The Global Healthcare Volunteer's Handbook

What You Need to Know Before You Go

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wives/10,000 people, African countries average only 2 physicians and 11 nurses and midwives/10,000 people.[5]

When groups of clinicians arrive in remote areas of the world to set up temporary medical/dental clinics, the demand is so great that the local police and military often have to control the crowds. Unfortunately, many who need treatment never get past these barriers.

Acute Disasters

Acute disasters can result from man-made (e.g., terrorism, war) or natural forces (e.g., hurricanes, floods, earthquakes, landslides, volcanic eruptions, tsunamis, epidemics). The key features of disasters are "threat, urgency and uncertainty, which affect not only the victims themselves, but also the organizations that have to respond."[6] The assistance provided varies greatly, depending on a host of factors, including how long the conditions are likely to last, how much help is required, and the amount of degradation to healthcare services and to the social order (riots and unrest) that may occur.

After such disasters, additional healthcare professionals from outside the region may not be needed, and they may even hamper rescue and medical treatment. Further, "it is not possible to determine the number of injured persons who will require clinical care. Following acute onset disasters such as earthquakes, 85% to 90% of those rescued alive are generally extracted by local emergency personnel or by their neighbors and families within 72 hours."[7] Specific problems associated with different natural disasters are listed in Table 3.2.

Healthcare professionals who respond after disasters may be most effective when treating chronic illnesses in the affected population. Contrary to popular belief, substantial numbers of patients seeking care during disasters do so because of chronic medical conditions rather than trauma. Often, they have lost access to their usual sources of primary medical care, some of which may no longer exist. Many individuals need their personal medications replaced because their home was destroyed, they have evacuated so quickly that they forget to pack them, or they may have underestimated how long it would be until they could return home.[8]

Table 3.2: Medical Problems Commonly Seen in Specific Situations

Earthquake

Long-bone fractures	Animal attacks
Head, spine fractures	Dust asphyxia
Soft tissue trauma	Crush or compartment syndrome

Infectious disease problems generally related to water and food.

Usually little increase in infectious diseases.

Tsunami

Drowning	High mortality to morbidity ratio
Blunt injuries	

Infectious diseases may temporarily decrease, in part due to elimination of insect vectors.

Tornado

Eye injuries	Blunt, crush and penetrating wounds

Volcano Eruption

Blunt, penetrating & crush trauma	Dust asphyxiation
Burns	Eye injuries

Little evidence of increased infectious disease

Adapted from: Rega P, Bissel R. *Disaster Health Consequences*. NDMS Response Team Training Program, http://mediccom.org/public/tadmat/training.html (accessed September 2003).

Post-Disaster Response

Who Is Needed?

In the immediate aftermath of a disaster, as in many chronic resource-poor situations, a variety of volunteers are needed. While individual volunteers from the immediate area are easily integrated into the response, those from more distant areas can best be used if they are part of an organized team. Table 3.3 lists the various categories of people that may be needed at this critical time. Note that healthcare professionals are divided into those that need to be credentialed and those that do not.

Table 3.3: Types of Volunteers Useful after a Disaster

Healthcare Professionals (credentials required)

- Physician
- Dentist
- Nurse Practitioner
- Nurse (RN, LPN, LVN, etc.)
- Physician assistants
- Psychologist/Psychiatrist

Healthcare Professionals (no credentials required)

- Medical technologist/laboratory technician
- Dental assistant
- Radiology/Ultrasound technician
- Medical records librarian
- Mental health specialist
- Nursing assistant/technician
- Phlebotomist
- Morgue assistant
- Biomedical engineer
- Paramedic
- Pharmacist/pharmacy technician
- Respiratory therapist
- Chaplain
- Social worker

Volunteers having other vital skills

- Communication
- Food services
- Security
- Urban search and rescue
- Computer operations/maintenance
- Engineering
- Logistics
- Facility maintenance/construction
- Transportation
- Local access/political connections
- Translation
- Waste disposal
- Heavy equipment operator

Other volunteers

- Runner (messages)
- Patient transporter
- Assistant to skilled personnel

Who Is *NOT* Needed?

Most people are surprised to learn that a massive influx of well-meaning, unorganized volunteers from outside the affected area is generally not needed or desired. For example, after nearly 300,000 people perished in the 2004 Southeast Asia tsunami and millions were displaced from their homes, Dr. Sherwin Nuland hopped on a commercial plane with six compatriots and went to Sri Lanka to help. As he later wrote, this was a bad idea:

> I am not sure just what it was that made me drop everything on December 31 and join six colleagues on a medical relief mission to Sri Lanka. At the moment I made the decision, it simply seemed like the right thing to do, and in retrospect it still does. But it turned out that the need for our small group was very different than we had anticipated: there was far less acute disease and injury than expected, but the human misery was of a sort that will require attention for years to come. In a strictly clinical sense, we accomplished far less than we had hoped… Disaster relief is only the most immediate kind of relief that this punished place requires… In retrospect, we were like an amateur and astonishingly naive flying squad or rapid-response team… I had brought with me a set of surgical instruments to be used as though in a field hospital, assuming that my principal work would be to treat the late consequences of major trauma. I was wrong. The tsunami had an effect similar to that of September 11, when emergency rooms all over Manhattan prepared themselves for an influx of the seriously injured, and very few came. The reason was the same: almost everyone caught up in the disaster was killed.[9]

If you are interested in joining a team designed to respond after global disasters, you may want to ask them the set of questions (Table 3.4) modified and expanded from those developed for the American College of Emergency Physicians Section of Disaster Medicine.[10] This list includes both general and mission-specific questions.

Table 3.4: Questions to Ask about a Disaster Team

Team Composition

- How large is the team?
- Who selects team members and leaders? On what basis?
- Is the whole team from the same country and region? Do they all speak the same language?
- Are there logistics, communications, and management personnel in addition to healthcare professionals?
- What is the breakdown (physicians, nurses, mental health, etc.) of the team? What specialties of healthcare personnel are normally deployed?
- Are there restrictions on couples participating on the team?
- Does the team provide, or must individuals bring their own, equipment and supplies to use for at least the first few days?

Credentials and Time Commitment

- How often is the team deployed?
- Is there a requirement to participate in every deployment? If not, what number or percentage each year?
- What are the minimum, maximum, and average times for each mission?
- How soon after notification must you deploy? (Can you leave your family or job on short notice without negative repercussions?)
- How much individual/team training is required? Is training specific to the team or the mission required?
- Does the organization require proof of specific credentials or evidence that they are up-to-date?

Command and Control

- Who will provide the team's overall leadership and the team's medical direction? How are the leaders selected?
- Will the team and its equipment travel and work together, or will members work with various other teams?

Table 3.4 (Continued)

- If members will not work together, who coordinates this?
- How will the team work with and fit into the local command and control structure?
- How will public information be managed?
- Who will provide updated epidemiology, public health, and situation reports?
- What type of communication will the team have available to contact on-site locations and to their homes?
- Can the team use personal communication devices in the field?

Transportation

- How is the team activated and their mobilization coordinated?
- Where is (are) the team's assembly and staging location(s)?
- How will personnel and team assets be transported on-site?
- What has been done to expedite destination and domestic customs clearance for any equipment, supplies, and pharmaceuticals that the team may bring?
- Are there required items for individuals to bring on operations?
- Are there limits (size or weight) to what individuals can bring?
- How will team deactivation and demobilization be coordinated?

Team Operations

- To what types of missions does the team deploy? Are there regions or types of missions where the team will not deploy?
- How will the team receive supplies and equipment?
- What levels of treatment are expected?
- What triage system will be used? Who will do triage?
- How will patient transport, distribution, and tracking be managed?
- What ancillary (e.g., laboratory, imaging) services will be available and who will provide them?
- How will the team integrate into the local health care delivery system?

(Continued)

Table 3.4 (Continued)

- What local medical assets are available and who controls them?
- Will there be a briefing on and continued education about local customs and expectations?
- Will local interpreters be supplied?
- Will specialists be available for hazardous materials, engineering, and public works?
- Will there be search and rescue capability?
- Are there contingencies for a mortuary system?
- What are the specific record-keeping or documentation requirements and formats?
- May the team have a public health or scientific research mission on deployment?

Team Health and Security

- What are the medical or fitness requirements, such as BMI limitations, physical activity level, immunizations, and disallowed chronic medical conditions?
- Who is responsible for the team's health?
- Who will coordinate safe food and drinking water?
- What measures will be taken to ensure appropriate sanitation?
- What are the expected work/rest/sleep cycles?
- What type of shelter will be provided? Is it adequate for the expected conditions?
- Are there any recreation plans for the team?
- Will mental health resources be available for patients and team members?
- Will the U.S. State Department coordinate, or be aware of, the response?
- What security will the team have throughout their assignment—during deployment, on arrival, on-site, at their lodgings, and in transit from lodgings to work site?
- Will the team issue any politically sensitive statements related to their deployment?

Table 3.4 (Continued)

Insurance and Remuneration

- Are medical, disability, and life insurance provided while on deployments? (If not, do your personal policies cover foreign or out-of-network expenses?)
- Do these insurance policies have coverage for voluntary entry into war zones and other dangerous locations? (Most do not.)
- Will you need medical liability coverage for this mission? If so, who supplies it?
- Will you be paid for your time and services?
- Will travel, food, and lodging be paid as incurred or reimbursed later? What about personal equipment/supplies consumed during the deployment?
- If expenses are not paid or reimbursed, will you get documents identifying these as contributions?

Extending Scopes of Practice

While it is not unusual for healthcare personnel to go beyond their normal duties in extreme emergencies, little is said about it. Some oral surgeons may do other surgeries, nurses may diagnose and prescribe treatments, and internists may help with wound care. These extensions of clinicians' scopes of practice are informal, based on supervisors knowing the individual's capabilities and on the extenuating circumstances. Without this oversight, however, there is great potential to do harm.

> *An emergency physician working in remote Africa frequently performs C-sections and epidurals, having been taught by his wife, an obstetrician-gynecologist. While they practice together, he often does these procedures alone and has become very competent, even though both procedures are beyond his specialty's traditional scope of practice. (Suzanne Shepherd, M.D.)*

Although this may not be consistent with the standards in the most-developed countries, extending scopes of practice most often provides patients with the best available health care. It is not the time for "cowboys" or a "chance to practice."

> *During the post-earthquake response to Haiti, many unnecessary, often scheduled surgeries were done so that foreign residents could "gain experience." (Katie O'Brien, M.D.)*

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