Medical Volunteers in Disaster Situations

First it was Haiti. Then it was Chile. The vivid television reports showed just how quickly “Mother Nature” can turn upside down the lives of hundreds of thousands, millions of people in the course of an earthquake.

But there were striking differences, too. Haiti was ill-equipped to handle the catastrophe that descended on the poor island nation. The lack of infrastructure and the location of the epicenter of the earthquake so close to dense population centers exacerbated the situation. In contrast, Chile experienced an 8.8 magnitude event, stronger than the Haitian earthquake. It too, did considerable damage, but thankfully the loss of life and the number of severe injuries was far less than in Haiti. Chile, as a country in the “ring of fire” on the Pacific Ocean rim, had developed strict building codes in anticipation of strong and frequent earthquakes. It had also developed an advanced infrastructure to respond to severe earthquakes. Although many governments offered to supply help, as did a number of well-known charitable organizations, Chile politely declined such assistance.

Sadly, the temblors in Haiti and Chile will not be the last large-scale catastrophes to be witnessed on television, the Internet or in print media. Americans need not think back too far to the tragedy of Hurricanes Katrina and Rita in 2005 to remember what transpired in what was thought to be “the” country most equipped to handle a large-scale disaster.

The Haitian earthquake brought out the best in cooperative giving on a worldwide scale. Governments from around the globe supplied food, tents, water sanitation, medication and
rescue teams. Non-government organizations (NGOs) offered up medical teams, portable hospital units, and supplies, too. Individual healthcare professionals volunteered to help, too.

But Haiti has proven to be quite different than the large-scale volunteer effort witnessed along the Gulf shore in the aftermath of the 2005 hurricanes. Soon after the Haitian disaster, a number of challenges became clear, including language barriers, cultural and legal differences, and coordination challenges of healthcare teams from around the world. The shear magnitude of the destruction was overwhelming in Haiti, with an estimated 230,000 killed by the earthquake. Others died as a consequence of wounds suffered during the event and still others are threatened with the risk of death from infection and exacerbated public health threats. Looking into the faces of news reporters and hardened disaster professionals, there was a palpable difference in reactions from what was seen just five years ago after Katrina and Rita.

Well-intentioned, and energized by a shared passion to help those in distress, healthcare volunteers merit much respect and praise. However, volunteers may take on much more than they anticipate when they immerse themselves in catastrophic events. As discussed here, there are practical, legal, and healthcare risks that may confront well-intentioned catastrophe volunteers when they return from their volunteer duty. Although similar issues may face volunteers who provide service within the United States or on scheduled charitable medical work assignments abroad, the stakes are higher in major international catastrophes. Communication of risk factors is important in making certain that the compulsion to “do good” does not result in “doing harm.”

**A Reality Check.**

Hospitals, ambulatory surgical centers, and medical group practice leaders are in a good position to provide prospective catastrophe volunteers with a dose of reality. Communicated in a balanced, none-threatening manner, the conversation may serve as a “speed bump” to prevent the would-be healthcare volunteer from making imprudent choices.

**Clinical Matters** — Physicians, nurses, and emergency personnel may be eager to assist, but they may not have the clinical competence for the specific catastrophe event. Even if such well-intentioned individuals have the appropriate skill set, the need for these healthcare professionals may be further along in the evolution of the event. To travel to a catastrophe at the wrong time may result in the volunteers' services going unused, or
their presence complicating the arrival of others with more appropriate training.

**Cultural and Linguistic Challenges** – When disasters occur in unfamiliar countries, cultural disparity and possible language barriers may impede the delivery of appropriate care. Well-intentioned volunteers can be set up for failure if they are unfamiliar with customs, culture and local mores in the delivery of emergency and medically necessary services. Furthermore, even if they “speak” the native language, the lack of familiarity with local dialects, colloquialisms and idioms can create important communication challenges.

**Attending to the Needs of Those Left Behind on the Staff or Practice** – When a colleague accepts a volunteer assignment, those who remain must be able to pick up the slack. At a time when healthcare facilities and medical groups are trying to control expenses, it may not be feasible to use a “temp” to fill the slot. Even if financially possible, it may be impractical, especially since that the volunteer may be back on duty by the time the interim search was completed, the position filled, and the interim individual was familiarized with the position. The choice may be to “share” the volunteer’s duties among colleagues. That such a step could cause overwork and fatigue is a serious concern for clinical leadership. It may also trigger feelings of resentment among remaining personnel who are asked to assume additional responsibilities.

**Is this Volunteer Assignment “Covered” by Workers’ Compensation?** – It is one situation when a volunteer is provided with insurance for workers’ compensation while traveling abroad on behalf of a hospital-sponsored medical mission. It is quite another matter when the employer provides a few facility-sponsored volunteers for an overseas emergency assistance without considering whether the existing workers’ compensation program covers the healthcare responders.

**Health Insurance Coverage for the Traveling Volunteer** – If an individual goes abroad as a volunteer responder to a catastrophic event, he or she might assume that his or her health insurance will “cover” healthcare problems treated abroad. Such an assumption may be flawed, especially in situations in which the health insurance plan does not provide coverage for healthcare treatment beyond the United States. Travel insurance is a prudent consideration in such situations. However, the terms and conditions of the travel policy merit close scrutiny to make certain what will be covered, including evacuations.
Is the Volunteer “Covered” for Medical Malpractice  – An interesting issue is the prospect of litigation for professional negligence. Nurses and physicians could be named as defendants in medical malpractice claims for errors and omissions that occur in the course of providing services in a disaster situation. Some may question how this could be the case. So-called “Good Samaritan” laws may be in place in other countries to which the volunteer travels to provide assistance. Although treaties or conventions might be executed between the government of the receiving nation and that of the United States to “protect” volunteers, this may not be true for individual volunteers or NGOs that have not considered obtaining a document waiving exposure to medical professional liability. Most health professional liability insurance policies are limited to errors and omissions within the United States. While a hospital, academic medical center, or a large medical group may secure specific coverage for volunteer services abroad, it is important to find out if such insurance is in place prior to providing healthcare services overseas.

The Return Home: Fatigue and Post-Traumatic Stress Disorder  – Any catastrophe is full of horrible scenes and nightmarish images for eyewitnesses and volunteers. Depending upon the scope of the volunteer’s work, he or she may well return to the “day job” fatigued. The volunteer may also have post-traumatic stress disorder or PTSD. The symptoms of the latter may not be detected for several weeks. A fatigued or stressed volunteer returning to the work side may be risk-prone in terms of errors and omissions. In essence, he or she could become a hazard to themselves, colleagues and patients.

Volunteer or Carrier  – Some volunteers may return to the healthcare facility or practice as a carrier of contagious disease. Although immunized against well-known ailments, in a catastrophic event, other exposures may occur for which immunizations are unavailable. A good illustration is multiple drug-resistant tuberculosis. In other situations healthcare professionals might have discounted the need for immunizations prior to their departure. While on location at the scene of a disaster, they might be exposed to a contagion and then travel back to the United States. The onset of the symptoms might take several days to weeks, possibly longer. Having been in close contact with patients after their return from their volunteer period, these healthcare workers may be the source of serious illnesses for patients. Furthermore, they might be the source of infection among fellow healthcare workers. The particular contagious disease may not be one with which other healthcare workers are familiar.
Patients Who Feel Abandoned – Although many might congratulate care providers for their voluntary spirit in the midst of catastrophe, there are some patients who might feel abandoned by trusted caregivers. Such feelings of abandonment might be anticipated especially when patients experience postponed treatments or rescheduled appointments to accommodate care providers traveling to provide volunteer treatment.

When Volunteerism Clashes with Revenue Projection – It is laudable that many healthcare entities and medical practices encourage or support healthcare professionals responding as volunteers in the aftermath of a catastrophic event. However, there may well be situations in which such volunteerism can put a drain on revenue of the healthcare facility or medical practice. A ten-day or two-week volunteer leave of absence can mean diminished income for a smaller acute care facility, ambulatory care center or medical practice, particularly if the volunteer is a high volume revenue producer.

Observations on Catastrophe Volunteerism.
It can prove challenging to balance the desire to volunteer after disaster with the practical realities of a busy healthcare facility or medical practice. It is not a simple task to extricate a busy professional who is in high demand at the local level.

Many healthcare professionals belong to Disaster Management Assistance Teams (DMATs, www.dmat.org). Healthcare facility and medical group employers are aware that healthcare professionals serve as DMAT members and may be mobilized following a catastrophe. In such situations, contingency plans are in place to address these events. It is quite a different situation when a person decides to volunteer without thinking through the impact of such a choice on the organization, family members, colleagues, and patients.

The old expression “eyes wide open” comes to mind when discussing catastrophe volunteerism with well-meaning care providers. Expectation-setting is important for all affected constituencies. A reality check may be in order too; especially if the prospective volunteer is made to realize that at this stage of the disaster process his or her services are not welcome. In other words, with careful planning and good communication, the prospective volunteer can determine when it would be appropriate to offer aid to those affected by a catastrophic event. Such planning would be much appreciated too by those left behind who must provide for continuity of care.
Strategies for Improving Communication with Medical Volunteers in Disaster Situations.

Expectation-setting and planning are key factors to emphasize with those who wish to serve as medical volunteers in a disaster situation. Making certain that they know what to expect once on location at the disaster is one matter; recognizing how to establish a clinical continuity plan for patients and medical practices is another. Central to this process is good communication. Strategies to consider include the following:

1. **Provide Prospective Volunteers with Useful Information.**
   Think about providing prospective volunteers with a checklist of important factors to consider when contemplating service as a health professional volunteer in response to a disaster. Make certain that the content is broad enough to encompass important personal and professional factors [See sample tool].

2. **Verify that Appropriate Clinical Continuity is in Place.**
   Work with clinical leadership in the facility and medical practice to make certain that there is a sufficient number of clinically qualified personnel available to fulfill patient care requirements during the period that the volunteer will be unavailable. Determine if locum tenens, agency personnel or traveling nurses will be needed to fill the clinical care gap.

3. **Provide Patients with Treatment Plan Information.**
   Work with the prospective volunteer to provide current patients with relevant information. Recognize that this may be done through a website posting, correspondence, and communication by phone. Document the communication.

4. **Set Expectations with Clinical Staff.**
   Let remaining personnel know what will be expected of them during the absence of the disaster volunteer. Address any concerns or reservations of staff. In a unionized organization, think about discussing any concerns about increased obligations of remaining staffing in the context of collective agreement requirements.

5. **Document Discussion with Prospective Volunteers.**
   Having provided the prospective volunteer with the checklist [See Item 1] and discussed continuity of care and return to duty, be certain to document the discussion, including date and time.
6. Communication with, and Management of, the Returning Volunteer.
Contemplate the framework for discussion with the returning volunteer. Consider for this purpose a time to re-orient to routine, discuss management of on-going patients, and the need for possible counseling. Give thought to screening tests for possible diseases or injuries that occurred while serving as a volunteer. Also consider screening for fatigue that might impair the person’s ability to discharge his or her normal clinical duties.

7. Monitoring for Illness.
Implement a monitoring program for returning volunteers, particularly if it is known that they were exposed to serious ailments with a latent onset. Take appropriate action when the care provider manifests symptoms of such ailments. Such action should include medical care for the health professional, and if necessary, follow-up with colleagues and patients who might be at risk of contracting such ailments from the disaster volunteers.

8. Providing Support for the Volunteer.
Offer counseling and other types of EAP-style support for volunteers who manifest post-traumatic stress or other difficulties readjusting to normal clinical services.

Conclusion.
It is laudable when healthcare professionals volunteer to respond to disasters like the one that occurred in Haiti. It is a selfless act that is emblematic of why care providers became physicians, nurses, pharmacists, etc. But when deciding to respond to such situations, care provider volunteers need to understand the consequences of their actions. The impact on current patients, the care provider’s family, colleagues, and others should be made clear to them along with the potential dangers of such assignments.

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Sample Tool

Questionnaire for Prospective Disaster Volunteers

Dear ______________________:

This questionnaire is for healthcare professionals who do not belong to Disaster Management Assistance Teams (DMATs) or established medical non-governmental organizations (NGOs).

If you are considering service as a volunteer in a disaster zone located outside the United States, this questionnaire may be useful to you. Specific resource information entitled, *Health Recommendations for Relief Workers Responding to Disasters*, may be found on the website of the Centers for Disease Control and Prevention at: [http://wwwn.cdc.gov/travel/content/relief-workers.asp](http://wwwn.cdc.gov/travel/content/relief-workers.asp).

- Do you have proper immunizations for the disaster location?
- Do you have a health condition that mitigates against participating as a health care volunteer in the disaster location?
- Do you have the clinical competencies to serve as a health professional volunteer in a disaster situation?
- Have you obtained travel health insurance?
- If your employer is not sponsoring your volunteer activity, have you arranged for insurance protection in the event that you are injured while serving as a volunteer?
- If your employer is not sponsoring your volunteer activity, have you obtained professional liability insurance (malpractice) insurance coverage for services provided while serving at the disaster location?
- Do you have a current Passport?
- Do you have evidence of current licensure or registration?
- Have you secured medical coverage for existing patients in your practice?
- If you are responsible for executing legal documents or authorizing payment of bills, have you made arrangement for another signatory in your absence?
- If you are disabled or die as a result of serving as a volunteer, have you put in place a practice continuity and succession plan?
- Have you signed an advance directive and provided a copy to your lawyer and/or a trusted advisor?
- Have you executed a testamentary will and provided a copy to your attorney and/or a trusted advisor?
- Have you identified the essential articles of clothing and toiletries for this trip?
☐ Have you identified the essential clinical equipment that you may be able to transport with you?
☐ Have you assembled an emergency medical kit for your own needs, including several weeks of prescription medications?