Uncle Sam Needs YOU for Next Disaster Response

BY MARY ELLEN SCHNEIDER
New York Bureau

DALLAS — Last year's Gulf Coast hurricanes and their devastating aftermath left many physicians wondering how they could help in future disasters, Dr. Joseph A. Scott, director of the division of prehospital and emergency health care at the University of Miami, said at the annual meeting of the National Medical Association.

There are a number of federal disaster response teams for which physicians can volunteer, Dr. Scott said.

The National Disaster Medical System (NDMS) is a public-private partnership, based primarily in the Department of Homeland Security, which coordinates teams of medical providers to respond to storms, floods, airplane crashes, and even large-scale events like the Olympics or presidential inaugurations. The NDMS was set up to supplement state and local medical resources.

The disaster medical assistance teams (DMATs) make up one component of the NDMS. DMATs are 35-person teams that can be on the ground at a disaster anywhere around the country within 24 hours. A DMAT typically comprises physicians, nurses, paramedics, emergency medical technicians, pharmacists, respiratory therapists, psychologists, and social workers. All team members are cross-trained in medical, logistical, communications, and administrative aspects of the response, said Dr. Scott, who serves as medical officer for a DMAT based in south Florida.

These teams handle a variety of medical situations—from triage to primary medical care to trauma—once they are on the ground, he said. The DMAT usually rolls out the door with a cache of medications provided by the federal government. The medications include drugs for treatment as well as for dispensing purposes, because most pharmacies will be shut down in a disaster, Dr. Scott said. The NDMS also supplies the equipment, but Dr. Scott said his group also accepts donated equipment to supplement that stock.

Emergency medicine training is ideal for these types of teams, he said. Experience with urgent care, trauma, and pediatrics is especially important for disaster deployments.

The usual deployment period for members of a DMAT is about 1-2 weeks, which includes predisaster staging. Physicians in the past were required to commit to a 2-week deployment, but that has been changing to 1 week for physicians only, he said.

Volunteering to be part of an organized response team can forestall many of the problems that can occur at a disaster site when individual, well-meaning volunteers flood the scene. An overabundance of volunteers can divert resources, Dr. Scott said. And unsolicited volunteers often lack appropriate training, equipment, and supplies. They may also be outside the formal accountability system and may lack proper credentials, he said.

A big fear when volunteers—especially physicians—show up without formal coordination is that no one will be at home to take care of the regular emergencies, he said. Thus, physicians who can't volunteer for a DMAT can still help in a disaster while staying home, Dr. Scott said. Not everyone has the flexibility—either at home or at work—to volunteer for a 1- to 2-week deployment. But physicians can make a difference by volunteering to cover shifts for a colleague who is a member of a response team.

There are also increasing opportunities for physicians to volunteer for similar teams at the state level. Physicians can check with their state emergency management offices to find out if their state has a team, he said.

Other federal teams that need physician volunteers include:

► **National medical response teams.** These are 50-member teams that deploy less often than DMATs. They are generally tasked to respond to nuclear, biologic, and chemical incidents.

► **Disaster mortuary operational response teams.** These teams include pathologists, forensic pathologists, fingerprint experts, and dental assistants who help to identify victims' remains in a disaster. There are about 9 or 10 such teams in the country.

► **International medical/surgical response teams.** These teams generally take care of American civilians overseas, Dr. Scott said. They are similar to DMATs, but generally deploy with a trauma surgeon and anesthesiologist; they can perform surgery in the field.

► **Urban search and rescue teams.** These teams specialize in on-site medical treatment for victims trapped in confined spaces, such as those resulting from structural collapses. The physicians on these teams frequently care for both victims and responders, he said.

Physicians who are deployed as part of a federal team become federal employees during deployment and do collect a small paycheck, Dr. Scott said. Physicians get other protections during their deployment, including federal liability protection.

But there are some disadvantages, Dr. Scott said. The initial credentialing process can take 6 months or more.

Overall, the experience can be very rewarding, Dr. Scott said. It's an opportunity to provide good care to appreciative patients with minimal paperwork. ■

To learn more about volunteering for a disaster response team, visit www.ndms.fema.gov or contact Jack Beall of the Federal Emergency Management Agency at jack.beall@dhs.gov.

How to Prepare For Deployment

Dr. Joseph A. Scott, who serves on both a disaster medical assistance team and an international medical/surgical response team, offered tips for physicians preparing for deployment:

► Update your immunizations before heading into the field.

► Get packed. Physicians should carry cash, water, food, protective clothing, medications, flashlight, batteries, sleeping bag, gasoline, insect repellent, and their credentials, Dr. Scott said. Credit cards will be useless if the power is out. Physicians need to carry enough of their own supplies that they don't end up becoming victims themselves, he said.

► Take care of your own mental health. This means making sure that your home and work situations are under control during deployment, he said. Make sure in advance that colleagues can cover your shifts. This will go a long way toward making you more effective during deployment, he said.

Specialists Encouraged to Immunize More Adult Patients

BY JOYCE FRIEDEN
Senior Editor

WASHINGTON — Specialists who treat adults should be encouraged to give preventive vaccines to their patients, Dr. William Schaffner said at a press briefing sponsored by the National Foundation for Infectious Diseases.

"A lot of adults don't see their internists or family physicians. They are taken care of by specialists," Dr. Schaffner said in a discussion with journalists after the briefing.

One problem with getting adults immunized is that many of them don't go to doctors in the first place, said Dr. Schaffner, chairman of preventive medicine at Vanderbilt University in Nashville, Tenn.

"Women, at least, go to ob.gyns., and ob.gyns.—under the leadership of the American College of Obstetricians and Gynecologists—are increasingly acknowledging that they're primary care physicians. They're beginning to get the word that part of what they have to do as primary care physicians is immunize."

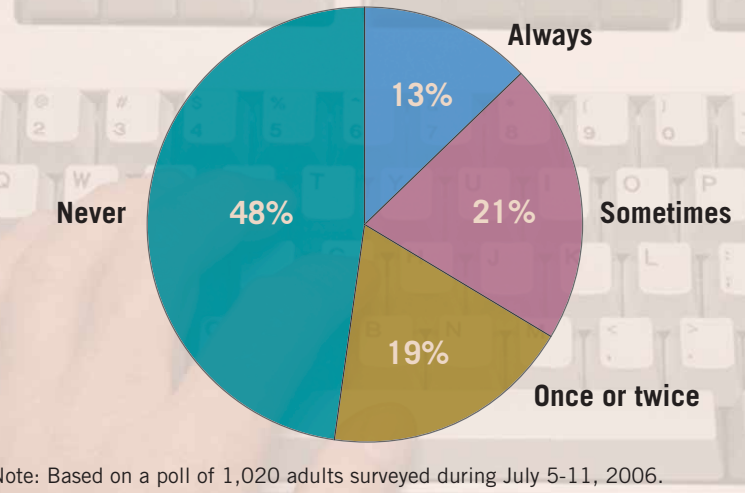
Ob.gyns. have already taken responsibility for cervical cancer screening, noted Dr. Schaffner, who is also professor of infectious diseases at Vanderbilt. "I predict they'll be avid promoters of the human papillomavirus vaccine. If we can get them to expand their purview, they can think about hepatitis B: 'That's a sexually transmitted disease—I know how that works.' " Ob.gyns. can also be approached regarding influenza vaccinations for pregnant women, he added. "We've got to bring them along. These are wonderful opportunities, and I think we're going to see a major change in ob.gyns. doing this."

Internal medicine subspecialists are another likely target, according to Dr. Schaffner. "If you have rheumatoid arthritis or lupus, the only doctor you may be going to is a rheumatologist. Nephrologists take care of patients with kidney failure, and gastroenterologists take care of a lot of patients with inflammatory bowel disease who don't very regularly go to a general internist." These subspecialists could start with pneumococcal and influenza vaccines, which all their patients are eligible for, he said.

There is one group of internal medicine subspecialists that may be a tougher sell, however: cardiologists. "They haven't been reached [with the message] that in their outpatient practice, they ought to be ordering and delivering vaccines, because in large measure many of their patients don't have internists who take care of them," Dr. Schaffner said. But even with so many specialists who could be vaccinating patients, none of them will be very interested in doing so until the reimbursement situation has improved, he said. ■

DATA WATCH

Most Patients Have Discussed With Their Physician Health Information Found Online



Note: Based on a poll of 1,020 adults surveyed during July 5-11, 2006.
Source: Harris Interactive

ELSEVIER GLOBAL MEDICAL NEWS