Non–Hospital MDs Should Be at Forefront of Pandemic Flu Plan

BY MIRIAM E. TUCKER
Senior Writer

PHILADELPHIA — The American College of Physicians is calling for greater involvement of physicians in pandemic influenza preparedness than is specified in the U.S. government's plan.

The ACP's new policy paper, "The Health Care Response to Pandemic Influenza," generally supports the U.S. Department of Health and Human Services' national strategic plan for responding to a possible pandemic influenza outbreak (www.pandemicflu.gov). But the ACP paper criticizes HHS for its "failure to thoroughly incorporate the role of physicians in non–hospital-based settings in playing a leading role in the health care response."

The ACP document also faults the HHS plan for not providing enough detail about the logistics of rationing health care resources should the H5N1 influenza strain now circulating among birds in Asia and Europe emerge into a human pandemic.

A pandemic "will require all non–hospital-based health care providers … to be prepared to counsel, to diagnose, to treat, and to monitor patients outside of hospital settings in order to decrease the likelihood of surges that could and would overwhelm hospital capacity," said Dr. Donna E. Sweet, then chair of the ACP Board of Regents, at a press briefing during the ACP's annual meeting.

The HHS plan is based on the assumption that an average of 20% of working adults would become ill during a community outbreak, and of those, 50%—about 45 million—would seek outpatient medical care over a 6- to 8-week period.

According to Dr. John A. Mitas II, ACP deputy executive vice president, "while the government's current plan begins to address the elements needed during [an influenza pandemic], it needs to go further to involve all physicians. It is critical that internists, who will be on the front lines of care should an outbreak occur, be involved. … ACP calls for a plan for hands-on clinical training of internists to address the public health crisis."

ACP's position falls under five major headings:

► **Physician involvement.** Local task forces should be developed that include physicians from all practice settings. Federal or state agencies should coordinate the utilization, licensing, and registration of physician volunteers during public health emergencies.

► **Surveillance, monitoring, and reporting.** Health care providers should have access to two-way communication with public health authorities. Any necessary breaching of patient confidentiality should minimize harm while heeding applicable laws. Infection control measures must be clear and as minimally disruptive as possible. Physicians should not be penalized for failure to follow orders that are inappropriate or beyond their control.

► **Vaccines and antivirals.** It is essential to end chronic delays in vaccine delivery. ACP supports national procurement of enough vaccine to protect the entire U.S. population, and of antiviral medication for 25% of the U.S. population, with equitable distribution to states based on the number of high-risk individuals. Additional courses of antiviral drugs should be procured for all personnel in direct contact with patients.

► **Ambulatory care.** An effective response to pandemic influenza will require all non–hospital-based health care providers to counsel, diagnose, treat, and monitor patients outside of hospital settings in order to decrease the likelihood of surges that would overwhelm hospital capacity.

► **Physician security.** The safety of health care personnel must be provided for during public health emergencies. Those who store or administer vaccines, antiviral medications, and other supplies must be fully informed about preplanned security measures.

Asked about how realistic these goals are and in what time frame they might be achieved, Dr. Mitas responded: "The training could occur within a 6- to 12-month period, starting with the awareness. In terms of having the vaccine and the antiviral agents, that's going to take more time."

"The education is easier than putting into place the physical system, the reporting system, the communication networks, the electronic technology," Dr. Sweet said. "The hard part is we're not going to have enough [antivirals] or vaccine in the short period of time the way the progress is going right now."

But "the planning has to be done now," Dr. Sweet added. "It's going to be way too late when we see the first 10 cases." ■

Government Offers Two Ways to Serve During Emergencies

BY MIRIAM E. TUCKER
Senior Writer

PHILADELPHIA — Two government-affiliated programs provide a way for physicians and other health care professionals to serve as volunteers in the event of a national, regional, or local emergency, Dr. Anand K. Parekh said at the annual meeting of the American College of Physicians.

The Medical Reserve Corps (www.medicalreservecorps.gov) is a nationwide network of community-based groups of credentialed and trained volunteers. About 73,000 MRC volunteers serve in 404 units in 49 states.

The Emergency System for Advance Registration of Volunteer Health Professionals (www.hrsa.gov/esarvhp) registers health professional volunteers in advance of an emergency, with 13 state systems fully operational thus far. Although federally funded by the U.S. Health Resources and Services Administration, it is state-run and state-operated. Those interested in volunteering should contact their state public health departments, said Dr. Parekh, a medical officer in the U.S. Department of Health and Human Services' Office of Public Health Emergency Preparedness.

In general, the MRC is an option for those who want to become actively involved in volunteer services by receiving training in advance as part of a local unit. The ESAR-VHP, on the other hand, functions more as a reserve unit: The state keeps your name on file and calls only if an emergency arises.

Both groups were involved in the response to Hurricane Katrina. In the communities directly hit, 6,000 MRC volunteers supported local relief efforts. Another 1,500 MRC volunteers from elsewhere expressed willingness to deploy to the affected areas, and 600 of them actually did so. Along with the 13 established ESAR-VHP state systems, another 7 state systems were temporarily launched within 2 weeks after the hurricane hit. In all, more than 8,300 health professional volunteers assisted Katrina victims through ESAR-VHP, Dr. Parekh said.

Both programs are still evolving, with current efforts underway to standardize the credentialing procedures and to increase pre-event training opportunities. ■