A northern physician and wildfire lessons

by Sarah Cook MD CCFP FCFP CCPE

Imagine this: you are 38 weeks pregnant leaving your home, not with all the baby gear you imagined taking to the hospital but with a single bag, unexpectedly boarding a plane with other pregnant women to fly to another province to wait out the remainder of your pregnancy in an unfamiliar city. You've said a rushed goodbye to your partner and your kids who are embarking on a sixteen-hour drive - at times through road-side wildfires - to eventually meet you where you land. There is no space for them on the obstetrics evacuation flight and they need to leave prior to the city's evacuation deadline. Your baby will have a birth certificate from another province, not your home territory. You will deliver not surrounded by friends and family but in a city that is not home, where you will remain for you know-not how long.

This was the reality for many of the full-term pregnant women I accompanied out of the Northwest Territories by plane last August 17 with an emergency obstetrical delivery bag in hand, as the city was suddenly and unexpectedly evacuated due to encroaching fires, the first time in modern Canadian history an entire capital city has been evacuated.

Our memories and collective worry are resurfacing now as wildfire season is again upon us. In many parts of the country, intermittently apocalyptic skies have become the summer norm. The Air Quality Health Index (AQHI) is part of our common vernacular; we check it daily during wildfire season to determine our outdoor activity risk, just like we check the weather to see if we need a raincoat.

The new reality is that we will all experience increasing climate-related extreme weather and consequent crises that result in sudden human displacement. In times such as these we need both health systems and healthcare providers who are adaptable and resilient. We also need to have the skills and tools to navigate the turbulence safely. I, like many, find myself wondering whether we've learned enough, prepared enough for what's to come. Are we honing the skills we and our future physicians need to adapt, respond and support the people we serve through these unpredictable times?

Evacuating a capital city and a large territorial hospital is an experience we never want to repeat, but we do need to learn and be prepared. Fortunately, crises present excellent opportunities. Just as COVID propelled parts of our system forward with rapid advances in previously-stuck areas such as virtual care and interjurisdictional emergency licensing and billing, so too can climate crises and human displacements propel our healthcare system forward to be more patient-driven, responsive, and effective.

So, what can learn from this mass evacuation from Yellowknife, and how can we prepare as a healthcare system and as a profession for future events of this nature? There were a lot of lesson learned last summer, but here are a few of my top ones:

1.Patients need seamless access to their own health records, regardless of where they are in Canada.

One of our biggest logistical challenges in the obstetrics evacuation (only one small part of the overall feat of evacuating a city and territorial hospital) was getting prenatal records to patients and their healthcare providers wherever they ended up across Canada. Yellowknife residents had less than 48 hours to leave the city once the evacuation order was announced. We were able to print prenatal records from the EMR for the most complex and most pregnant patients before leaving, but the majority left the territory without any records in hand. Healthcare providers in other jurisdictions cannot access the NWT electronic medical record (a common obstacle in our country across provincial, regional and even clinic borders), so we NWT healthcare providers (ourselves evacuated to various places and working on laptops) faced the significant challenge of trying to safely and securely connect patients with their health records.

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In a country where we are nowhere near having an integrated health record, displacement of people from one location to another, whether within a province or across borders, means inaccessibility of health information. We need interoperable health records in Canada, but more importantly, patients should always have timely access to their own health records and be in charge of granting access to whomever is in their circle of care, wherever they are.

2.Remove barriers to physician practice across borders in Canada

Not only were our patients largely evacuated to Alberta, so were we as their healthcare providers. Without Alberta licenses, we were unable to provide care to these patients even though we were at times in the same physical locations.

National licensure - the ability for physicians licensed in one province to practice in another - would have significantly decreased both the burden of the NWT evacuation on the Alberta system and would have allowed NWT practitioners to provide continuity of care to our displaced NWT patients.

3. In the midst of chaos, 1:1 connection is just as important as system-level communication

In a crisis, we all know that clear communication on a system level is critical. But when supporting people in vulnerable situations, listening and addressing individual needs is just as important as keeping one's eye on the big picture of coordination and planning. I believe that the 1:1 connections our team made, spending just a few moments hearing the specific situation and worries of each of our patients, is what allowed us to ensure safe transfer of care.

We are taught excellent doctor-patient communication skills in our medical training, and those with leadership training are taught the principles of group and system communication, but medical training does not necessarily prepare us to do both at the same time. With increasing demand to adapt and respond to crises, physicians as both clinicians and leaders must learn the skill of seamlessly weaving between meeting individual and system-level communication needs simultaneously.

4. Multiple patient-centered methods of communication should be encouraged and expected.

Privacy concerns often prevent healthcare providers from being able to effectively and efficiently communicate with patients. For example, neither email nor texting are considered approved means of communication with patients in the NWT. Our EMR does not have a patient portal (and even if it had, patient or provider access to their portal during transit would have been challenging). During Yellowknife's evacuation, phone calls were often not even possible as people were in transit through areas without cellular access.

Out of necessity, during the evacuation we did communicate partially by email (with patient consent). Pregnant evacuees themselves created their own Facebook pages to share information and to troubleshoot healthcare logistics.

In a crisis, we need fast, efficient and effective means of communication between evacuees and their healthcare team. These systems need to be identified in advance, they must be easy to use, and ideally they should capitalize on common platforms already in use, rather than requiring patients to log into cumbersome provider- or system-centric platforms.

5. Train for (and consider selecting for) adaptability and flexibility

Disasters and crisis situations require a high level of adaptability. As we will be called upon increasingly as healthcare providers to help navigate these crises, we need a workforce skilled in responsiveness, resilience

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and adaptability. Medical schools should examine their training with a critical lens to developing these qualities. Furthermore, as debate continues about entrance criteria to medical schools to identify the best candidates for the practice of medicine, we should consider selecting for people who already have these traits.

On a positive note, the evacuation experience showed us that we are in this together, across borders and systems. No one will be immune to the impacts of climate crises going forward. All the patients in the Northwest Territories are a tiny blip compared to the volume of patients in Alberta, yet our experience was that our closest neighbour stepped up in a major way to help, both as a system and as individuals. When our obstetrics evacuation plane landed on the evening of August 17, we were met by two AHS Edmonton Zone Executive leaders. Far from their usual executive duties, they immediately got into the trenches with us and stayed late into the night, helping to figure out hotels, food and bus rides for our displaced pregnant patients travelling to Calgary, Red Deer and Edmonton. From this impressive welcome, to the family doctors and specialists who received our patients into their practices, to the many people along the way who offered help to NWT evacuees, it was heartwarming to feel that we were not alone.

Further, the solutions I've suggested are well within reach. As we saw during the global pandemic, necessity can be a catalyst for great change. With some ingenuity and determination, we can harness the challenges of our new climate reality to move toward higher quality care that is continuous, seamless, connected and patient-driven. In this way, regardless of where we find ourselves displaced, we as both providers and patients can remain connected to something that is so critical in times of stress, our healthcare homes.

Dr. Sarah Cook is a family physician in Yellowknife, Northwest Territories. Her practice includes community-based primary care, GP oncology, reproductive health services and maternity care. She received her MD from Dalhousie University in 2005 followed by her CCFP in 2007 (University of Ottawa) and FCFP in 2018. She also holds both the Canadian Certified Physician Executive and Certified Health Executive designations. She serves as a Board Director and Honorary Secretary-Treasurer for the College of Family Physicians of Canada.

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