Conscription fears accompany threat of pandemic

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Despite some physicians' fears, proposed Ontario legislation is not intended to conscript them into service during an emergency, such as a flu pandemic, the provincial government says. The province has also promised to talk to medical stakeholders on all issues concerning the bill and will consider amendments.

Several Ontario physicians complained to the Ontario Medical Association (OMA) and media outlets in February, saying provisions in Bill 56, Ontario's proposed Emergency Management and Civil Protection Act, would allow the government to force doctors and other health care professionals into service. For many, that interpretation of the draft legislation was reinforced by the Offences section of the bill, which sets fines at $100 000 and a year in prison for each day an order is disobeyed.

The complaints target 3 items under the "Emergency Orders" section of the bill, 2 of which allow the government to issue orders governing the "use" and "procurement" of necessary goods, services and resources. The third item authorizes the government to order "any person, or any person of a class of persons, to render services of a type that that person, or a person of that class, is reasonably qualified to provide."

The conscription issue, says the OMA, hinges on the broad definition of the word "services" at the beginning of the draft legislation. If you substitute the word "physician" under "services" — or if physicians' services are covered by the wording — that raises the spectre of conscription.

But in a March letter to the OMA, Community Safety Minister Monte Kwinter wrote: "It is not the intention of the proposed legislation to conscript any individual during a provincially declared emergency."

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Some Ontario physicians are concerned new Emergency Management legislation could force them to work during a pandemic, making them choose between family and work.

Andrew Hilton, Kwinter's spokesman, told *CMAJ* the new legislation defines government authority during any emergency, from floods and earthquakes to a SARS-like event or pandemic. But its primary goal, he says, is to facilitate the provision of services in a positive way. For example, the section on "authorization" is intended to provide tools to speed up such cumbersome protocols as the authority to allow licensed doctors to cross jurisdictional boundaries to serve in other provinces.

In a non-medical framework, Hilton says, the same provision would allow someone to drive a bus or truck without the required licence. "It would authorize people to do something that they are not necessarily authorized to do technically, but which it is reasonable to expect that they could do," he says.

While medical professionals, including doctors, are also captured under the "use" and "procurement of necessary goods, services and resources" section of the bill, it's intended to facilitate the use of such things as ambulance services and to help bypass normal tendering processes.

"The point of this legislation, and the point of preparing for an emergency, is to make sure that people like health care professionals … are given what they need to manage it," says Hilton. "It's not to force anybody to work against their will and it's not to conscript anybody."

The OMA believes the government has heard its concerns about conscription, but the Association says it will continue to make sure there is no room for a different interpretation and wants the legislation to explicitly state that individuals will not be conscripted in a pandemic or other emergency.

"There is no reason to think that doctors won't come and take care of patients," says Dr. Greg Flynn, the president of the OMA. "Even at the height of SARS when we didn't know what we were dealing with, doctors and nurses and other hospital workers were prepared to put their health at risk to take care of the public," he says.

The conscription debate underscores the need to resolve other issues related to emergency preparedness, such as whether health care professionals are properly trained and equipped, insured and compensated, says Flynn.

This broader discussion with the Ontario Ministry of Health is currently unresolved, he says. (The Ministry did

not respond to requests for comment.)

Fears of conscription have arisen before as provincial governments grapple with physician shortages or introduce new emergency legislation and pandemic plans. As in Ontario, questions about compensation, indemnity and insurance have followed.

In Quebec 4 years ago, physicians raised concerns about Bill 114, which would have required all Quebec doctors with recent ED experience to provide ED coverage in the event of a staffing shortage. The proposed legislation was drafted in response to a shortage of emergency department doctors. Although the Bill did not become law, later efforts to manage Quebec physicians met equal protest. When Quebec released details of its pandemic plans in mid-March, the plan called for the "voluntary" assistance of retired medical professionals to cover any shortages.

Conscription fears also arose in Alberta last December when Calgary's Medical Officer of Health, Dr. Brent Friesen, released his Pandemic Influenza Response Plan for the Calgary Health Region.

As Friesen explained to *CMAJ*, the province's power to conscript is not new, stemming from amendments to Alberta's 2002 Public Health Act. The Act allows the Medical Officer of Health to conscript individuals to meet emergency needs.

"If you look at most emergency legislation across the country, it's written in such a fashion as to allow organizations to conscript people that they require," says Friesen. "But again, it is done as a last resort."

Despite news headlines, current discussions with Alberta's health care professionals about emergency and pandemic issues are not focused on conscription, but instead around ensuring health care workers have training to serve in whatever capacity they are needed, as well as on indemnity and compensation concerns.

The obligation, says Friesen, is "to make sure that we've got it laid out well in advance in terms of the measures we're going to have in place to protect people if we are asking them to undertake these works and do these things for the benefit of society as a whole."

With health care clearly under provincial jurisdiction, these debates have been focused at the provincial and local levels. However, in a catastrophic national emergency, doctors could be forced to serve under the federal Emergencies Act, which in 1988 replaced the old War Measures Act. Such an order can only be invoked at the request of a province if there is no other existing legislation, provincial or otherwise, that could be used to manage a situation. — Pauline Comeau, Ottawa

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Apples, oranges and wait times: CIHI report

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The first major effort to compile comparable nationwide data on health services wait times suggests that skyrocketing demand in the so-called priority areas of cancer, heart, diagnostic imaging, joint replacements and sight restoration hasn't appreciably lengthened the time it takes to get treatment.

But Canadian Institute for Health Information (CIHI) officials are quick to caution that conclusions drawn from its recent report, *Waiting for Health Care in Canada: What We Know and What We Don't Know* are suspect because of data collection and methodological issues.

"We do not have a comprehensive, cross-Canada picture," said CIHI Chair Graham Scott, at a Mar. 7 press conference. "But our expectation is that there will be better, more comparable data in the future."

CIHI President Glenda Yeates says the data are highly variable because of factors ranging from physician practice patterns, referral procedures and things like "what type of care you need, whose list you are on and where you are waiting, how processes of care and wait lists are managed and special factors related to individual patients or conditions."

"There is no average person or average wait," Yeates says.

This is the first time comprehensive wait time data has been compiled, and without a valid reference point it's impossible to conclude whether the situation is improving, Scott said in an interview. "But the one thing we can do is show that there's been a huge increase in volume and the wait times don't seem to have gotten worse, so if there's a positive message, I suppose that's positive."

Scott stressed the need for more standardization of the way wait times are measured across Canada. "In the vast majority of the country, wait times are controlled by individual physicians.

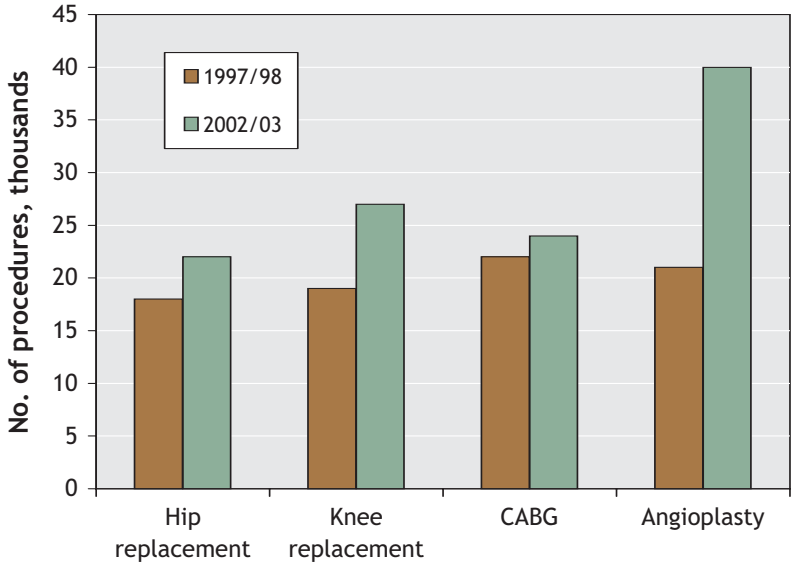

Fig. 1: Five-year increase in numbers for 4 procedures. Note: CABG = Coronary artery bypass graft.