Return to April 3, 2001 Table of Contents

Canada's Ebola scare over but questions just beginning

It was 7 am on Feb. 5 when Dr. Douglas MacPherson, a tropical disease expert at the Hamilton Health Sciences Corporation, received a call from the neighbouring Henderson Hospital asking for help in diagnosing a 32-year-old Congolese woman brought to the hospital the night before. Three hours later, MacPherson walked into the intensive care unit, spent 5 minutes examining the patient and talking to doctors, and then ordered the national contingency plan for viral hemorrhagic fevers (**www.hc-sc.gc.ca/hpb/lcdc/publicat/ccdr/97vol23/continge/index.html**) put into effect.

Although fears of an Ebola-type outbreak eventually proved groundless, MacPherson, who was moving to a new job with Health Canada the following week, says the contingency plan worked well. It was brought into play because of the woman's country of origin — Ebola and other hemorrhagic fevers have taken thousands of lives in Africa — and the fact she was bleeding from the mucous membranes and had severe flu-like symptoms.

The contingency plan called for the introduction of a strict protocol: isolation of the patient, the introduction of precautionary measures such as contamination suits, communicating plans to health care workers and the public, and arranging for the transportation of the patient's body fluids to the 2-year-old Canadian Science Centre for Human and Animal Health in Winnipeg for testing. Body fluid samples were also sent to the Centers for Disease Control and Prevention in Atlanta for confirmatory testing. The contingency plan also involved monitoring 70 people, mostly hospital and laboratory staff, who had come in contact with the woman or her body fluids.

"I would say it [the plan] is probably as good as you're going to get," MacPherson told *CMAJ*. He says the question now does not concern whether medical procedures were followed properly — he says they were — but what might have happened had the same incident occurred at a small, out-of-the-way community hospital instead of a tertiary care centre. He says the issues raised by this case should teach a powerful lesson to anyone diagnosing patients in what is now a global community.

"We have porous borders and high volumes of people moving within wide areas of the world. In every diagnosis we have to be thinking, 'Where did this person come from? What [has she] been doing since [she] got here?' This is an essential part of clinical diagnosis."

Over the next few years, he says, more than a billion people will be travelling annually from one area of the world to an-

(Continued on page 1032)

Health policy analyst, economist CMA's new secretary general

Courtesy Bill Tholl

Bill Tholl, daughter Alexa: a vote of confidence

If the Canada Health Act (CHA) becomes a political hot potato again, the CMA won't have to look far for advice on how to respond. Its new secretary general, Bill Tholl, was one of the 3 Health Canada personnel who helped craft the CHA, which has set the rules for Canada's medicare system for the past 16 years. Tholl, who left Health Canada in 1990 to become the CMA's director of health policy and economics, has been executive director at the Heart and Stroke Foundation of Canada since 1996. He returns to the CMA as its senior nonelected official Apr. 17. He is only the second nonphysician to hold the job in the CMA's 133-year history. "I see it as a vote of confidence in what I've done at the CMA and Heart and Stroke, " he says.

About his new job, he adds: "I'm hopeful about the future for medicine, medicare and for health care. We just survived the black '90s, and they left medicare a severely traumatized patient. Two budgets ago we received stabilization of funding for health care, and then last September the Health Care Action Plan restored funding, with the CMA playing a critical role in both accomplishments. Now that the patient has been stabilized, we must transport medicare into the future and ensure that money invested in this patient is invested strategically."

Tholl says improving professional unity is a key priority. "We have to overcome the real or perceived lack of common purpose between the CMA and its divisions. We have to get back to basics and establish a stronger sense that we are in this together." He also thinks the CMA has become "unplugged" in terms of the opportunities presented by last September's federal-provincial health accord and the creation of the Canadian Institutes of Health Research. "I want to work on getting us plugged in. You're going to see a lot more policy research that will allow us to take our messages to [Parliament] Hill and to Tunney's Pasture [Health Canada headquarters]."

As for the Canada Health Act, Tholl remains proud of his involvement. "I'm not saying it's perfect," he says, "but the CHA guarantees that medicare's fundamentals are sound, and that fact helped shield MDs from the worst of the '90s recession."

He replaces Dr. Peter Vaughan, who left the secretary general's job last year. — *Patrick Sullivan*, CMAJ

(Continued from page 1031)

other, and this holds major implications for Canadian physicians. "One of the messages to medical students should be that any fever requires these 3 questions: Have you travelled? When did you travel? Have you had visitors from abroad? Travel history is as important as anything else doctors ask."

The patient in Hamilton, who had arrived in Canada from Ethiopia Feb. 3, was released from hospital Mar. 2 after making a complete recovery. By mid-March the medical sleuths responsible for her case were still attempting to discover what illness she had developed. "As someone who is interested in epidemiology, I would really like to know," MacPherson says. "But we may never know. It could be a totally new organism, or we may not be applying the right test. It could be an old organism that has undergone modification. In all these things, medical technology is always chasing to catch up.

"In terms of international mobile health surveillance, it really causes you to prick your ears up. Much of this is gumshoe epidemiology, and we all have a responsibility to be alert." — *Ken Kilpatrick*, Hamilton

Hong Kong considers medical savings accounts

As Hong Kong approaches the fourth anniversary of its return to Chinese sovereignty, its government is refining proposals for reforming the region's publicly funded health care system.

In a discussion paper released in December, Health and Welfare Secretary Yeoh Eng-Kiong outlined a wide-ranging series of proposals for revamping Hong Kong's system of public hospitals and medical clinics. Among the most controversial are plans to introduce individual medical savings accounts to help pay for postretirement medical needs and to establish an office within the health department to investigate complaints about public health care.

Bob Neufeld

Dr. Lai Kang-yiu: least harmful option

Currently, patients using Hong Kong's public hospitals pay approximately HK$68 (Cdn$13) per day for accommodation and medical services. The discussion paper proposes a comprehensive review of this fee structure and suggests the establishment of a compulsory contribution scheme under which Hong Kong residents aged between 40 and 64 contribute 1% to 2% of their salaries to a personal "health protection account." The money would be available only to fund medical or dental expenses or to purchase medical or dental insurance.

Reaction has been mixed. Dr. Lai Kang-yiu, president of the Hong Kong Public Doctors Association, says the proposals on mandatory health care savings are the "least harmful" option available, particularly when compared with earlier proposals for reform that would have set much higher levels of compulsory contribution. Over the long term, however, he feels that setting fees for public medical services that more closely reflect actual costs will help take pressure off the public system.

"The real solution is to narrow the price gap between the public and private sector and let citizens buy their own private insurance once they have anticipated their future needs," says Lai. — *Bob Neufeld*, Ottawa

Bob Neufeld, former editor of MD Management's *Strategy* magazine, won the 2000 Dateline Hong Kong Fellowship sponsored by the Canadian Association of Journalists and the Hong Kong Trade Office. This article was written after a visit to Hong Kong funded by that fellowship.

Canada's 17th medical school to be in northern BC?

Canada may soon have another medical school, albeit a small one. If the plan reaches fruition, the University of Northern British Columbia in Prince George will collaborate with the much larger University of British Columbia to launch a Northern Medical Program (NMP). Annual enrolment would be 15 to 20 students.

Part of an attempt to ease BC's chronic shortage of rural physicians, this plan is itself part of a proposed expansion of the UBC medical school's undergraduate and residency rural training programs. Under the Provincial Medical Education Plan (PMEP), undergraduate enrolment would increase from 120 to 200 students by 2006, with a corresponding increase in the number of residency positions.

The UBC medical school already has a "very successful" residency program in Prince George, and Dean John Cairns says many of its graduates stay in the North. Under the proposed NMP, students would complete about half of their medical education at the northern university and the remainder at UBC; they would graduate with a UBC medical degree.

The hope is that the northern program — slated to start by the fall of 2004 — would attract Aboriginal and other rural students who would be more likely to stay and practise in these underserviced areas. "I see this as a bold step in medical education in Canada," says UNBC President Charles Jago, who studied similar programs in Scandinavia, Australia and the US.

UNBC already has nursing and master's degree programs in community health and is launching a health sciences program. Jago hopes the outcome of the new program will be similar to what he saw in Australia, where educators are focusing on making rural practice "an exciting and preferred form of practice for students entering medical school." Residents and medical students will be tracked to see where they ultimately practise. — *Heather Kent*, Vancouver