

THE INCLUSION OF PRIMARY CARE PHYSICIANS IN PANDEMIC FLU PLANNING

AN ANALYSIS OF HISTORICAL LESSONS AND CURRENT ISSUES

A Paper Presented to the
College of Agriculture Honors Committee
of
Kansas State University

by
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In partial fulfillment of requirements
for the honors program of
Kansas State University.

April 2007

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Acknowledgements

The research contained in this paper reflects one of the most valuable learning experiences that I have had during my time as an undergraduate student. I have gained countless skills in research, writing, and critical thinking. However, these lessons would have never been found had it not been for the efforts of a few helpful and very talented individuals.

I would like to thank Sue Zschoche, PhD, Chair of the Department of History at Kansas State University. Her course, The Social History of American Medicine, stimulated an understanding of the complex historical nature of this issue. I would also like to acknowledge James Kallail, PhD, and his help with the University of Kansas School of Medicine's Scholars in Primary Care Program, which provided the initial framework and guidance for this project. Dane Ditto, MD, has served as my mentor physician for that program for the past two years. He has been a constant source of information and a helpful perspective from which to gain ideas and insight. I'm thankful for his willingness to show me the ins and outs of the practice of medicine. The College of Agriculture Honors Program at Kansas State provided me with funding for portions of this project, allowing me to travel for the interviews involved with my research.

Finally, I am most grateful for the help of Justin Kastner, PhD, at Kansas State University. Dr. Kastner was kind enough to allow me to use this project as an internship in his Multidisciplinary Food Safety and Security Internship Program. His personal coaching and unending advice drastically improved my writing and allowed me to learn about tools and resources for research. Most importantly, however, Dr. Kastner constantly challenged me to think more critically and more broadly about the subject.

Because of his help, this project became a learning experience in research, rather than just another college paper. He has been an exceptional mentor, a patient teacher, and a valued friend. Without his help, this project and experience would have been next to impossible.

Undoubtedly others have provided me support and resources for this project. I am grateful for their efforts on my behalf, and their investment of time and energy in this experience.

Jacob Lauer
April 2007

Preface

This project, which began as a search to answer a single question, slowly evolved into a web of history, sociology, biology, and epidemiology. As the research developed its multidisciplinary nature, my interest in the matter grew. The topic is relevant and important; I believe my research has exposed additional critical questions and highlighted issues related to influenza and the public health system. However, it was the process of learning and understanding involved with the search for an answer that has brought me the most joy. This quest has led me through respected historical works, library databases, government websites, state government offices, and the desks of historians. At times, it seemed as though my research was complete, but at those times another topic, question, or thought would inevitably reveal itself, pleading for an answer.

Just as an artist's work is never truly finished, I believe this issue has many more questions to answer and topics to uncover. However, I have tried to dissect one of these issues—the role of primary care physicians—and shed light on its roots, its current state, and direction for future solutions.

Introduction

Most infectious disease experts believe that the world stands on the verge of an influenza pandemic that could cause tens of millions of deaths.¹ The realization that the U.S. health care system is poorly prepared for such a disaster has prompted detailed planning, preparation, and practice for agencies from the local to the international level.²

Primary care physicians, the initial source of treatment for most Americans, will undoubtedly serve as a crucial arm of the public health response to an influenza pandemic. However, the autonomy in which most primary care physicians practice presents a challenge to the coordination of the public health system. Their independence as a profession, with no required responsibility* to the public, begs the following question: are primary care physicians adequately integrated into pandemic influenza preparedness planning? The aim of this paper is to discuss the role of primary care doctors during an influenza outbreak. This will be accomplished by reviewing historical examples and analyzing current preparation issues.

Background, Rationale, and Research Question

Influenza is a highly contagious disease of the respiratory tract caused by one of three virus types: A, B, or C. The A type virus is generally considered the most threatening to human populations, partially because of its ability to be quickly transmitted. The classification scheme for this type includes two antigen glycoproteins:

* While physicians are very altruistic, the medical system in the U.S. does not provide systematic control over their practices. The vast majority of primary care physicians practice in private clinics—preventing direct government intervention in their work.

hemagglutinin and neuraminidase. These are abbreviated as H and N, respectively, in the virus name. These two antigens are used to differentiate various serotypes based on their antibody response.

The challenge in battling the Influenza A virus comes from its ability to undergo major genetic re-assortment in an animal host resulting in a novel strain. If this new strain is able to be transmitted from human to human, it could birth an epidemic and cause widespread destruction.³

It is important, when discussing disease from a public health perspective, to clearly define descriptive terminology. Differentiating between “pandemic” disease and “epidemic” disease is critical, not only for communication’s sake, but to distinguish correctly between different levels of disease presence and propagation. While an epidemic denotes a disease with “limitation to a smaller area (p. 129),” a pandemic is a more global occurrence that affects different parts of the world simultaneously.⁴ Therefore, an epidemic, if sufficiently transmissible, can become a pandemic by moving through populations in more widespread geographical locations.⁴

Three major pandemics (1918, 1957, and 1968) of influenza have occurred in the past century.⁵ Of these three pandemics, the H1N1 virus that spread globally in 1918 was the most devastating. Statistics for this pandemic, though only estimates, have changed since the first attempt at quantifying the death toll in 1927. At that time, the American Medical Association estimated that 21 million people, worldwide, had died because of the disease. However, since that time, epidemiologists have estimated that the actual death toll was more likely around 50 million.⁶ The U.S. alone lost almost 675,000 people out of a population of 105 million.⁷

In studying the health care response to the 1918 pandemic in the U.S., it is clear that the medical system was overwhelmed. This was, at least in part, because there was no confirmed knowledge of influenza's cause. At the time, most physicians and researchers still believed it to be a bacterium, *Pfeiffer's bacillus*.⁸ This lack of understanding led to the trial of many therapeutic techniques. Everything from saline vaccines and opiates to cupping and bleeding was used to treat the seemingly unstoppable disease. Around the world, hospitals were so congested that "it was impossible to remove the dead quickly enough to make room for the dying (p. 364)."⁶ Individual physicians were left to face the disease virtually empty handed.

The 1918 virus was especially virulent. A typical influenza pandemic produces a mortality rate of about 0.1 percent. The H1N1 virus of 1918 caused the death of 2.5 percent of those who contracted the virus.¹ The mortality was astonishing, but even more surprising was the age group that was most violently affected. Most disease pandemics, influenza or otherwise, cause the majority of deaths in the most susceptible ages of the population—the very young and the very old. In this pandemic, by contrast, most deaths occurred in young adults.^{1, 6}

Since the aftermath of the 1918 pandemic, the world has seen multiple epidemics and two pandemics of influenza. Although science has advanced our understanding of the disease and improved standard treatment, social and technological changes (e.g., faster and more frequent international travel) could cause a pandemic to be more widespread.⁹ In addition, outbreaks of an avian influenza virus, especially in Asian countries, have spawned renewed fear of influenza's virulence in the human population. This virus of the H5N1 strain killed 68 percent of humans who

contracted it in early 2004. Vietnam and Thailand both reported additional deaths later that year (see FIGURE 1).¹

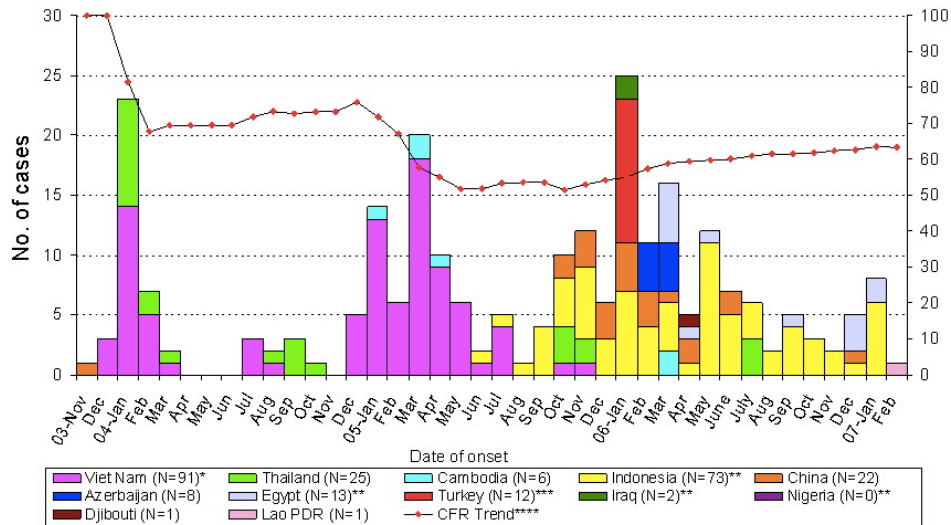


FIGURE 1: Cases of Human Avian Influenza (H5N1) by Date and Country (Source: World Health Organization¹⁰)

Since 2004, the number of confirmed human cases reported by the World Health Organization has increased steadily. The high mortality caused by this virus serves to highlight the potential impact of an influenza pandemic. If this virus were to become transmissible between humans, it could spread with speed and mortality previously unseen in pandemic disease.

The potential for such devastation in the event of a pandemic has challenged governments, health agencies, and hospitals to begin preparations for such a disaster. Primary care physicians, who will surely have a key role in the health care response, also have been forced to consider how they should plan and prepare. However, in the midst of all the planning, some physician-based organizations have pointed out that most plans do not clearly provide for the involvement of primary care providers.

The American College of Physicians (ACP), with its 120,000 members, has been vocal in responding to this shortcoming.¹¹ In 2006, the ACP described its concerns about voids in the U.S. Department of Health and Human Services (HHS) Pandemic Influenza Plan. They noted that the HHS plan “provides a much needed step forward (p. 16)” but does not describe clearly how medical care will be rationed.¹² Additionally, the ACP voiced its concern regarding “the plan’s failure to thoroughly incorporate the role of physicians in non-hospital based settings in playing a leading role in the health care response (p. 16).”¹² They pointed out that this inadequacy could have serious consequences:

“Failure to integrate physicians in the local and state health care response plans will result in the underutilization of a key community resource and may contribute to an unnecessary bottleneck in the provision of patient care that will only serve to further strain the capacity of the nation’s hospitals for treating the most severely ill (p. 16).”¹²

This uncertainty—whether or not physicians are adequately integrated into pandemic response plans—must be addressed. Two important research questions emerge from this uncertainty:

1. What challenges to physician involvement were uncovered in past influenza pandemics, particularly the 1918 pandemic?
2. What challenges to physician involvement remain in today’s pandemic-flu planning?

Methodology

The complex and multifaceted nature of a public health system assessment dictated both a multidisciplinary and multidimensional analysis. The primary methods of research were personal interviews, database searches, and literature reviews. In assessing the potential effectiveness of public health preparedness measures, historical examples of healthcare system responses provided valuable insight into present issues. For this reason, the research was focused into two areas: a historical comparison and a current analysis.

First, the history of past influenza epidemics and the health care system's response to them was analyzed. The Centers for Disease Control and Prevention (CDC) and other public health agencies have chosen the 1918 influenza pandemic as a model from which to understand this historical perspective.¹³ This pandemic was chosen because of its high mortality, speed of transmission, and breadth of global impact. The same pandemic was used in this assessment of the health care response. Two major historical works, *America's Forgotten Pandemic* by Alfred Crosby⁷, first published in 1976, and *The Great Influenza* by John Barry⁶, and other historical source documents were used to study this model.

An analysis of current plans in order to understand the role of primary care physicians in influenza epidemics was conducted through a comprehensive literature review and multiple interviews. PubMed¹⁴ and Google Scholar¹⁵ were used to search for articles and research focused on this aspect of public health planning. Multiple government planning documents were obtained and scrutinized for their inclusion of non-hospital based physicians. These included plans from the U.S. Department of

Health and Human Services (HHS)¹⁶, the Kansas Department of Health and Environment (KDHE)¹⁷, and the World Health Organization (WHO)¹⁸. Planning documents were also considered from private primary care clinics and regional hospitals.

Throughout the research, multiple perspectives of the healthcare system were taken into account. Practicing physicians have a very different view of pandemic influenza than do government officials and hospital administrators. Consequently, it is impossible to study completely all the various components of health care system's response. However, by considering as many different elements of the system as possible, a widely inclusive frame of reference was obtained.

TABLE 1 outlines the methods utilized for each area of research.

TABLE 1: Areas of research and methods used

Disciplinary methods and areas of research	Databases consulted, major literature reviewed, and persons interviewed
<p>Historical research regarding the role of physicians and the healthcare system in the 1918 pandemic</p>	<ul style="list-style-type: none"> ▪ Journal Storage – JSTOR (keywords: 1918 influenza pandemic, influenza pneumonia pandemic) ▪ Sue Zschoche, PhD – Professor of History, Kansas State University, Manhattan, KS¹⁹ ▪ <i>The Great Influenza</i> by John Barry⁶ ▪ <i>America’s Forgotten Pandemic: The influenza of 1918</i> by Alfred Crosby⁷ ▪ <i>Public Health: Past, Present, and Future</i> edited by Raj Bhopal and John Last²⁰
<p>Literature based research regarding current planning and preparation for pandemic flu</p>	<ul style="list-style-type: none"> ▪ PubMed (keywords: pandemic influenza, primary care physicians and influenza, pandemic preparedness)¹⁴ ▪ Google Scholar (keywords: pandemic influenza, influenza preparedness)¹⁵ ▪ Kansas State University Library Catalog (keywords: pandemics, influenza planning)
<p>Interview based research involving policy makers, physicians, and researchers</p>	<ul style="list-style-type: none"> ▪ Howard Rodenberg, MD, MPH – Director of Division of Health (KDHE)²¹ ▪ Deborah Doubek, MD – Family Physician, Manhattan, KS and former president of the Kansas Medical Society ▪ Dane Ditto, MD – Family Physician, Manhattan, KS²² ▪ Joe Phillip, MD – Chief Medical Officer, Mercy Regional Health Center, Manhattan, KS ▪ Dan Leong, Kansas Hospital Association, Topeka, KS ▪ Mindee Reece, Director, Center for Public Health Preparedness, Topeka, KS²³

Results – Historical Research

During the 1918 outbreak of influenza, the health care system faced challenges from many directions. Some of the issues were circumstantial and specific to the time of the pandemic, while others arose from the fledgling public health system and the state of the medical establishment. The major reasons why the 1918 pandemic overwhelmed the healthcare system, and specifically, what prevented physicians from having an influential role, will be outlined using four different sources of stress:

1. Uncontrollable circumstances of the time;
2. The government (federal, state, or local) supported public health system;
3. Coordination among the government, private agencies, and the public; and
4. The training, supply, and coordination of physicians.

The first three sources of stress directly influenced either the supply of physicians, or their ability to understand and execute their roles in the healthcare response.

The major historical event that influenced the unfolding of the 1918 pandemic was World War I (WWI). The preparations for the war, especially in the U.S., involved a massive build-up of troops, concentrating men from different geographic areas and contributing immensely to the rapid transmission of the virus.⁶ Additionally, the military expansion necessary for war created a shortage of medical personnel, including physicians and nurses. This directly decreased the quality and amount of healthcare available to the civilian population during the pandemic. Although the war contributed to the effects of the pandemic, it also provided some benefits to the advancement of public health. For example, the military was able to keep precise data regarding the spread of the virus through its personnel, the efficacy of various treatments, and the mortality of

the virus. These detailed records have enabled researchers to learn much from the events of 1918.¹⁹

In 1918, the major government entity charged with battling infectious disease was the United States Public Health Service (USPHS). However, when the pandemic struck, this federal agency was unequipped to handle the massive demand of leadership and resources. While many states and locales had their own public health departments, these independent agencies were not integrated effectively at the national level. This lack of cooperation created a challenge for the USPHS to gather data and to organize personnel for the needs of individual communities.⁷

Local public health departments began to appear in America shortly after the U.S. Civil War (1861-1865) and would, for at least the next fifty years, struggle to define their roles and implement services into the larger systems of healthcare and medicine.²⁴ These programs were largely born out of the sanitary campaigns of the mid-1800s and were relatively insignificant at the turn of the century—focusing almost entirely on the physical environment of the community.²⁵ However, as science began to unravel the microbiological causes of human disease, public health began to develop as a science of its own. The significance of this new field was reflected in the founding of the first institution devoted specifically its study—the Johns Hopkins School of Hygiene and Public Health in 1918.* As a response to new discoveries linking individual illness with

* Ironically, William H. Welch, the first dean of the school, was not able to attend the opening ceremonies on October 1, 1918. He was sick – likely suffering from contraction of influenza – the very disease that his prestigious institution was battling.⁶ Though the Johns Hopkins School of Hygiene and Public Health was the first of its kind in the U.S., Europe had recognized public health's value years before. In October 1902, The John Usher Institute of Public Health was established at the University of Edinburgh in Scotland. This institution was largely responsible for the development of Edinburgh, once a city of stench and filth, into one of the twentieth century's greatest cities.²⁰

disease transmission, public health departments began to assume broader roles including some aspects of diagnostic medicine. This widening of responsibility led to conflict between physicians and health departments regarding access to the patient population. Physicians strongly objected to “actual or potential encroachment on the area of medical practice and its economic aspect (p. 42).”²⁵ This disagreement over the jurisdiction of the two establishments produced a public health system that was neither organized nor effective. Physicians viewed the treatment of patients by public health departments as government funded competition to their businesses and the required reporting of certain diseases as an infringement on the patient-doctor relationship.²⁴ While public health departments sought to curb disease transmission by treating patients, physicians contended for the sovereign right to diagnose and cure.²⁵

Despite the disagreement with physicians over their respective roles, the influence of public health was strong in the early 20th century. From 1904 to 1924, the number of physicians employed by public health departments grew steadily.²⁵ These agencies were riding on the wave of effective campaigns such as that of New York City’s Metropolitan Board of Health in 1866 and the National Association for the Study and Prevention of Tuberculosis between 1905 and 1915.²⁴ Although their influence in communities through programs and campaigns was significant, public health departments lacked authority in the relationship between themselves and physicians. This was evidenced by their inability to effectively require the reporting of communicable diseases by doctors in private practice.²⁴ Consequently, this produced a system which was ineffective in gathering data on epidemic disease and contributed to the difficulty for the healthcare system to mount an appropriate response to the 1918 flu.⁷ Over time,

public health departments would take an auxiliary role to physicians and their efforts in diagnosis and treatment.²⁴

As the war put a demand on the supply of physicians and the government scrambled to organize and disperse those that remained, the entire healthcare system struggled to find solutions, leadership, and direction in the face of influenza. Multiple organizations, from both the government and the private sector, attempted to meet the seemingly immeasurable demand for healthcare. The American Medical Association (AMA) appealed to its membership for service to flu victims.⁷ The American Red Cross made an effort to organize both nurses and physicians.⁶ The USPHS, ill-equipped and unprepared, tried to coordinate and ration healthcare to the most needed cities and states.⁶ These efforts failed to designate a central point of leadership: a primary coordinator of medical personnel.

Clearly, one of the greatest challenges for the medical system in 1918 was the inability of physicians to treat influenza correctly and consistently. Initially, this reality was not realized by the scientific and medical community. In fact, the director of Philadelphia's laboratories stated that *Pfeiffer's bacillus* had been isolated as the cause of influenza. It was reported that this finding "armed the medical profession with absolute knowledge on which to base its campaign against this disease (p. 72)."⁷ Recently armed with advances stemming from germ theory and bacteriology, the revelation that no medicine, vaccine, or plan of care was effective was a blow to medical circles. Not even masks, distributed by the millions, were thwarting contraction of the disease.⁶ Preventing exposure by strict quarantine or isolation was the only tactic that proved to be at all effective.²⁶

The second collective problem for physicians in 1918 was the lack of a sufficient presence; there were simply not enough of them. The shortage of both medical doctors and nurses left the general public to scramble for adequate healthcare and advice. This was exaggerated by the military's increasing demand for medical personnel in the war effort. Tens of thousands of physicians were called upon to serve the country's needs in WWI, and the military accepted only those physicians who were competent and qualified. By the end of the war, 38,000 physicians were serving the military. This left the general American public with a small supply of physicians, and an even smaller supply of competent and well-educated doctors.⁶

As the outbreak wreaked havoc on communities, facilities were created or expanded to deal with the sick, the dead, and the dying. These haphazardly thrown together facilities put tremendous strain on the shortage of personnel.⁷ It also put doctors, nurses, orderlies, and other key problem solvers in an environment that increased their risk of contracting the virus. Indeed, this was the result as a great number of them fell ill.⁷ Without vaccinations or effective barriers to contraction, the educated, trained, and experienced medical workers died of influenza with a mortality rate over 50 percent.¹³

While the shortage of physicians alone was a significant burden on the healthcare system, another challenge arose in finding licensed and qualified doctors. The military did not accept physicians over the age of forty-five; as a result, the civilian population was left with many doctors who had been trained in archaic and non-scientific ways of medicine.⁶ The government had to find a way to coordinate the remaining competent physicians. In January 1918, the Council of National Defense

created the Volunteer Medical Service Corps (VMSC) whose aim it was to provide physicians as needed by the USPHS.⁷ The enrolled physicians were not enlisted in the military for various reasons but had been graded as competent by a local medical committee.²⁷ Unfortunately, the effort failed as the virus began to spread ubiquitously. Doctors had to tend to their own patients and the government's pay—\$50 a week—was not a significant draw.⁶ The VMSC had an enrollment of 72,219 physicians at the end of WWI, but only 1,045 physicians actually would serve the USPHS through the corps.²⁷

Results – Literature and Interview Based Research of Current Planning

In the planning for pandemic influenza, several assumptions have been made in order to help focus ideas and strategies. These include:

1. A pandemic is inevitable;²⁸
2. Infection rates will be high, most likely 30% of the population;¹⁶
3. The healthcare system will be strained, and care will have to be rationed;^{12, 28}
4. There will be high mortality;^{28, 16} and
5. It will cause both economic and social disruption.²⁸

These assumptions, along with others, have guided planning by agencies around the world. This endeavor has been led by the World Health Organization (WHO), which released its original plan for pandemic influenza in 1999.

The U.S. Department of Health and Human Services (HHS) plan¹⁶, released in October 2004, provides for primary care physicians in several ways. It is divided into two parts; the first is a strategic plan on a national scale, and the second is a guide for state and local health partners.¹⁶ The latter provides supplemental planning guides to help both hospitals and non-hospital practices (including private medical practices) develop plans for operation during a pandemic. It acknowledges that “management of

outpatient influenza cases will reduce progression to severe disease and thereby reduce demand for inpatient care (pg. 13).²⁹ Consequently, the HHS plan provides nine recommendations to non-hospital healthcare facilities. These include development of written plans, determination of communication strategies, coping with affected staff and employees, and procurement of supplies.²⁹ Another supplement in Part 2 of the plan contains clinical guidelines to aid physicians and other healthcare personnel in identifying, classifying, and treating influenza cases.³⁰ The HHS makes recommendations to state and local health authorities concerning priority groups for vaccination. Medical workers and healthcare workers are included in the first tier and sub-tier of this prioritization.³¹ Lastly, the monitoring of influenza cases is referred to under the presently existing “Sentinel Provider Network,” a collaboration of 2,300 physicians and health departments across the U.S. which are responsible for reporting cases of influenza.^{32, 33}

In October 2005, the KDHE released the Kansas Pandemic Influenza Preparedness and Response Plan.^{17*} This plan was based on planning recommendations from the CDC and WHO. It clearly addresses the strain that hospitals will face in the event of a pandemic, but it does not specifically address physician offices or clinics. KDHE responsibilities in the plan include maintaining the Public Health Information Exchange (PHIX) System to communicate information to both public health officials and healthcare professionals. Additionally, the plan acknowledges that the State Health Officer has convened a task force to “ensure that the medical community is made aware of issues related to pandemic influenza (p. 16).”¹⁷ This task

* In a 2006 report by the Trust for America’s Health, Kansas ranked second in the nation for public health emergency preparedness. This report is released annually and ranks states based on ten indicators of preparedness.³⁴

force has been working with organizations such as the Kansas Medical Society (KMS) and the Kansas Hospital Association (KHA) to detail the responsibilities of physicians and hospitals in a pandemic situation.²³

The ACP’s response to the HHS plan is directed at the aspects of the plan that “explicitly or implicitly call for the involvement of physicians.”³⁵ The College’s position is outlined in nine different positions. These positions are condensed and summarized in the following table:

TABLE 2: The ACP’s response to the HHS Pandemic Influenza Plan³⁵

Component of the HHS Pandemic Influenza Plan	ACP position and/or recommendation
The development of local pandemic influenza task forces	<ol style="list-style-type: none"> 1) Physicians should be integrated into the local task forces. 2) All physicians should be provided with a copy of state and local plans. 3) Strategies should be developed for the procurement of medical supplies for health care providers.
Communication between public health authorities and physicians	<ol style="list-style-type: none"> 1) The Sentinel Provider Network (SPN), which currently is used to monitor influenza cases, should be expanded to include more physicians. 2) Communication systems should be identified and developed which are easy to use and accessible to physicians.
Identification of volunteer emergency health care providers	<ol style="list-style-type: none"> 1) Plans should identify the agency responsible for the oversight of volunteers. 2) Volunteer’s licensing should be verified by an agency with the proper authority.
Distribution of vaccine and antiviral medications	<ol style="list-style-type: none"> 1) The current system for delivering seasonal flu vaccine should be improved and streamlined. 2) Plans should ensure that physicians will have access to vaccine and antiviral medications.
The use of nonhospital-based health care providers	<ol style="list-style-type: none"> 1) Physicians should be consulted to find the alternative sites. 2) Physician leadership should be established for the staffing and supplying of alternative care sites.

Howard Rodenberg, Director of the Division of Health, KDHE, is the primary official responsible for pandemic flu planning in Kansas. In response to the ACP's analysis of the HHS plan, Rodenberg commented, "In a lot of ways, the ACP has it right."²¹ He noted, however, that in planning for pandemic illness, the federal government does not deal with the individual practitioner; they deal with institutions (e.g., the Kansas Medical Society, the Kansas Hospital Association). The following question is begged: is there a role for the individual practitioner? "Absolutely," responded Rodenberg.²¹ He described this role as having three parts:

- 1) Being a clinician and treating patients;
- 2) Serving to educate the public; and
- 3) Serving as a leader for their community.

When asked if physicians are aware of these roles and capable of fulfilling them, Rodenberg answered, "As scientists, the physicians are fully capable and have the public's best interests in mind."²¹ He judged his confidence in primary care providers to understand and fulfill their roles in a pandemic as 7.5 out of 10. Rodenberg was questioned as to why he did not answer with a higher number. "Physicians are busy people and it is hard for them to find time to attend more meetings," he said.²¹ However, Rodenberg believed that the attendance of physicians at planning meetings would improve his confidence that they are "on board" in case of a pandemic.²¹

This conflict between the need for physicians to be involved in planning and their lack of time to do so was echoed by other officials and by physicians themselves.^{23, 22}

Mindi Reece, Director of the Kansas Center for Public Health Preparedness, is charged with guiding the Kansas Pandemic Flu Task Force. Funded by a grant from the CDC, this multidisciplinary task force is responsible for building a comprehensive planning

document for pandemic flu that incorporates numerous agencies and organizations. “It has been a challenge to get doctors involved,” admitted Reece.²³ The task force currently involves the Kansas Clinical Resource Network—a group of medical doctors through the University of Kansas Medical Center—to gather input from the physician perspective.²³

Clearly, physician involvement in pandemics is a critical factor in the healthcare system’s response. However, given the complexity and qualitative nature of the topic, peer-reviewed research is scarce. In a study conducted in 2006, 744 emergency and primary care physicians were surveyed about their preparedness for incidents of bio-terrorism and other potential public health emergencies.³⁶ A majority of primary care physicians—seventy-seven percent—described influenza as being a greater threat to public health than bio-terrorism. Ninety-three percent of them responded that their local health care system needs to be prepared for epidemics such as flu, but only forty-seven percent of them felt that the system was prepared already. The survey also probed the issue of the willingness of physicians to serve during a pandemic. Fifty-one percent of primary care providers said they would volunteer in a medical reserve corps. Fifty percent of them said they would be willing to put their lives at risk of contracting the illness if it was the only way to save the lives of others.³⁶

A qualitative study published by Australian researchers in 2006 addressed general practitioners’ response to pandemic flu.³ Each of the subjects interviewed in this study conveyed that they would continue to work during a pandemic. However, this willingness was somewhat dependent upon the “education, training, and supply of equipment (p. 267)” to support their efforts.³ For example, fifty-five out of sixty of those

interviewed said they would cease to work if personal protective equipment (e.g., gloves and masks) was not available. They insisted that the government had a responsibility to provide such equipment in the event of a pandemic. Additionally, many of the participants cited the care of their own patients as their primary responsibility. They expressed the concern that serving in at an alternative care site would compromise the well being of their own patients.³

Discussion and Conclusions

It is impossible to draw a complete comparison between historical examples and the current situation. The number of variables involved with such a comparison is virtually endless. For example, it is clear that the troop movement and concentration involved with WWI had a dramatic effect on the spread of the 1918 virus. Today, there is not the same level of organized people movement and localization. However, global travel by the individual is exponentially greater today than in 1918 and its speed and frequency brings another variable to any public health planning.

In light of the 1918 pandemic and current discussions and plans regarding influenza, the following conclusions can be made:

- 1) *Physicians are willing to serve during a pandemic. However, government support and the availability of resources will affect their level of involvement.*

Physicians generally possess an attitude of altruism in regards to their profession: they will not desert their role as a healer just because of a pandemic. However, as the risk to their own health, and the health of their staff and families' increases, the willingness of physicians to serve will

- diminish. Planning must provide for physicians to have access to vaccines, antivirals, and protective equipment, in order to ensure their well being and ability to continue working.
- 2) *Primary care physicians do not have the time to engage fully in pandemic planning activities.* Consequently, they must be informed, organized, and led through key community officials or appointed leaders. These leading physicians should participate in planning activities and communicate these plans to other physicians during a pandemic.
 - 3) *Communities should develop plans for coordinating local physicians that will allow alternative care sites to be functionally staffed.* Most physicians work within a private practice. During an influenza pandemic, they will work first to ensure that their own patients are provided with necessary medical care. This will leave very few physicians to fill volunteer roles for those without a primary care provider. Alternative care sites (e.g., schools, churches, long-term care facilities) that are established for the excess hospital patient load will not help if they do not have sufficient medical personnel.
 - 4) *Full coordination of physicians is not possible under the U.S. healthcare system.* The history of medical practice in the U.S. has established a system in which physicians work independently of the public health system and government agencies. Consequently, physicians will choose to respond to pandemic conditions differently and adjust their practice accordingly. No amount of planning or preparedness will account for all the variables involved in the health care system's response, including physician involvement. Focus

should be given to providing doctors with resources, information, and support so that their efforts are fully utilized.

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