From global threats to local practices: The important role British Columbian clinicians play in world health security

World Health Day is marked annually on 7 April to recognize the founding in 1948 of the World Health Organization (WHO), which plays a critical role in preserving the health of people around the world and promoting global health security—the capacity of health systems to prevent, detect, and respond to health threats while maintaining resilient health services and sustaining public trust.[1,2] In 2026, amid geopolitical fragmentation and substantial reductions in investments in public health institutions like the WHO, there is an increased risk of larger disease outbreaks and worse outcomes in population health overall. We must counteract these changes by preserving global cooperation, protecting the independent scientific voice of public health institutions, and upholding commitments that have been made. Despite lessons learned from COVID-19, global health security remains fragile and disparate; many systems are reverting to prepandemic vulnerabilities.[3,4]

Global health security is not a distant concern; it shows up daily in primary care, community health, emergency departments, hospitals, and laboratories in BC. The proficiency to recognize unusual presentations or clusters of illness, implement appropriate infection prevention and control measures, and ensure timely reporting of concerns to local public health departments are hallmarks of clinical vigilance, expertise, and system maturity. National and international frameworks devoted to controlling the spread of public health threats count on these everyday practices as the foundation of surveillance and early-warning systems.[5,6]

Additionally, health security depends on health system resilience—the capacity to absorb shocks, adapt, and continue delivering care.[7] Health system resilience is a clinical issue that shapes whether care can be delivered safely during times of strain, such as wildfire seasons, extreme heat events, infectious disease surges, or other prolonged system stress. Resilience is built through systems used every day to ensure staffing operations, referral pathways, technological infrastructure, and interdisciplinary collaborations promote high-quality clinical care and professional training.[8]

Few lessons from the COVID-19 pandemic are more certain than the importance of trust, an essential but fragile asset for health security. Trust in clinicians, public health institutions, and health systems shapes patient behavior, adherence to guidance, and, ultimately, health outcomes. Clinicians in particular play a unique role in preserving it, as trusted care providers who share evidence-based information with their patients and communities. There is growing evidence that trust deserves to be considered a determinant of preparedness.[9] When trust is present, communities are more resilient to periods of uncertainty and disruption. In its absence, even the most scientifically compelling interventions may be dismissed.

A One Health perspective—recognizing that human, animal, and environmental health are interconnected—is increasingly used to frame health security.[10] With our province's diverse ecosystems, frequent climate change events, and human–animal interfaces, biological threats occur routinely and require coordination to respond seamlessly and effectively across jurisdictions and sectors. For clinicians, this necessitates diagnostic considerations that encompass community and environmental factors that not only shape the health of the presenting patient but also prevent further escalation.[11]

To this end, systems that can act quickly and collaboratively matter. Preparedness is a capability that needs to be nurtured for proactive, coordinated practices that demonstrate response readiness. During times of crisis, systems often perform only to their level of preparedness.

When health security works well, it remains largely invisible. When it fails, its absence reverberates across borders, as we saw with COVID-19. This quiet paradox is the responsibility of modern public health and the shared duty of health system leaders and clinicians worldwide.

On World Health Day, let's recognize health security not as an abstract global agenda but as a core determinant of clinical care, system resilience, and public trust. ■

—Jat Sandhu, MPH, PhD, MBA
Chief Strategy Officer, BCCDC
Clinical Associate Professor, UBC School of Population and Public Health

This article is the opinion of the BC Centre for Disease Control and has not been peer reviewed by the BCMJ *Editorial Board.*

References

1. Malik SM, Barlow A, Johnson B. Reconceptualising health security in post-COVID-19 world. BMJ Glob Health 2021;6:e006520. https://doi.org/10.1136/bmjgh-2021-006520.

References continued on page 109

Key points

- Patients with a physical injury from a specific single incident at work (e.g., a fall, being struck by an object) can report it at www.worksafebc.com/report-injury.
- Patients can report other injury types and illnesses by calling 604 231-8888 or 1 888 967-5377.
- Free posters and wallet cards to inform patients about how to report are available at www.worksafebc.com/report-injury-poster.

rooms, and the wallet cards can be given to injured workers who visit for initial treatment. To order, visit www.worksafebcstore.com (click the Publications tab and then choose either the Posters or the Card category). The poster is also available to download and print at www.worksafebc.com/report-injury-poster. ■

—Angelo Cabalfin
Senior Manager, Claims Intake Services, Claims Intake and Adjudication Services, WorkSafeBC

COHP

References continued from page 106

6. Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the prevention, diagnosis, and management of COPD: 2026 report. Accessed 24 December 2025. https://goldcopd.org/2026-gold-report-and-pocket-guide/.
7. Petrella F, Rizzo S, Masiero M, et al. Clinical impact of vaping on cardiopulmonary function and lung cancer development: An update. Eur J Cancer Prev 2023;32:584-589. https://doi.org/10.1097/CEJ.0000000000000797.

BCCDC

References continued from page 105

2. UBC Centre for Disease Control. Global Health Security Forum. Strengthening global health security through collaboration and innovation. Accessed 15 February 2026. https://ubccdc.med.ubc.ca/.
3. Global Preparedness Monitoring Board. A fragile state of preparedness: 2023 report on the state of the world's preparedness. 30 October 2023. Accessed 15 February 2026. www.gpmb.org/reports/m/item/a-fragile-state-of-preparedness-2023-report-on-the-state-of-the-worlds-preparedness.
4. Kickbusch I. Europe has greater responsibility in the WHO without the United States. BMJ 2026;392:s182. https://doi.org/10.1136/bmj.s182.
5. World Health Organization. World Health Assembly adopts historic Pandemic Agreement to make the world more equitable and safer from future pandemics [news release]. 20 May 2025. Accessed 15 February 2026. www.who.int/news/item/20-05-2025-world-health-assembly-adopts-historic-pandemic-agreement-to-make-the-world-more-equitable-and-safer-from-future-pandemics.
6. Saif-Ur-Rahman KM, Burke NN, Murphy L, et al. Synthesizing public health preparedness mechanisms for high-impact infectious disease threats: A jurisdictional scan. J Evid Based Med 2025;18:e70019. https://doi.org/10.1111/jebm.70019.
7. Thomas S, Sagan A, Larkin J, et al. Strengthening health systems resilience: Key concepts and strategies. Policy brief 36. European Observatory on Health Systems and Policies. 2020. Accessed 15 February 2026. https://iris.who.int/handle/10665/332441.
8. Organisation for Economic Co-operation and Development. Ready for the next crisis? Investing in health system resilience. 23 February 2023. Accessed 15 February 2026. https://doi.org/10.1787/1e53cf80-en.
9. Bærøe K, Árnason V, Jansen M, et al. Pandemic and crisis preparedness and response: Conceptualizing cultural, social and political drivers of trustworthiness and collective action. Public Health Ethics 2025;18:phaf004. https://doi.org/10.1093/phe/phaf004.
10. Adisasmito WB, Almuhairi S, Behravesh CB, et al. One Health: A new definition for a sustainable and healthy future. PLoS Pathog 2022;18:e1010537. https://doi.org/10.1371/journal.ppat.1010537.
11. Jassem AN, Roberts A, Tyson J, et al. Critical illness in an adolescent with influenza A(H5N1) virus infection. N Engl J Med 2025;392:927-929. https://doi.org/10.1056/ NEJMc2415890.

JCCs

Continued from page 107

screening programs, diagnostic services, and regional follow-up. When these functions operate independently, pilots can help address immediate gaps, but integrating them into durable pathways requires coordinated planning across partners.

The experience also highlights the importance of shared direction, clear communication, and coordinated timelines among participating organizations.

Looking ahead, scaling approaches like CanScreen will likely depend on continued provincial engagement, integrated communication pathways, and clear program-level processes to support screening results and follow-up for unattached patients.

—Stuart Bax, MBChB, MRCGP, CCFP
Family Physician
Co-founder, CanScreen

—Cal Shapiro, MD, CCFP
Family Physician
Co-founder, CanScreen

BEYOND MEDICINE

References continued from page 95

4. Lejumeau, JA. Inauguration de la statue de Laënnec à Quimper. Bulletin de l'Académie impériale de médecine 1868;33:807-816.
5. Laennec R-T-H. De l'auscultation médiate ou Traité du diagnostic des maladies des poumons et du cœur, fondé principalement sur ce nouveau moyen d'exploration. Two volumes. Brosson et Chaudé, Paris, 1819.
6. Delp MH, Manning RT. Major's physical diagnosis. 8th ed. Philadelphia, PA: W. B. Saunders Company; 1975. pp. 12-15.
7. Rouxeau A. Laennec après 1806, 1806-1826, d'après des documents inédits. Paris: J.-B. Baillière et fils; 1920. p. 219.
8. Laennec, R-T-H. Traité de l'auscultation médiate et des maladies des poumons et du cœur. Two volumes. 2nd ed. Paris: J.-S. Chaudé, Libraire-Éditeur; 1826.
9. Lejumeau, JA. Notice sur le Professeur Laennec. Nouvelle bibliothèque médicale 1826;3:316-325.