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A Physician's Role in Providing Care in a Disaster

PHYSICIAN PREPAREDNESS FOR PROVIDING CARE IN A DISASTER

Host is Dr. John Armstrong.

Guest is Dr. Ralph Shealy, Medical Director of South Carolina Charleston County EMS and rescue squad and Codirector of the Disaster Preparedness and Response Training that work for the South Carolina Area Health Education Consortium. Dr. Shealy is an emergency physician and internationally recognized voice in disaster medicine.

Dr. JOHN ARMSTRONG:

Welcome Dr. Shealy.

Dr. RALPH SHEALY:

It is good to be with you.

Dr. JOHN ARMSTRONG:

Many of our listeners are wondering just what is disaster medicine.

Dr. RALPH SHEALY:

You know I have come to disaster medicine from a perspective of emergency medicine. You know that is a good starting place. In emergency medicine, we tend to work with the EMS and pre-hospital care systems and agencies that also take care of a community when something really bad happens. I use a short hand of speech. I call it a bad day, the day when something really bad happens that totally overwhelms the community's ability to manage using its normal resources, its normal methods and systems and forces the community to shift over into an extraordinary mode of action in order to attempt to meet the needs of the community. So emergency medicine has traditionally been focused on pre-hospital care and that leads to be involved in disaster planning and so on, but I think that as our view of the exposure of our community's to disasters have changed, as we are looking at larger and larger types of events that we had been spared for the most part in this country. We really have not had events that have created huge numbers of casualty or huge numbers of sick people that far exceeded the ability of our systems to manage. We have been lucky, but as we begin to look in to prepare for those kind of events and as we realize that increasingly these events are truly inevitable. Our notion of disaster medicine has had to expand outside of the realm of emergency medicine and enter the mainstream of how the physicians understand their duties to a

community and how they understand their obligations to support the community when such a bad day comes. No longer are we able to think of disaster medicine as being the focus or responsibility of a small group of people who are employed for that service. We know that if we are going to deal with something like pandemic influenza or some of it that creates a large scale causalities, then we will have to look to physicians who are involved in other kinds of practices to support first line acute care resources.

Dr. JOHN ARMSTRONG:

So, it sounds like then every physician has a second specialty, which one could say is disaster medicine.

Dr. RALPH SHEALY:

I think every physician has a responsibility, I would not say a second specialty, but I would say a responsibility that hovers in the background as they go about their daily activities and that responsibility is to come to aid of the community as a whole medical delivery systems fail and we certainly need additional resources to demand the casualties or too many the casualties are coming too fast. There are still processes in place that can create more casualties because the precipitating event has not been contained, the numbers of <_____> care is increasing and it far outstrips the ability of existing emergency services to manage and other physicians who are not providing frontline acute gear need to be able to come forward and fill some of those gaps and it brings forward a notion about scope of practice. We all have our comfort zone of our scope of practice, the things that we have trained for, things we specialized in, the things we do everyday and are familiar and comfortable with is where we like to be, but if we certainly found ourselves with patients far in excess of a normal capability of response, then folks have to stretch outside of a normal scope of practice. You know if we think back to your medical school and residency training, we were into a lot of stuff and a mass, a huge ornamentation, not only information, but skills, but as we move forward and sharpen some of those tools, we have let some of the tools lay aside and gather dust, and I think that if we are confronted to in our country with an event, where we have got to go back to work and provide primary services to a population of sufferers exceeding the normal capacity, then we have got to be able to reach back and dust off those tools and put them to use again.

Dr. JOHN ARMSTRONG:

In many respects it sounds like you are suggesting we need to get back to basics that just because the disaster has affected our community and we cannot do what we normally do does not mean that we cannot do something.

Dr. RALPH SHEALY:

Well that is exactly the point. I had the privilege of serving after havoc of the Katrina on the coast Mississippi. You know something happened there that was truly remarkable. I mean most of us never consider the facts that our hospitals could be destroyed, that it could go out of service, but that is what happened in this community, it was a modern 2-storeyed, steel and masonry building, and when I went there as a part of the federal <_____> team, the hospital was not operational. There was water standing in first floor. There were water <_____> swimming thorough radiology. That hospital was just gone and so if we were to provide medicine in that environment, we no longer could rely on imaging, we could not rely on laboratory, we could not rely on consultations, we could not really rely on referring people to referral hospitals, all have since gone away, and if care was to be provided at any level for population under those circumstances, fundamentally you have to go back to taking history, doing a physical examination, and then doing a process of deductive reasoning on limited data and making management decisions that were perhaps not perfect, not certain, but the best that could be done under that circumstances.

Dr. JOHN ARMSTRONG:

What sounds like you are describing good old fashion doctoring. Dr. Shealy you have talked about getting back to basics. What about the standard of care?

Dr. RALPH SHEALY:

Well usually when I talk with physicians about this issue, the first thing that comes out in somebody's mouth is well I can not expose

myself to the liabilities associated with providing care for people that is substandard. The issue of legal liability and a standard care immediately leap into consciousness and I think everybody worries about this, but you know when you think about the burden of truth of malpractice that there was a duty, that there was a failure of the duty, that there was a damage that occurred, and that the breach was the cause of the damage and apply standard of care principles to that scenario and the disaster. You know fundamentally, we have judged the standard of care is what another physician like me, similarly trained and equipped under same similar environment would do under that circumstance on behalf of the patient and we know what the standard of care is today and that is what we go down to the office of the hospital and do everyday and we are very comfortable with it, but the fact of the matter in an environment in which there is a major disruption of infrastructure, there is a major disruption in availability of resources. The way we normally practice medicine may not work and in a true disaster, it absolutely will not work because this is not available to us, so then we are forced in efforts to think in terms of a new standard of care of what a physician like me say in a similar training would do under these conditions, under there circumstances.

Dr. JOHN ARMSTRONG:

An important point is that the standard of care has a context that is attached to it.

Dr. RALPH SHEALY:

Absolutely and the problem mostly is that as we go about doing medicine, you know we have all been taught how to take a history, how to do a physical, how to write orders and we have got a little template for that that is engraved on the inside of our skull and if the truth be told, I think every time we write orders for hospitalized patient, we go down that template and fill in the blanks and all of a sudden none of that works, you know, you are in a environment where you cannot get the consultation, you cannot order the therapy or the study. You know now you are involved in a new standard of care of what does work in that context when a physician is applying the art and science of medicine to provide the best outcome possible for a patient under these circumstances and more importantly providing care which stretches those resources across the whole population of people in need and not just in terms of a single individual.

Dr. JOHN ARMSTRONG:

Understanding then that there is a change in the scope of practice and that it is if anything simpler and that there is a standard of care which also is different because of the disaster you can only do so much with what you have, how is it that you can navigate a large population of casualties to some good? How can you manage that large population?

Dr. RALPH SHEALY:

It comes down to principle of triage. You know triage as everybody knows is termed in sorting and fundamentally what it was down to is what the population of patients you try to identify first all those people for whom you can make a difference in outcome and then you assign priority of care in terms of who requires an intervention with the greatest urgency to achieve that out. I am involved in the EMS world and we do a great deal of training paramedics and firefighters and others who have to sort people in the field, on the ground, going back to the model of an airplane crash or some large of it in the space where you can walk out in the field literally and sort this people in according to priorities of care. In our thinking about doing that, we have to do shift - a shift away from thinking that we would do everything you can for given patient to improve their outcome, to a consideration of how do we do the most good for the most people, utilize care in terms of therapeutic efficiency of how can we use when having these tool box to the greatest and most efficient effect, to make the most difference in outcome for people and that is really the process.

Dr. JOHN ARMSTRONG:

I want to thank our guest, Dr. Ralph Shealy, for helping our minds get ready for the inevitable disaster.