Pearls before swine

Cal Gutkin MD CCFP(EM) FCFP, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER

With no disrespect intended to the words of the Sermon on the Mount (Matthew 7:6) (or the 1960s folk rock group), the past year of H1N1 adventures has conjured up thoughts of pearls before swine. Why has the planning for H1N1 been so difficult and why have the messages of public health officials been so convoluted and ever changing? Time and again, as we tried to understand how best to prepare for battle against this viral invader, we were told that the frequent amendments to the advice being offered were necessary because the research was ongoing and we did not yet have the evidence—the pearls of knowledge—that usually guide the development of health care protocols.

This created a bit of a nightmare for those responsible for developing and communicating the public health plan to control H1N1. With the research not yet completed, the virus began to carve its journey through the communities of the world—and recommendations were needed for immunization programs, assessment of symptomatic patients, and treatment, including the use of antiviral medications. The emergence of some not-yet-peer-reviewed research findings that might have required changes to advice already given trapped government and public health officials in an ethical corner. Should they share this new information publicly and alter recommendations already made—or should they ignore the research until peer review or further studies could be done? The latter might not take place until after H1N1 had run its 2009 course and done its damage. What if some of these early findings turned out to be valid and if acting on them could have helped prevent adverse outcomes? The moral imperative that won out was that it was best to share the available information, even if it meant changing some of the protocols that were already in place and creating growing public distrust of all public health recommendations.

Our College shared the concerns of Canadian family physicians with government and public health officials. Family physicians who had been through SARS and previous flu epidemics were apprehensive about the inconsistencies and gaps in the plans being made for H1N1.

Among the concerns shared with us by family doctors across Canada (and by us with government and public health officials) were the following: the overuse or misinterpretation of the word *pandemic* and the confusion and fear it created; redundant high-level information coming from too many sources and yet too little information at the practical, local level; the late timing of the start of Canada's H1N1 vaccine program; the inconsistent messaging about the sequencing of the seasonal flu vaccine and H1N1 (based on the questionable Canadian study suggesting that those who received the seasonal vaccine first might have a greater chance of becoming sick with H1N1); the confusion over adjuvant safety and the number of doses of vaccine needed; the challenges related to the prioritization protocols; and the ill-timed release of a 2007 report suggesting that hand washing might not be important in preventing the spread of viruses like H1N1.

Compounding the challenge of delivering a consistent plan across Canada, different strategies were implemented by health authorities in different provinces and even within provinces. Well into October, questions remained in many communities: where should patients go to get their H1N1 vaccines; who would give the shots and how would they get their supply of vaccine, needles, and syringes; who would pay for these supplies; would there be compensation for those called on to give the vaccine; where should people go if they had flu symptoms; how should family doctors arrange their offices so that infected patients would not contaminate others; which types of masks, if any, would be available in family doctors' offices; and how would family physicians and other health workers and their families be insured and cared for if they became sick with H1N1 flu? Physicians in many communities suggested that the biggest deficiency in planning and communication was at their local levels with respect to the availability of practical advice needed on the front lines.

Skilled and knowledgeable public health officials in Canada worked honestly and exhaustively throughout a very difficult time leading up to the possible H1N1 surge this fall. Developing national standards that would be embraced in all Canadian jurisdictions presented challenges that once again demonstrated the potentially negative effects on Canadians of ongoing federal-provincial-territorial tensions. And once again, front-line family doctors and nurses were not included in all stages of planning public health strategies both nationally and locally.

We hope that H1N1 will not turn out to be cruelly virulent and that Canada will emerge from this 2009 experience without catastrophic health outcomes. This has, however, been a unique situation in which the expert evidence—the gems of knowledge upon which expert population health recommendations would normally be based—was either flimsy, still emerging, or unavailable. To help prepare for H1N1, we could have used a few more pearls before swine.

Cet article se trouve aussi en français à la **page 1159.**