MLST Submissions on CPSO Draft Policy: Physician Services in Disasters and Public Health Emergencies

INTRODUCTION

The Medico-legal Society of Toronto (MLST) was founded in 1950 by a group of like-minded doctors and lawyers having the common goal of promoting medical, legal and scientific knowledge; and cooperation and understanding between the professions in the interest of justice and in the best interests of patients and clients. The MLST Submissions Committee is mandated to advocate on behalf of and in alignment with the MLST mission, vision and objectives, and to monitor and respond to government and stakeholder issues as well as calls for input.

The CPSO has invited feedback from all stakeholders to assist in updating its *Physician Services in Disasters and Public Health Emergencies* policy, currently under review. Accordingly, the following submissions have been developed by the MLST and are hereby respectfully conveyed to the CPSO.

MLST COMMENTS ON THE CPSO DRAFT POLICY

The MLST wishes to congratulate the CPSO on the draft policy. The MLST believes the policy will promote the highest possible quality of care in the midst of crisis and will promote and sustain trust and confidence in the physicians of Ontario. We wish in particular to congratulate the CPSO in clearly elucidating the guiding principles for physicians in such situations.

The MLST does however have significant concerns with the current draft policy that we will discuss below:

1. Terminology

(a) Definition of 'Disaster'

The current draft defines a disaster as:

A disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and results in human, material, economic or environmental losses

that exceed a community's or society's ability to cope. A disaster may require medical response for the treatment of injured persons, and can lead to the occurrence of a public health emergency.

We submit that this definition should be extended to include and reflect the consequences of a mass casualty situation on the health-care system itself, and thus not solely pertain to the impact of such an event on the community. Unfortunately yet realistically, during a mass casualty disaster event hospital and healthcare system resources can and likely will be either overwhelmed, or rendered unavailable. Physicians and healthcare teams will be expected to practice within an expanded scope where feasible and safe to do so. An alternate standard of care must prevail in order to save as many lives as possible. We submit that for these reasons, the definition of 'disaster' in the current draft policy needs to expand to reflect healthcare system vulnerabilities.

Further-more, any definition of a 'disaster event' should include mention of terrorism: similar to its inclusion in the CPSO's definition of Public Health Emergency.

(b) Definition of 'Alternate Standard of Care'

We submit that the CPSO policy should provide a definition of the term referred to in mass disaster preparedness literature as "alternate standard of care". We also submit that the CPSO policy should provide an acknowledgement that in disaster situations physician practices will likely need to acutely shift to this alternate standard of care. We propose a definition of alternate standard of care as follows:

The standard of care in a disaster situation or public health emergency must be defined by the scientific evidence for investigation/treatment and the skill necessary to providing such treatment, in conjunction with the standards of professionalism seen in every day clinical practice. In a disaster situation, resources – human, facility and equipment - are likely to be either overwhelmed or unavailable. In such situations, physicians are advised to follow developed disaster plans/policies and procedures which may need to include the imposition of reasonable, transparent, fair and system-wide limits on what investigations can be ordered and what treatments can be provided. Documentation of the altered standard of care necessitated by such extraordinary circumstances should be placed on each patient's chart.

(c) Definition of 'Altered Scope of Practice'

We submit that the CPSO should consider providing a definition of "altered scope of practice".

In addition to medical specialization and sub-specialization, there is considerable specialization of services and facilities within Ontario hospitals. It is conceivable, based on current worldwide experiences, that during a disaster non-trauma hospitals will find themselves providing resuscitation and other acute care services to acutely critical patients either because the event occurred in proximity or because trauma care systems are overwhelmed or rendered unavailable. It is equally conceivable that, even within trauma hospitals, non-trauma physicians will be needed to assist their trauma-skilled colleagues.

In parallel, during disasters, it has been repeatedly shown that when health care systems become overwhelmed or rendered unavailable, there may be a need for physicians to practice outside of their usual scope of practice in order to manage the needs of chronically ill patients, in order to prevent deterioration into critical illness, placing additional burdens on health care resources.

While we do not have a specific proposal for the definition of "altered scope of practice" we believe it should acknowledge that physicians may be asked to stretch their knowledge and skills well beyond their usual scopes of practice in order to provide emergency care and urgent treatment to a large number of acutely sick or injured patients in order to save and stabilize as many lives as possible.

Finally, we submit that the policy should include a discussion about palliative care. A state of disaster does not preclude a physician from the duty to provide palliative care. However, if it is clear that a patient cannot be saved, then the physician should not place his/herself (or be placed) at additional risk in a vain attempt to do so. This means that in some situations CPR and/or life sustaining treatments including surgery and critical care admission will not be offered.

2. Providing Physician Services

In the current draft, CPSO states:

There may be reasons related to the physicians' own health, and that of family members or others close to them, which may place limits on the physicians' ability to provide direct medical care to people in need during a disaster or public health emergency. In those instances, physicians who have a personal health and/or ability limitation must lend support during disasters and public health emergencies.

This support can include performing administrative or other support roles, as well as increasing capacity in one's practice to offset the increased strain placed on physician resources during disasters and public health emergencies. When deciding what role to undertake in a disaster or public health emergency, physicians must balance their competing obligations to the public, their patients, themselves and their families in accordance with the values, principles and duties of medical professionalism.

We support the involvement of physicians in providing services even if there are limits on their ability to provide direct medical care. We would however ask the CPSO to provide more guidance on what constitutes a limit on ability to provide such care when it consists of a "personal health or ability limitation and competing obligations to self and family". The MLST is concerned that a lack of more clarity in this area may lead to the unprofessional shirking of duties thus placing the burden of treating large numbers of patients on fewer physicians. The MLST is concerned that this could result in discrimination against those who are unmarried, not in relationships or childless; or even discrimination based on gender or religion. We submit such guidance would assist in promoting transparency and fairness and to ensure all physicians are aware of their duties.

3. Credential Confirmation and Temporary Licensing

It can be expected that during a disaster, physician volunteers will present themselves to health care facilities and triage centres. The majority of these would most likely be Ontario-licensed physicians from unaffected regions of the province. However, it is not inconceivable that physicians from adjacent, or even non-adjacent provinces will volunteer during the course of the disaster. We recommend that the CPSO should be prepared to rapidly put into place a system capable of rapidly handling requests for confirmation of physician credentials as requested by those health care facilities that are coping with a disaster, as well as by those Ontario physician volunteers who will need to provide such accreditation.

The CPSO should also have in place a policy and procedure for rapidly confirming credentials and granting temporary licensing to physician volunteers from other provinces.

Additionally, we recommend that the CPSO give consideration to developing both policy and procedure regarding physician volunteers from the United States, to include both rapid handling of credentialing confirmation as well as an overall policy for temporary licensing.

A system of rapid credentialing would also preclude pseudo-physician imposters from gaining access to patients and their families, health care facilities, medical records, drug supplies etc.

4. Issues of Capacity and Consent

We submit that the policy should state that the standards of care regarding patient capacity and consent to treatment - including the provision of emergency treatment - should be maintained. This policy would be strengthened by linking it with the relevant sections of the CPSO policies Consent to Treatment and Planning for and Providing Quality End of Life Care.

In addition, this policy should itself clearly reference the relevant HCCA sections on the provision of emergency treatment

5. Documentation

Similar to the statements provided in its Consent to Treatment policy, we submit this policy would be strengthened and would provide more helpful guidance to physicians if it included details of what needs to be documented in disaster/ public health emergency situations regarding capacity, and consent to treatment. While a reference to the Consent to Treatment policy would be helpful, we submit that additional documentation is required to promote patient safety and ensure quality of care is maintained. This additional documentation would include a description of altered standard of care reflecting any resource limitations - human, equipment or hospital services - and the rationale for and impact on the patient's treatment/ treatment plans. Such information may be captured by attaching documentation of mass casualty plans and policies to patient charts or by handwritten notes. This documentation would be standardized and prepared in advance. It is appreciated that in a mass disaster of significant proportions it may be hard to maintain the level of documentation that is routinely provided by doctors in non-disaster situations. However, even if minimal, documentation would remain of critically importance. As an alternative, the possibility of electronic documentation should also be addressed. The need to document will have the additional benefit that physicians will maintain an awareness of federal, provincial and hospital disaster/ mass casualty plans and procedures as they evolve to address a given event.

6. Physicians In the Triage Role

In a disaster or public health emergency, physicians may find themselves in a patient/resource triage role. We submit that the CPSO policy should provide some guidance to physicians in such roles with respect to what their professional obligations would entail in terms of their conduct, duty of fairness, consistency, transparency; and their duty to follow federal, provincial and hospital disaster plans; and what documentation of any triage decisions would be required and what their professional obligations would entail if they question or disagree with the effectiveness of the proposed deployment of resources.

CONCLUSION

In conclusion, the Medical Legal Society of Toronto supports the draft policy but does propose some amendments to provide further clarity to ensure that the doctors in Ontario can provide the best possible services if there were to be a disaster and that doctors have a clear understanding as to what their role and obligations are in such an event so that they can focus on the needs of those requiring their care.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 2nd day of December, 2017.