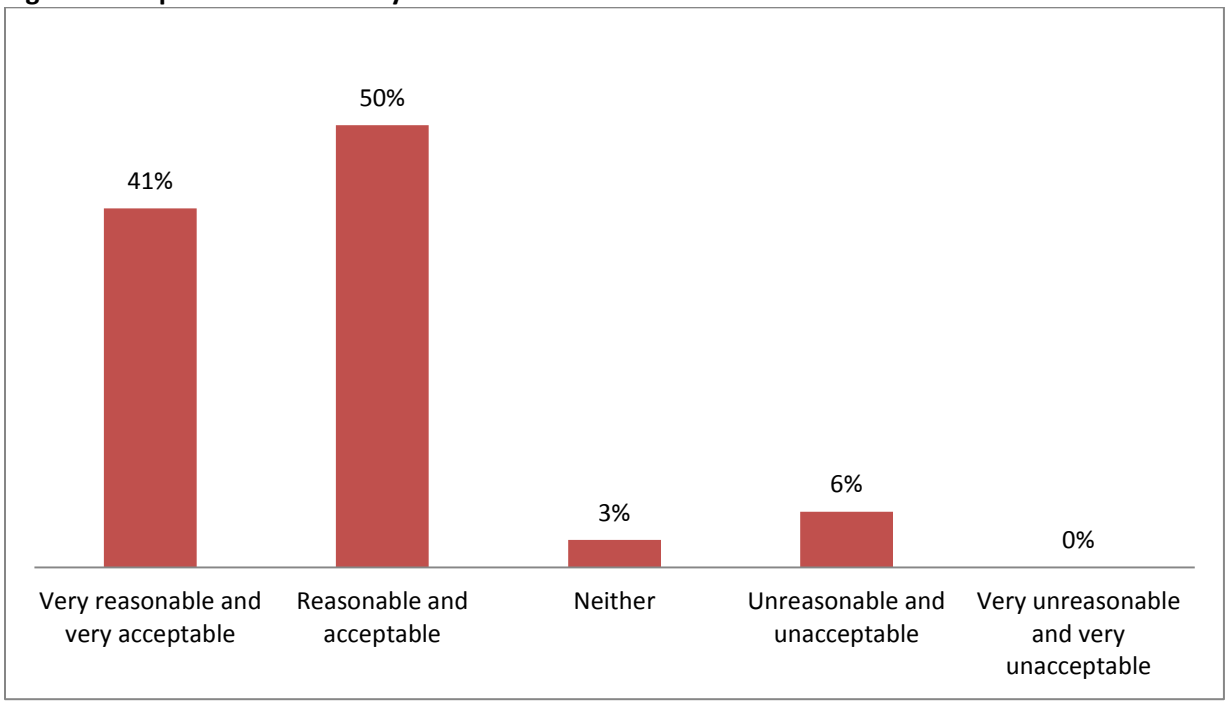
The following questions assess respondents' general opinions of the current policy. As such, the questions in this section were only posed to those respondents who indicated that they had read the current policy (n=32, or 86% of total survey respondents).

Q13. "In your view, is the current policy position regarding scope of practice during a health emergency reasonable and acceptable?"

A large majority of the respondents (n=29, 91%) indicated that the policy position regarding scope of practice during a health emergency was reasonable or very reasonable.

Those who responded that the policy's position regarding scope of practice during a health emergency was unreasonable and unacceptable (n=2) were asked 2 subsequent questions to gather more information on why they thought it was unreasonable and unacceptable. These respondents did not provide a clear indication of why they felt the policy's position was unreasonable and unacceptable. Instead they responded with conflicting positions; one responded that the policy's position on scope of practice was too restrictive while the other indicated that it was not too restrictive.

Figure 5: Scope of Practice Policy Position

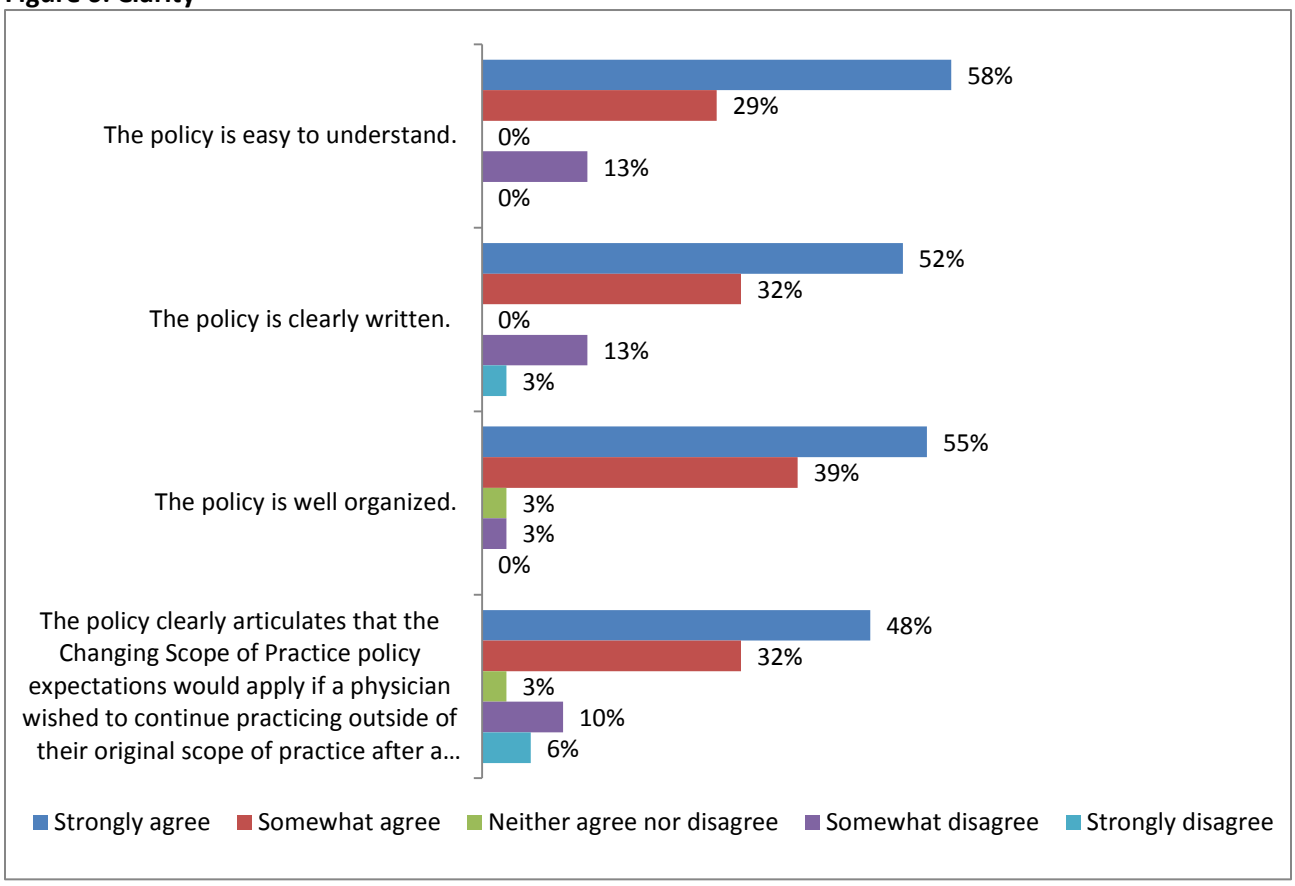


Assessments of the Policy:

Q16. "We'd like to understand whether the policy as a whole is clear. Please indicate whether you agree or disagree with each of the following statements regarding the clarity of the policy."

As reported in *Figure 6* below, most respondents agreed[1] that the current policy is easy to understand (87%), is clearly written (84), and is well organized (94%). Most respondents also agreed that the policy clearly articulates the Changing Scope of Practice policy expectations would apply if a physician wished to continue practicing outside of their original scope of practice after a health emergency has ended (80%).

Figure 6: Clarity



Base: n=31

Q17. "How can we improve the policy's clarity?"

Open ended feedback regarding the clarity of the policy was received from 11 respondents. Respondents suggested that the policy could be clarified by:

- Providing guidance on what constitutes the end of the emergency and the process for handing over care to the more qualified health care professional who is acting within their scope of practice.

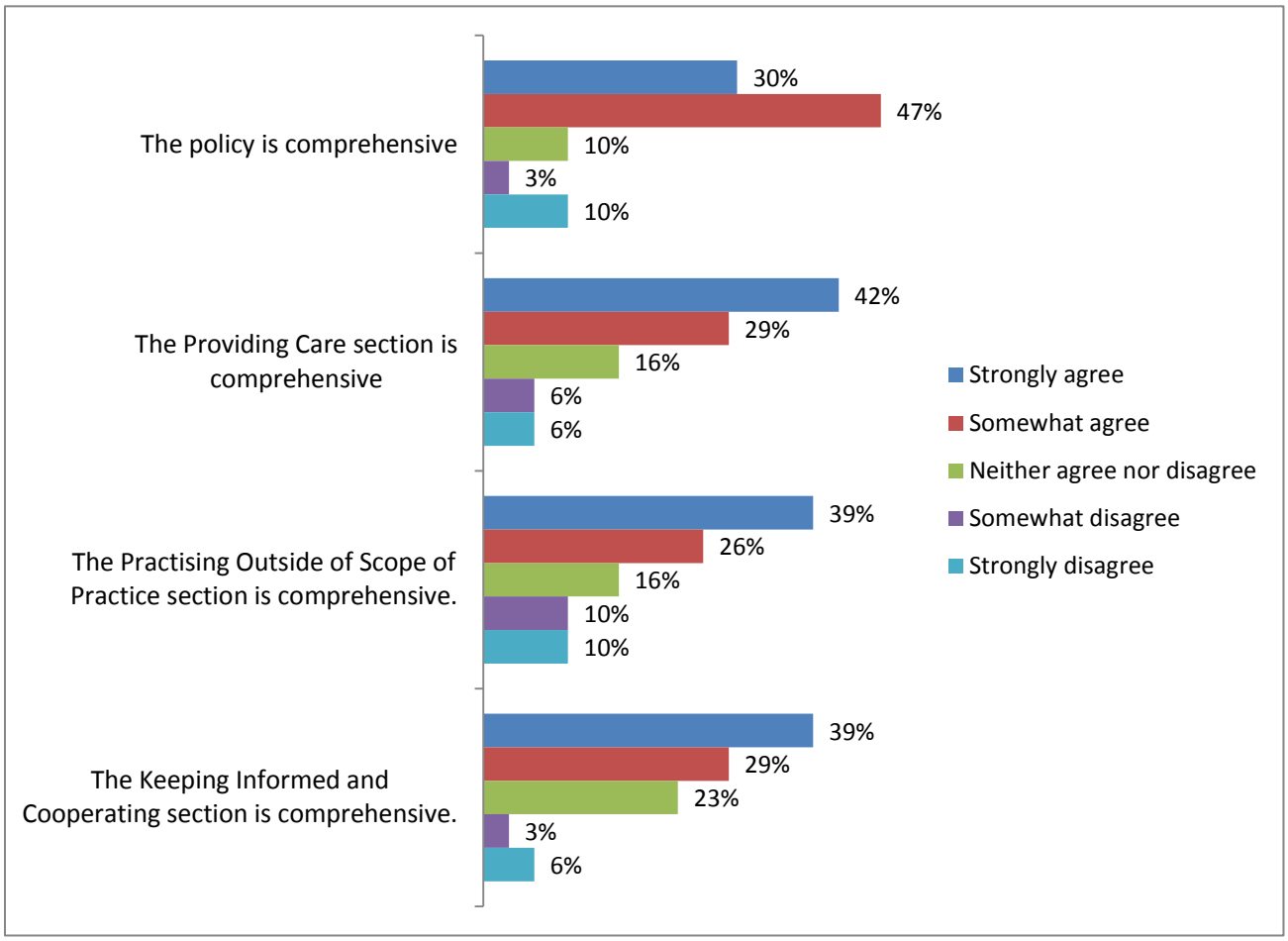
[1] Throughout this report the number of respondents reported to have "agreed" include both those who "strongly agreed" and those who "somewhat agreed". Complete data are reported in the figures following each question.

- Providing clarity on the changing scope of practice expectations (Note: no suggestions were made on what parts are unclear or how to address this respondents concerns around lack of clarity).
- A stronger statement would be made if the policy referred to penalties for those who fail to follow the Changing Scope of Practice policy expectations.
- The current policy reads as an example of what the altruistic physician would rather than providing specific direction as to what the College expects all physicians to do. It is too permissive in facilitating physicians “walking away” from a health emergency. This concentrates the risk onto a narrow group of physicians willing to volunteer during a health emergency.
- There is a need for the policy to include examples that illustrate the appropriate use of “not providing the care would lead to worse consequences than providing it”. A physician with no advanced skills in emergency management of airway, breathing and/or circulation will no doubt contribute to worse consequences than not attempting to provide care - the "worse" including death and long-term morbidity. Some examples of "acceptable consequences" related to an unskilled physician attempting to provide care might strengthen the policy.
- More detail in all aspects of the policy (i.e. what is a health emergency, process and more details about responsibilities and legal protection while working out of scope of practice). Eliminate broad terms like “should not be expected” and “the emergency is over”.
- One respondent asserted that there needs to be an understanding that their first priority is to the safety of their family, and that once that is assured, the public comes next.
- The scope of practice section must be clear that when a health emergency has ended, physicians who have not received Emergency Medicine training must not and cannot practice in that capacity.
- The policy waivers between expecting a physician to be present and on duty vs. balancing the needs of their own family and life. Although logically one knows physicians will step up and help if available - it is not clear that they must. It leaves a lot of room for personal choice in a crisis rather than a clear plan of duty and responsibility. It also omits any right a physician may have to choose to not practice outside an area of competency and has no umbrella statement describing how a physician should be protected/trained prior to working in a crisis situation. This respondent felt that the current policy is lacking scope of the reality. There should be ongoing crisis training available, and physicians should be allowed to work only within their scope of practice if they choose.

Q18: "We'd like to understand whether the policy is comprehensive. That is, it addresses all of the relevant or important issues related to physicians practising during a health emergency. Please indicate whether you agree or disagree with the following statements."

As reported in *Figure 7* below, over seven-in-ten respondents agreed that the current policy is comprehensive (77%). In particular, respondents agreed that the sections titled 'Providing Care', 'Practising Outside of Scope of Practice', and 'Keeping Informed and Cooperating' were comprehensive (71%, 65% and 68% respectively).

Figure 7: Assessing Comprehensiveness



Base n=31

Open ended feedback regarding the comprehensiveness of the policy and the sections within the policy was received from 13 respondents. Respondents suggested that the policy could be made to be more comprehensive by:

- Indicating how and/or where to access provincial and federal emergency plans and policies, and to ensure this is updated in a way that it is useful for the membership. The College should provide a one stop shop for members that contain regular updates for the profession.
- Having a list of examples based in reality within the policy (e.g. would a paediatrician assisting an elderly passenger on an airplane to the best of their abilities be appropriate? Would it be acceptable to conduct surgeries outside their scope?)
- Providing more detailed clarity around expectations for physicians.

- Stating that the government and/or authorities will have clear plans in place to provide security and safety to the physician's family so that the physician can provide care to those in need.

One respondent noted that from their perspective physicians should have discretion, and that those willing to volunteer to assist should get appropriate training or supervision in the short-term for support.

Another respondent noted that when reflecting on past disease endemics (e.g. SARS and Ebola) much of the work, and risk, was concentrated on those working in the Emergency and Intensive Care settings. Those working in these settings were thrust to the forefront and it felt as if all other physicians retreated.

A third respondent offered that the use of digital health technologies could facilitate meeting the expectations set out in the "Keeping Informed and Cooperating" section of the current policy. This could include direct physician-to-physician connections as well as providing a clear path to related government information.

A fourth respondent stated that "physicians should be responsible for providing health care if a need is urgent and a patient cannot be given help by a more skilled physician in a reasonable amount of time. Sending patients to emergency constantly isn't providing care during a crisis; it's an abdication of their duties."

A fifth respondent added that the current policy is clear, however, it is difficult to determine how one will ensure that they keep informed if there are multiple sources of information. "Which will be the "leading" authority in terms of physician determining that they are 'informed'? Will it be the CPSO, Provincial authorities, Hospital, Public Health, Health Canada, others?"

A final respondent was curious about whether physicians are expected to access courses in order to keep up with treatment options in emergencies, and suggested there should be funded courses online with CME credits.

Physician-only questions:

Specific questions were posed to respondents who indicated they were a current or retired physician. Of the 34 physician respondents (*Table 2 above*), 29 opted to answer the questions posed only to physicians.

Q21. "Have you ever provided care to patients/people in need during a health emergency?"

All 9 respondents who indicated they had not provided care during a health emergency, responded that this was the case because there hadn't been an opportunity for them to do so as of yet. Twenty physicians (69% of responses for this question) indicated that they had provided care to patients during a health emergency. These respondents were asked to elaborate on their experiences.

Q23. "If you answered Yes above, please elaborate. Were there supports in place to assist you in providing care during the health emergency?"

This question was posed to only those physicians that indicated they have provided care to a person during a health emergency. Their responses reflect their personal experiences accessing supports while providing care during a health emergency. Open-ended feedback is summarized into 3 categories:

1. Summary of experience providing care during a health emergency:
    - Several respondents had experience providing care of some form during the SARS outbreak. One respondent noted that there were clear roles and responsibilities provided. Another responded that they had been involved in community education during SARs.
    - Several respondents had experience providing care of some form during the H1N1 outbreak. Experience was indicated as providing vaccinations and flu clinic support.
    - One respondent was involved in providing care to people after a terrorism act in London, England. They noted there was excellent support available within the hospital's emergency plan.

2. Supports used:
    - Guidelines for practice during SARS.
    - H1N1 Specialists in a flu clinic that was overseen by ER physicians.
    - Equipment needed was available, including ECG machine, endotracheal tube, ambu bag and epinephrine.
    - Protective gear and emergency department procedures.

3. Assessment of support received:
    - Supports were available for some respondents. Some perceived there to be very little support available, while others noted the supports available were adequate.
    - SARS, Ebola, H1N1 in general – One respondent noted that it felt as if there were not enough supports, and that they were inconsistently available. This led to the respondent feeling like they were being put in harm's way. This respondent felt similarly in the case of H1N1 and Ebola outbreaks.
    - Specific to SARS - Outreach and communications were not optimum for any of the affected parties (clinical staff or members of the public). Physicians were often left to their own devices to determine how to handle particular situations in particular contexts.
    - Specific to H1N1 – Confusing information made it difficult to provide care. Supports were there but limited at the start. During the initial days of the H1N1 oubreak this respondent felt that the health safety of the treating teams was compromised.

Six respondents outlined their experiences that upon review were identified as emergency situations for the people involved, but not what would be considered a health emergency under this policy. This is because, the term health emergency is used to describe an emergency situation that poses a risk to a population as a whole, and not to individuals specifically. The experiences received by these respondents are provided as a way to show the difference:

- One respondent had experience providing care in a rural setting. It involved flying to logging camps to provide emergency care and transportation to patients as a sole physician. This involved the respondent using their personal car to transport patients. Once at the area hospital, the physician as able to receive support from the physicians and nurses there.
- One respondent assisted a family whose child had a febrile seizure at the gate of an airport
- One respondent provided care to a large number of people involved in a bus accident, and has been a first responder in 3 head-on collisions.
- One respondent stopped to provide emergency assistance during 2 separate motor-vehicle accidents until the ambulance arrived.
- One respondent noted that when there was a major fire in a tertiary paediatric hospital the emergency response was well organized.
- One respondent mentioned that they had little trauma exposure and that during their long-term family practice there were few real emergencies.

Q24. "Were there aspects of your experience that were challenging and/or inhibited your ability to provide care?"

This question was posed to only those physicians that indicated they have provided care to a person during a health emergency. These responses reflect their assessment of what they found to be challenging, and/or that inhibited their ability to provide care.

Five respondents indicated that they did not experience any challenges or felt that their ability to provide care during a health emergency was inhibited in any specific way.

The respondents that experienced challenges and/or were inhibited in their ability to provide care provided detail that is summarised below:

- Protective gear created challenges for physicians as they attempted to intubate.
- The sheer number of people who need care is overwhelming during a health emergency
- Personal protective measures (training and equipment) did not reassure the respondent during the emergency.
- During a disease endemic, high risk exposure patients and suspected cases were not sufficiently segregated from regular clinical areas.
- Goals of reducing physician exposure to disease resulted in "front-line" physicians being required to stay on service while others were available as a "reserve force" in the event one of the on service physicians became ill and unable to work. The workload was very heavy because of this approach.
- Long hours providing care led to chronic injury.
- Concern over how providing care would affect the physician's family's health.
- There was fear and mis-education amidst colleagues who did not have training or background in emergency medicine. Not having prior crisis experience or crisis training contributed to the fear experienced.

- No vaccination available to physicians before entering into a care situation that could put them at risk of disease.

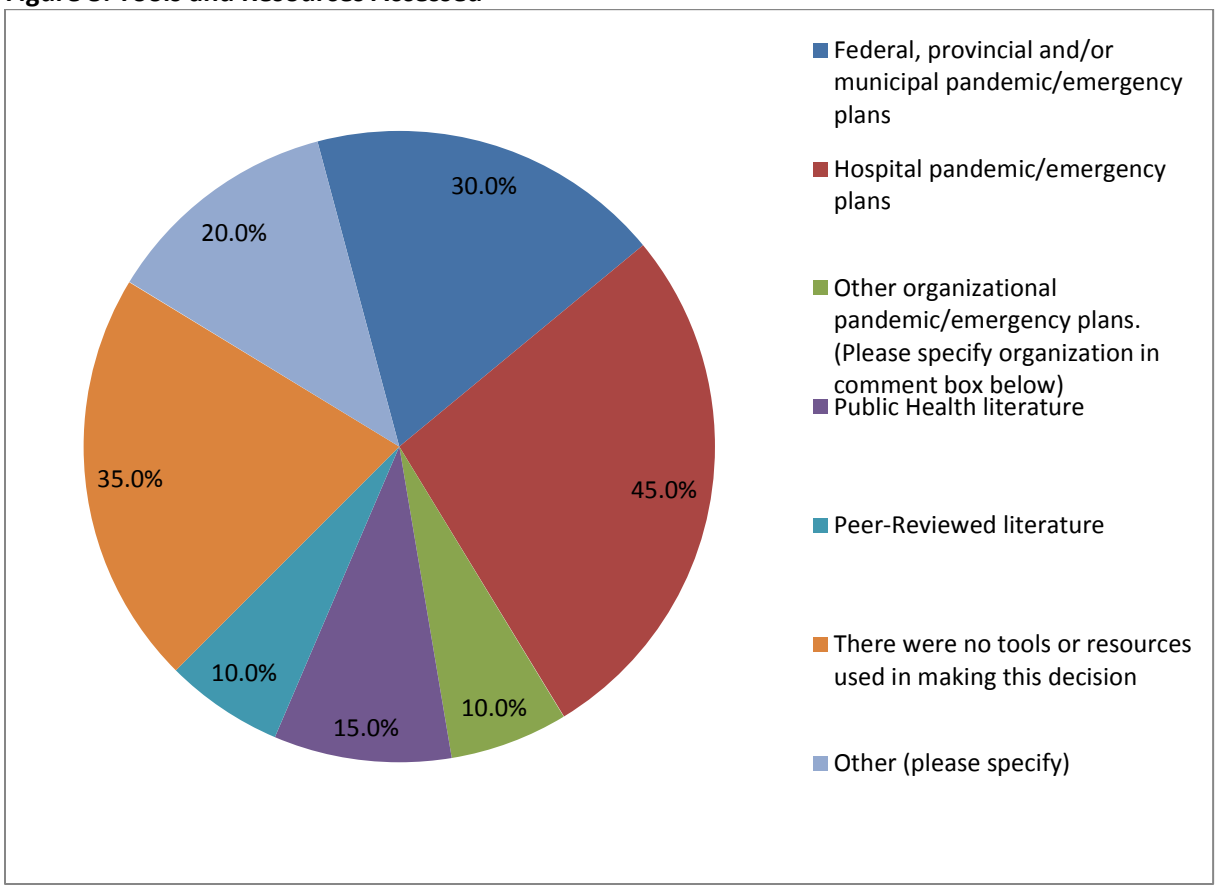
One respondent pointed out that in an era of planning that leaves no room for redundancy in hospitals and care centres, how can appropriate care be provided during a health emergency to the many that will need it?

Q25. "What tools or resources helped you make the decision to provide care during a health emergency?"

Twenty respondents provided insight into the tools and resources they had accessed which helped them make the decision to provide care during a health emergency.

- 6 respondents (30%) indicated they had accessed federal, provincial and/or municipal pandemic emergency plans
- 9 respondents (45%) indicated they had accessed hospital pandemic emergency plans
- 2 Respondents (10%) indicated they had accessed other organizational pandemic emergency plans
- 3 respondents (15%) indicated they had accessed public health literature
- 2 respondents (10%) indicated they had accessed peer-reviewed literature
- 7 respondents (35%) indicated they had not accessed any tools or resources when making the decision to provide help during a health emergency.

Figure 8: Tools and Resources Accessed



Base: n=20

Open-ended feedback was received from 4 respondents who indicated they had used other forms of information during a health emergency that helped them decide to provide care:

- A personal decision as someone had to do it.
- Lack of other medical staff to help required action on the part of the available physicians.
- Feeling like it was the right this to do.
- Using the local epidemiology of the situation as it emerged.

Q26. "Can you provide an overall summary of your experience providing care to people in need during a health emergency?"

Twenty respondents provided open-ended responses that, upon review, could be grouped into three themes/categories:

1. Positive Experiences

Nine respondents indicated that overall their experience providing care was a positive one. Common points these respondents made included:

- Feeling supported by Infectious Disease and Occupational Health interventions and that in general people were helpful and cooperative.
- Excellent communication, assistance was received and questions were answered.
- That a health emergency presents physicians with the opportunity to come together and show real leadership, and to practice medicine in a fast-paced complex traumatic situation.
- That it felt good to be able to help people and ease suffering. It also felt good to be able to help as part of a larger team (when appropriate to the situation).

2. Negative Experiences

Four respondents indicated that their overall experience providing care was negative. Common points these respondents made included:

- Working in fear daily
- Finding it very chaotic, and recognizing that there are not adequate resources to handle the influx of patients.
- Feeling exhausted and questioning whether they would be able to devote that kind of energy to another health emergency situation if it arose in the future.
- Confusion over what, if any, legal protection CPSO policies provide to physicians who opt not to provide care for a variety of reasons, or who opt not to provide care outside their scope during the health emergency.

3. Neutral or Unclear Experiences

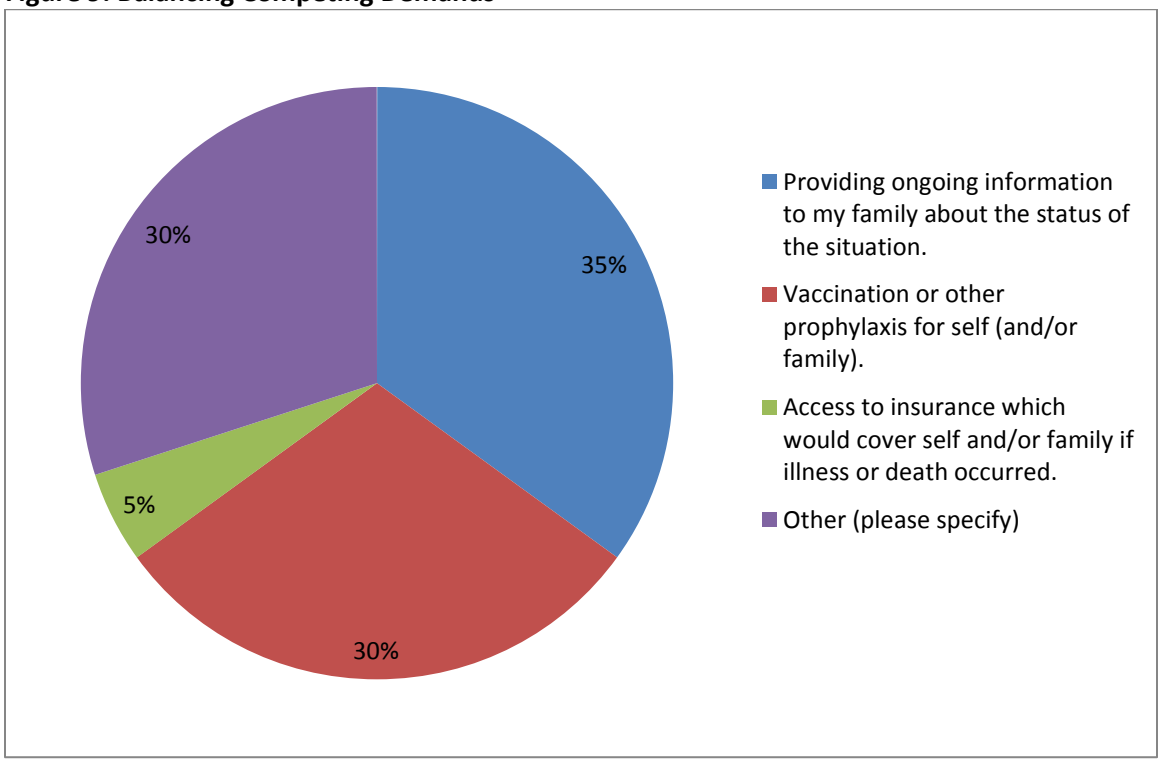
There were 5 responses received that were either unclear or appeared to be neutral towards the respondents experience providing care. Comments these respondents made can be summarized as follows:

- Providing care in one-off personal emergencies
    - Providing care to someone in need within the respondent's scope of practice was a non-issue
    - Providing assistance in the event of motor vehicle incidents.
    - Providing care on an airplane with minimal support from crew or others
- One respondent stated that providing care during health emergencies requires an in-depth understanding of the disease at hand, the system in which one operates and the resources available to support the provision of care.

Q27. "**The duty to provide care and respond to suffering is an inherent part of medical professionalism, and the professions' commitment to the public. Research into the ethical considerations physicians must make during health emergencies indicates that demands on physicians can be great and they will have to weigh these demands with other competing obligations to their own health, to family and to friends. When providing care during a health emergency, how did you balance these competing demands?"**

Of the 20 respondents that answered this question, 7(35%) provided information to their families on an ongoing basis, 6(30%) used a prophylaxis on themselves or their family members, and 1(5%) respondent indicated they had access to insurance in the event of death or illness.

Figure 9: Balancing Competing Demands



Base: n=20

Open-ended feedback was received by 6(30%) respondents who added the following:

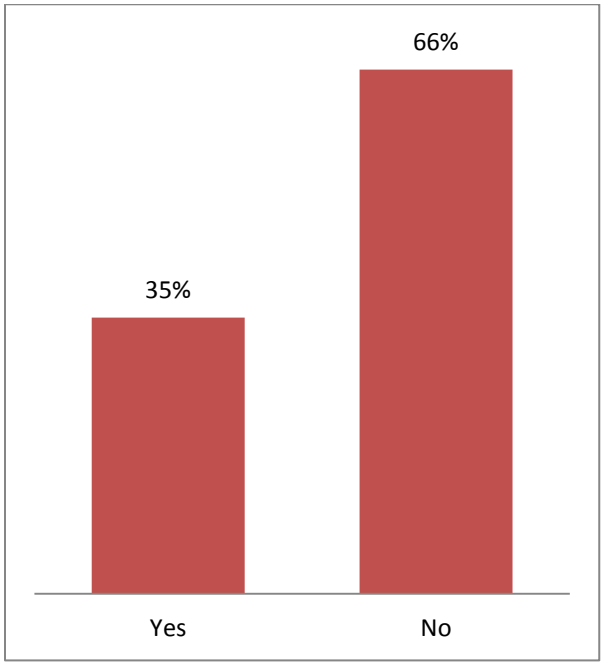
- "I was practising medicine and that was it. My family (parents) knew what I was doing."
- "I segregated myself. "
- "My family has to come first. If they are in danger I am obligated to protect them."

- "I made sure my family was vaccinated for H1N1. We didn't take out extra insurance. I talked to my family about what was going on at work."
- "Used team discussion and onsite leadership groups to help discuss issues and care challenges."

Q28. "In your role as a physician, have you been involved in any sort of emergency preparedness planning in your practice, in your community, or with any organization or government?

Ten respondents (35%) indicated that they had been involved in emergency preparedness planning, while 16 respondents (66%) had not.

Figure 10: Involvement in Emergency Preparedness planning



Base: n=29

Those who indicated they had been involved with emergency preparedness planning were asked to provide a synopsis of their experience. Nine of the 10 respondents who answered "Yes" provided a summary of their experience with emergency preparedness planning. Descriptions are summarized below:

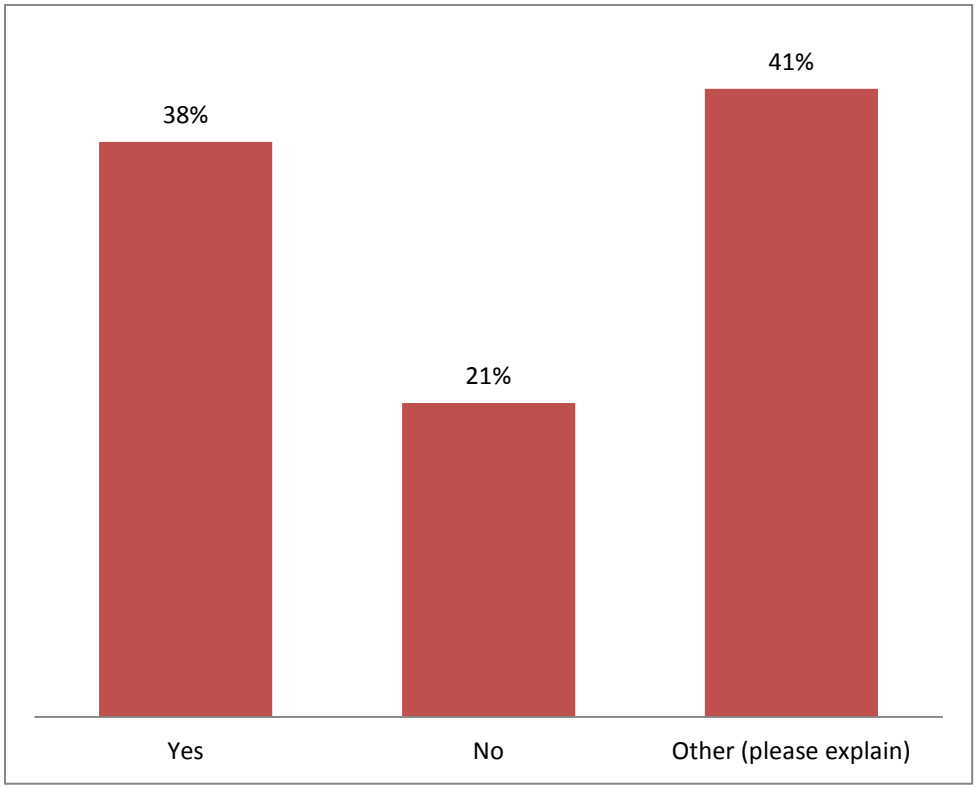
- The use of emergency recall systems for physicians and other health care professionals in an operating room.
- Federal disaster planning and nuclear disaster planning in a local municipality.
- Monitoring the World Health Organization website and reading government guidelines and policies during times of crisis.
- Planning for flu clinics during H1N1 within a hospital setting.
- Developing a hospital disaster plan, as well as the emergency preparedness plans of other health organizations.
- Internal training to learn how to put the emergency response into action.
- Practicing responses during mock disasters and mock public health emergencies.

One respondent observed that although they felt the plans looked good, they were concerned that the application of the plans would fall short of intentions.

Q30. "**Within the current policy there is a section that states 'Physicians are expected to be aware of pertinent federal, provincial and local emergency plans, particularly with respect to matters that affect medical care in practice.' Have you been able to access information about federal, provincial and local emergency plans when needed?"**

Of 29 respondents, 11(38%) indicated that they have been able to access federal, provincial and/or local emergency plans when needed; Six (21%) indicated they had not.

Figure 11: Accessing Relevant Information



Base: n=29

Twelve respondents indicated "other" and provided open-ended feedback. Responses are summarized below:

- 7 respondents indicated they had not tried to access this type of information. Some had determined they had not needed too. Another found this consultation to be the impetus for searching out these plans.
- 3 respondents indicated that this type of information should be readily available to physicians in a reliable and comprehensive place. One respondent suggested that the CPSO be the reservoir for this information. Another noted that they rely on the hospital they are affiliated with to provide necessary emergency planning information.
- One respondent shared that the hospital they were affiliated with did not have a plan at the time.

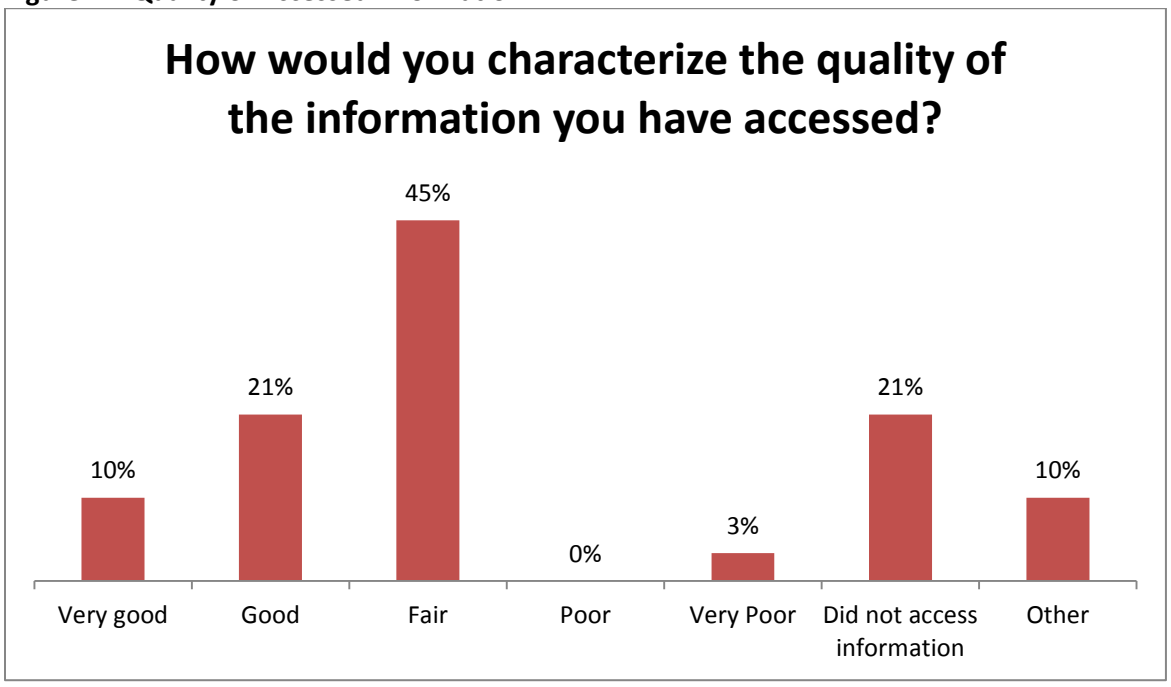
- One respondent observed how their ability to access emergency plans was dependent on the functioning of the communication channels between the developers of emergency plans and the front-line receivers of the information.

Q31. **"How would you characterize the quality of the information you have accessed?"**

Nine respondents rated the quality of the information they had accessed as 'Good' (6/21%) or 'Very Good' (3/10%). Thirteen respondents (45%) thought the quality of the information was 'Fair', while 1 respondent rated the quality as 'Very Poor'. Six respondents (21%) did not access any information so could not provide a rating on the quality of the information.

Three respondents (10%) provided open-ended feedback that highlighted the challenges experienced during SARS around the quality of the information and its dissemination.

Figure 12: Quality of Accessed Information



Base: n=29

Q32. **"Please expand on your answers about accessing emergency planning information."**

Twelve respondents provided more information about their experiences.

- 2 respondents indicated they do not know where to look to access relevant information about emergency plans.
- 3 respondents were able to access the information they needed when they needed because they knew how to seek out the appropriate information, and one found that proactive email updates from Public Health were helpful.
- 3 respondents indicated that although they had accessed emergency plans, they were either hard to follow or confusing, or they were not comprehensive enough.

- 2 respondents indicated that they thought the quality of the information available was good, but that the challenge continues to be ensuring the information is easy to access and up-to-date.
- 2 respondents had not tried to access the information.

Q33. "If you have any additional comments that you have not yet had the opportunity to share, please feel free to provide them below, by email or through our online discussion forum".

Two respondents provided some additional comments for consideration.

One felt that new physicians should be encouraged to practise in isolated areas for a while so that they get a taste of "real medicine" and lose the fear of providing care during health emergencies. That said, this respondent noted that they must be trained for such an experience beforehand.

The other respondent stated that expecting physicians to be aware of federal plans is not reasonable. They felt that local plans should incorporate salient concepts from provincial and federal plans.