Canadian Association of Emergency Physicians (CAEP)
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Emergency Situation facing Canadians in Light of the Second Wave of COVID-19
Statement from the Canadian Association of Emergency Physicians
CAEP Statement

Thank you for the opportunity to appear before the Standing Committee on Health. On behalf of the Canadian Association of Emergency Physicians (CAEP), we plan to utilize our time before the committee to focus on the immediate situation of vaccination and the vital need to engage with frontline workers and their associations; however, we wish to supplement our remarks with these written comments on other aspects of the pandemic, including the conditions that existed prior to the pandemic that are hampering efforts to respond.

Our first priority has to be to repeat our call for increased transparency around the prioritization and administration of COVID-19 vaccines and the plans for vaccination going forward. Unfortunately, there remains confusion, lack of transparency, and mixed messaging around prioritization. There needs to be central, federal coordination of efforts with clear consistent transparent messaging.

A stark example of the problems around this is the fact that that there are still people working in Canadian emergency departments who have not been completely vaccinated. Of particular concern are those working in smaller, isolated, and rural communities. We highlight healthcare workers because of the precarious state of the healthcare system and its dependence on overstretched workers. Plainly said, if healthcare workers are incapacitated due to COVID-19 infection, the system will no longer be able to care for the population. Most troubling is the fact that vaccination has been delayed for emergency personnel in rural and isolated communities where the risk of system collapse is higher because of the lack of back-up personnel – the smaller population of providers means that there are not others who can step up and fill in for colleagues who fall ill.

The frustration this has caused for healthcare personnel has added to the burden of working in a system that was overloaded even prior to the pandemic.

Healthcare workers have been repeatedly thanked, and even hailed as “heroes,” but the reality is that we are workers who require, no less than any others, a safe work environment. Instead, the assumption has been that we will simply accept increased risks, without consistent, evidence-based assessment and mitigation of those risks. In fact, as recently as last week in one province, the government has failed to recognize that emergency department nurses are a group that is at higher risk and that treats COVID-19 patients, often before they have been identified as cases. Our members and our colleagues on the front lines have and continue to step up to care for the sickest patients in our communities. Transparency, communication, and adherence to an ethical framework in vaccine prioritization and administration are the minimum they should receive in return.

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Lessons Learned and Corrections Needed

We also need to point out to the committee the conditions that hindered the response to the COVID-19 pandemic and that need to be addressed in order to prevent a third wave that is worse than the second, to support the healthcare system's ability to respond, and to resolve vulnerabilities prior to the next health crisis.
While we will expand on some of these items below, the common theme is that the healthcare system **must** have the following in order to be able to respond:

- Surge capacity, which is eliminated when there is crowding,
- Adequate staff, which requires HHR planning,
- Adequate supplies, which requires stockpiles of PPE and other supplies, domestic production capacity, and a strategy to prevent shortage of medications and supplies,
- Appropriate working environment (hospital design), and
- Adequate leadership/decision making (IMS and communication)

Our first point fits within this theme because vaccination of key staff in vulnerable communities is necessary to preserve what ability the system has to respond, limited as it is by the above points.

The Need for National Coordination of Public Health Measures and Consistent Messaging

The command and control of the pandemic, a national health emergency of unprecedented proportions, laid bare some of the inherent jurisdictional difficulties of our federation. As front-line health care providers, we noted with concern, the apparent lack of national coordination of public health measures, resulting in confusing and differing rules for business closures and public gatherings. Rules vary from region to region and province to province. There must be clarity and federally coordinated messaging with respect to strict and uniform preventive public health actions, including masking, gathering sizes and travel restrictions.

The importance of consistent messaging should outweigh jurisdictional concerns. Currently, the federal government is one voice among many. This has led to conflicting and confusing direction to the Canadian public and to health care providers.
During a crisis, it is well established that an effective and lean command and control system is critically important; yet we still do not have the ability, nationally, to respond quickly to changing science and circumstances. As a result, we have multiple ministries, departments and agencies involved in a confusing and overlapping span of control.
Therefore, we see an urgent need for the following:

- A national incident management system (IMS) vertically integrated with provincial and local systems.
- Standardization of public health measures and communication nationally.
- Use of the IMS and the emergency powers act to ramp up domestic production of PPE, equipment, and medication, and create a national distribution system to avoid balkanization; and

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- Ramped-up national testing capacity and a standardized, aggressive national surveillance strategy for all infectious emergencies, to go along with isolation and contact tracing of those who test positive.

Pre-existing Hospital Crowding

Prior to the COVID pandemic, Canadian hospitals were chronically overcrowded, frequently exceeding 100% bed occupancy. Safe hospital occupancy has long been accepted to be 85%, allowing for the ready transfer of hospitalized emergency patients to the wards and ICUs. It also allows for adequate surge capacity in the case of infectious disease outbreaks and national disasters. Though there are a number of factors leading to crowded EDs and delayed access to care, above and beyond all others is a crowded hospital. Capacity in the hospital system must be reconsidered to ensure adequate emergency access. There are multiple consequences to crowding in emergency departments, which have been well-articulated in international studies. Specifically, in the context of pandemic planning, it should be recognized that the crowded emergency department can worsen the transmission of any infectious disease and can become a reservoir of nosocomial infections.

Adequate surge capacity for this and future pandemics, as well as other disasters yet to pronounce themselves must be a priority and the Canadian health care system must commit to ending hospital crowding.

Emergency Department and Hospital Design

A crowded emergency department can be a nidus for infectious disease transmission. This was identified in the SARS outbreak of 2003, which was centered in Ontario. This led to a rapid redesign in Ontario emergency departments for negative pressure rooms in every department. Regrettably, COVID has demonstrated that we need more than the current allotment.
We must also not go back to the era of the continually crowded waiting room. Adequate physical distancing must become the new normal. Canada's emergency physicians have a role to play in reducing crowding in the waiting room. Some have embraced the practice of virtual care, other have called for enhanced telephone triage.
We must be assured of the continuous availability of Personal Protective Equipment and combat PPE fatigue.

Hospital bed occupancy must be maintained at a level that promote good infection control and the abandonment of four-patient wards must become a priority.

Health Human Resources and Maintaining Staff Resilience

Canadian emergency departments are already threatened by a national shortage of emergency physicians. Canada has an estimated shortfall of 1,000 emergency physicians, insufficient numbers are being trained and the burnout rate of those practicing emergency medicine is estimated at an astonishing 86%.

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Without sufficient staff, the burden of the pandemic due to either illness or moral injury, will threaten the continued integrity of our emergency health care system. The demands on ED staff due to anticipated sick calls, as well as isolation of school aged children will be large.

The high morale we have seen in colleagues through this unprecedented world crisis, along with the collaboration between disciplines, professions, and communities, have helped members of the medical community reaffirm a sense of purpose and reassured us that the risks we take daily are not going unnoticed.

Unfortunately, we also know that many health care providers have suffered and will continue to suffer from ongoing mental health consequences as a result of this pandemic. Many are leaving the emergency department, some are leaving their profession, and we have lost at least one colleague to suicide.

Leaders have a responsibility to foster an environment in which they support their teams while making it acceptable for members to voice cries for help. They must demonstrate visible and authentic leadership, not only in words, but by offering formal psychological support in stepped ways (e.g., information, support, first aid, intervention) though national programs designed to support emergency physicians and other front-line staff at risk, regardless of location.

Our teams are our most precious resource; we must ensure we keep them healthy and well so they can continue to provide care for Canadians on this challenging journey.