

# Two Out of Three Ain't Good!

## Will You Be Prepared?

*By J. Kent Garman, M.D., M.S.; Associate Editor; Editor of Electronic Media; CSA Past President*



This article will be about disaster preparedness and how physicians can volunteer to help. It is interesting that FEMA, in August 2001, predicted the three most likely catastrophes that might hit the United States. First was a terrorist attack in New York City, second was a full strength hurricane hitting New Orleans, and third was a major earthquake in California along the San Andreas fault. Two of these predictions have already come true—now it is our turn.

Many Stanford physicians were motivated to want to go to the Gulf disaster area to help. In fact, when we asked for physician volunteers we had approximately 85 physicians who were willing to be deployed there on short notice for a two- to three-week tour of duty. I think this is an amazing response. As of yet, the Stanford contingent has not been notified, however it is still very possible that FEMA or the Red Cross will ask for assistance to relieve another group of volunteers. This need may persist into December.

I, too, wanted to help and was frustrated at my inability to do so. Many of my friends were, in fact, deployed within two days of the disaster and served under very harrowing, dangerous, and frustrating conditions. I decided to find out how deployments were done at the federal or Red Cross level.

The first fact is that emergency agencies do not want individual, unsolicited, and uncredentialed physicians to just show up for work. Physicians who try this are usually sent home. If they do actually work, they are subjecting themselves to extreme liability since they are not covered under one of the federal programs. Also, since they are not credentialed to practice medicine in other states, they are actually violating state law if they do practice without a license. Organized, federally-credentialed groups are working as federal agents and are exempt from these problems.

The American College of Emergency Physicians and the National Association of EMS Physicians have published a Policy on Unsolicited Medical Volunteers that states that an organized approach is needed for all medical volunteers in a disaster. Medical personnel should not respond to an emergency unless officially requested by the jurisdiction's EMS agency.

It turns out that there are several methods to join an organized group of physicians (and other health care workers who make up the team) in case of a national disaster. Much of the material below is taken from websites.

### 1. Direct Request to Hospitals from HHS/FEMA

The first is the method being used by Stanford Hospital. We were asked by the Hospital Council of our region to assist in this effort at the request of Secretary Leavitt from the U.S. Health and Human Services Department (HHS). The hospital was asked to develop a list of credentialed health care volunteers. If asked by FEMA, we will send a group of physicians, nurses, and others. This hopefully works because we have already done the credentialing and can work together as a cohesive unit. We will perhaps see if this is actually the case. The biggest problem with this approach is that the group is not actually pre-trained in disaster and field medicine subjects and techniques.

### 2. Individual Volunteering Online Via HHS

You can also volunteer as an individual online directly through the federal system. The Office of the Surgeon General and the Office of Public Health Emergency Preparedness are in the process of mobilizing and identifying health care professionals and relief personnel to assist in Hurricane Katrina relief efforts. The web page includes a form that can be completed and submitted online: <<https://volunteer.ccrf.hhs.gov/>>. The Office of the Surgeon General will not respond to individual inquiries but will contact those who submit an application and meet the requirements and needs of the field. Once again, as an individual, you may not really be able to contribute much due to lack of disaster training.

Within two weeks after the Katrina disaster, HHS had received 33,000 online applications. At this point, they suspended the program, not accepting further applications. A communication from them seemed to say that very few, if any, of these volunteers would be deployed, mainly due to the problems of organization and credentialing.

### 3. Disaster Medical Assistance Team (DMAT)

The next and most pre-organized method is the DMAT. Many of these units were, in fact, immediately deployed to the current disaster under FEMA. This is a federal program for organizing and pre-training medical volunteers. Nationally, there are currently more than 29 deployable teams, each with 50 to 150 civilian volunteers. California has five deployable teams. The nearest unit to us is California Bay Area DMAT CA-6 with its Operations Center in Menlo Park ([www.dmatca6.org](http://www.dmatca6.org)). (Note: Dr. Tom Cromwell deployed with DMAT CA-6 when he went to New Orleans recently.) Deployed teams usually consist of 35 medical professionals and support personnel.

The National Disaster Medical System (NDMS) under the Department of Homeland Security, fosters the development of DMATs. A DMAT is a group of professional and paraprofessional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide emergency medical care during a disaster or other event.

## Will You Be Prepared? (cont'd)

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Each team has a sponsoring organization, such as a major medical center, public health or safety agency, non-profit, public or private organization that signs a Memorandum of Understanding with the Public Health Service. The DMAT sponsor organizes the team and recruits members, arranges training, and coordinates the dispatch of the team.

In addition to the standard DMATs, there are highly specialized DMATs that deal with specific medical conditions such as crush injury, burn, and mental health emergencies. Other specialty teams include Disaster Mortuary Operational Response Teams (DMORTs) that provide mortuary services, Veterinary Medical Assistance Teams (VMATs) that provide veterinary services, and National Medical Response Teams (NMRTs) that are equipped and trained to provide medical care for victims of weapons of mass destruction.

DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. In mass casualty incidents, their responsibilities include triaging patients, providing austere medical care, and preparing patients for evacuation. In other types of situations, DMATs may provide primary health care and/or may serve to augment overloaded local health care staffs. Under the rare circumstance that disaster victims are evacuated to a different locale to receive definitive medical care, DMATs may be activated to support patient reception and disposition of patients to hospitals. DMATs are designed to be a rapid-response element to supplement local medical care until other federal or contract resources can be mobilized or the situation is resolved.

DMAT members are required to maintain appropriate certifications and licensure within their discipline. When members are activated as Federal employees, licensure and certification is recognized by all states. Additionally, DMAT members are paid while serving as part-time federal employees and have the protection of the Federal Tort Claims Act in which the federal government becomes the defendant in the event of a malpractice claim.

DMAT teams are expected to be deployable within 12 hours and wear military style uniforms while deployed. An individual is expected to complete extensive, free online and field training before being qualified for deployment.

Meetings of DMAT CA-6 are held every two months, some overnight or multi-day field exercises. DMAT CA-6 is supported by five Bay Area counties. They are also part of the California Emergency Medical Services Authority ([www.emsa.ca.gov/dms2/dmats.asp](http://www.emsa.ca.gov/dms2/dmats.asp)) and can be activated by either state or county EMS agencies as well as by the federal government. There are immunization, training, and meeting attendance requirements to maintain membership. I personally am in the process of joining DMAT CA-6 and have just completed filling out the extensive federal application forms (over 30 pages). I am happy to talk to anyone about my pending experience.

### 4. Medical Reserve Corps (MRC)\*

Another method to volunteer is to join an MRC ([www.medicalreservecorps.gov](http://www.medicalreservecorps.gov)). MRCs have been deployed in the current crisis to provide medical support. There are 29 MRCs in California. Your closest one can be located on the web site.

A Medical Reserve Corps (MRC) is a community-based network of volunteers that assists public health efforts in times of special need or disaster, e.g., during a major communicable disease outbreak, an earthquake, flood or an act of terrorism. Members of an MRC may also volunteer their time throughout the year in order to promote community public health and education.

The Medical Reserve Corps program office is headquartered in the Office of the U.S. Surgeon General. It functions as a clearinghouse for information and best practices to help communities establish, implement and maintain MRC units across the nation. The MRC Program Office sponsors an annual leadership conference, hosts a web site, and coordinates with local, state, regional and national organizations and agencies to help communities achieve their local visions for public health and emergency preparedness.

MRCs bring volunteers together to supplement existing local emergency plans and resources. In order to be effective during times of emergency, volunteers must be organized and trained to work in emergency situations. The MRC is designed to provide that organizational structure and promote appropriate training of volunteers according to local community needs and vulnerabilities.

MRCs may be comprised of any variety of individuals depending on community need. Volunteers may include, but are not limited to, current or retired health professionals (such as physicians, nurses, mental health professionals, dentists, dental assistants, pharmacists, veterinarians), social workers, communications/public relations professionals, health care administrators, clergy, et cetera.

MRC volunteers can choose to support communities in need nationwide. When the southeast was battered by hurricanes in 2004, MRC volunteers in the affected areas and beyond helped communities by filling in at local hospitals, assisting their neighbors at local shelters, and providing first aid to those injured by the storms. Over this two-month period, more than 30 MRC units worked as part of the relief efforts, including those whose volunteers were called in from across the country to assist the American Red Cross and FEMA. MRCs are also part of the California Emergency Medical Services Authority ([www.emsa.ca.gov/dms2/medical\\_reserve\\_corps.asp](http://www.emsa.ca.gov/dms2/medical_reserve_corps.asp)) and can be activated by either state or county EMS agencies as well as by the federal government.

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\* Founded in 2002 to encourage Americans to support their country, the MRC is a specialized component of Citizen Corps, a national network of volunteers dedicated to ensuring hometown security. Citizen Corps, along with AmeriCorps, Senior Corps and the Peace Corps are all part of the President's USA Freedom Corps.

### Hospital Preparedness

I am sure you had the following list of questions in your mind when you saw what happened in the Gulf to hospitals. The rapid deterioration in the ability of the hospitals to provide just basic patient care, security, evacuation, and even care of the dead was an eye-opener for all of us and prompts a very hard look at our own preparations.

1. Are our emergency generators protected from falling debris and water?
2. How much diesel fuel do we have for our generators?
3. How much drinking water do we have stored?
4. How much emergency food do we have stored?
5. Will our buildings stay functional in a major earthquake?
6. Will we have any communications when the cell, pager, and land lines go down?
7. How much security do we have available to protect us?

I am sure you can think of other questions as well. If you have not done so already, you should ask your hospital administrators to answer these questions. Also, if you are not yet involved in your hospital's emergency preparedness committees, volunteer immediately.

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### Commentary by Thomas H. Cromwell, M.D., Past CSA President

The article by Kent Garman is excellent and quite comprehensive. I would emphasize his comment that the DMAT system is the **only** pre-trained cohesive unit by which a physician can volunteer at this point. I belong to the MRC in Marin County that is just in its infancy and would be of little help in a needed response at this point. Likewise it is a very unusual hospital that, at this time, would be able to respond in the first wave to a disaster outside its own community. Physicians can volunteer individually and two members of my medical staff at CPMC did so, including Barry Rose, an anesthesiologist. That was a week after the incident, however. Kent mentions that there are five deployable teams in California, which is true, but only two are fully equipped and staffed as a complete team—CA-6 in the Bay Area, and CA-4 in San Diego. CA-6 can be deployed in four to six hours, not 12, and physicians must realize that that leaves little time after an actual ringdown to find coverage for what may be a deployment of a week or two. Arrangements must be made beforehand in the event you are deployed and gear has to be perpetually packed and ready to go. While you are paid on deployments at a government grade, it is far less than the income physicians can generate in their usual practice environment and it is a sacrifice financially. On the other hand you have an opportunity to work very closely with a group of dedicated nurses, paramedics, EMT firefighters, and non medical volunteers in an environment in which you really can make a difference—the kinds of friends you will have forever!

That said I am delighted with the 33,000 physician response Kent mentioned. To my way of thinking, volunteerism for physicians should be considered a moral imperative given the education we have been provided and the status we are allowed to enjoy in this society. We possess skills that are sorely needed in a disaster response and we should be among the first to participate—if not in the first wave, a week or two later after things become a bit less chaotic. Speaking of skills, anesthesiologists need not worry that they no longer possess primary care skills they may have learned years ago in medical school but have long since forgotten. The usual medical skills needed in a disaster environment are those of survival medicine, not definitive medicine—skills that are part of every physician and come back very quickly.

### **2005 CSA *Bulletin* Cover**

The photograph that appears on the cover of the 2005 *CSA Bulletin* is one of an old dead bristlecone pine tree that the photographer, Gordon Haddow, M.D., discovered while traveling in the White Mountains, east of Bishop, California. The altitude there is approximately 10,000 feet and the picture was taken in late September 2002 around 8 a.m. Dr. Haddow used a Nikon F100 camera with a Nikkor 18-35mm zoom lens at 18mm and a red filter. This photographic masterpiece was awarded the “Best of Show” at the 2003 ASA Art Exhibit.