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Personal Reflections on Humanitarian Medical Aid and Professional Development

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Abstract

Global events such as humanitarian disasters and crises or developmental programmes in resource constrained settings represent opportunities for well-meaning international medical volunteerism. However, imperative to these efforts is the appropriate contextual knowledge, understanding, training and development of medical specialists who seek to participate in such efforts. Three first-hand narratives are summarised with reflections on the potential harm of humanitarian response, the importance of personal and professional development as a medical volunteer, in addition to the reciprocal gains to institutions and systems involved in hosting and implementing programmes.

Introduction

Sometimes, even when you think you're prepared, you can still be shocked. As I got out of the minivan on the east coast of Sri Lanka just before sunrise following the South Asian Tsunami of 2004, the devastation where the waves had hit was complete. Stretching inland hundreds of metres, debris, damaged vessels, carcases of cattle and empty ruined shells of buildings littered the coastline in both directions as far as my eyes could scan. The waves, now rolling onto the beach under dark billowing clouds still looked menacing, a reminder of the death and destruction just recently meted out onto communities who had never heard of the word 'Tsunami' until a few days prior.

Coordination in humanitarian emergencies

UI was joining the initial assessment team who had set up a clinic service within a school housing displaced families. My role was to consider how best to expand our relief operations, as well as plan for the arrival of further volunteer teams. However, it was clear when attending the local coordination meetings that there were a significant number of international Non-Government Organizations (NGOs) with varying capacities, approaches and historical presence that were also scaling up their responses, expressing their challenges and seeking 'territorial' ownership for the responsibility of supporting displaced communities (1). What was surprising was the absence of any significant government health representation at these meetings. In the coming days, our team quickly realised and verified, that despite the immense loss of life and destruction to infrastructure, the local Ministry of Health had re-established provision of services through community halls and other public facilities (2). Many of their staff, having dealt with funeral arrangements for loved ones, were now returning to serve those in need. What they lacked were the physical structures from which to coordinate and deliver their work, particularly given that there was now competition for real estate, in addition to requirements for furnishings and equipment given that some many public and private properties had been destroyed. Additionally, the significant psychological impact on communities could not be underestimated (3).

We pivoted our plan. We stopped recruitment and deployment of volunteer emergency medical teams, negotiated the rent for 3 months for an office space to be used by local government health administrators, initiated and completed the construction of a new primary health care facility in coordination with regional development plans, as well as organised a national psychological trauma workshop for local health workers. Collaboration and consultation with the Ministry of Health as well as involvement of local partners guided our success.

Interestingly, this nature of collaboration is now embedded in humanitarian practice as part of the 'cluster' approach which brings together multiple stakeholders to coordinated the response based on need as well as sector expertise (e.g.: water and sanitation, health, shelter,

food security etc) and it is imperative that agencies that respond to disasters register with the local cluster system (4).

Knowledge, skills and attributes of the humanitarian medical volunteer

Many healthcare workers are spurred into action by witnessing the impact of disasters on communities, driven by faith, altruism and a desire to make a difference (5). However, it is important to recognise that the discipline of Humanitarian Medicine and Disaster Management also requires an understanding of key concepts and attainment of skills (6). While we may be trained and skilled as clinicians in our ability to respond locally to a mass casualty incident within an established and development hospital/healthcare system where we have defined roles and responsibilities, a disaster management approach emphasises an appropriate needs assessment involving stakeholders, planning and setting project goals and objectives while incorporating monitoring and evaluation indicators, as well as being accountable and learning from practice. Information and personnel management are critical. We are not often exposed to such environments of comprehensive response in our day to day practice, and while a professional discipline in its own right, it is clear disaster management develops a transferable skill set and dynamism that is a would support the systems in which we normally work.

Emergency Medical Teams in disaster response

These skills were again put to use while responding to the earthquake which struck Haiti in 2010, where I joined an American team. Here we had the good fortune of working in partnership with a local Haitian civil society organisation that had mobilised their volunteers, as well as tapped into their US networks for support and funding, in addition to being able to provide us with food and shelter. It is surprising to observe how often these most basic of needs are a neglected oversight by short term humanitarian response workers, and reiterates the need on emergency medical teams to ensure pre-deployment preparation, developing mental and physical resilience, as well as considering personal health and safety (7,8). Needless to say, I was grateful for the evening meal of beans and rice, and even more grateful for the open yard in which I was sleeping when the aftershocks hit.

We had set up a field clinic inside an abandoned amusement park compound, which gave us the added security of high walls, as well as single entry and exit points. During one of our afternoons of service, two bus-loads of American medical volunteers rolled up, comprising of nurses, doctors and a team of surgeons, representative of the massive response and good will from the US. However, as the teams visited regional hospitals to offer their services, they returned back to the field site frustrated in recognition that the hospitals were overwhelmed, with patients, staff and volunteers, with no surgical theatre or ward capacity from which they could contribute. There were scores of post-operative injured patients lining the hospital walkways with soaked dressings that had not been changed for days. The benefit of communication, coordination and integration with the WHO-hosted health cluster came into its own. Not only were we able to advocate for the needs of our local Haitian partner (who were not permitted access to the meetings by security staff), but we were able to rapidly develop a plan and secure resources to set up a post-operative surgical review and revision service. Patients languishing at hospital sites could be transferred to our field site, have their wounds debrided and managed, as well as remain sheltered post operatively in the 8-bed tented facility we had set up. However, one of the critical learning points was that of the need for international teams to have the right skill mix, training and resources in order to deploy and offer an impactful response. Such issues are emphasised in the WHO guidance on Emergency Medical Teams which has been developed following the Haitian experience (9).

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Leadership skills and professional development

Although utilising technical expertise as an emergency physician to see and treat patients, I found myself drawing upon and developing non-technical skill sets to inspire a shared purpose and vision, while engaging and developing our team's capability, and ensuring our service was connected to the wider network of field hospitals and clinics, all essential behavioural facets of the NHS healthcare leadership model (10). I believe that my experiences as a medical volunteer with the charity Doctors Worldwide on other international projects helped to further nurture this attitude and approach.

While participation in disaster response and relief accelerates and reinforces growth in a range of leadership, inter-personal and cross-cultural skills, these can often be more sustainably advanced through involvement in longer-term health development programs in low and middle-income countries, or where healthcare systems are still at an early stage of maturity (11).

An example of this was during my time as a member of faculty during the inaugural year of the emergency medicine residency/specialty training program launched through the pioneering US-funded Human Resources for Health Program, Rwanda (12). While a key focus of the role was to deliver didactic content as well as supervise trainees on the shop floor, it was also imperative to build upon opportunities to develop the emergency department system and improve safety in a challenging and resource constrained environment. It is often said that to teach is to learn. Working alongside nursing and physician colleagues who had been working at Kigali University Teaching Hospital for years was often a humbling experience given the patience, resilience and tolerance displayed. This often called for us to be innovative in our instruction, collaborative in our approach to improve patient outcomes, and humble in engaging our colleagues for change. In this setting where major trauma represents a significant clinical burden, I recall the case of a young man injured by a collapsing wall who was brought in unresponsive with profound haemorrhagic shock from a suspected grade V splenic injury (13). As the nursing staff peeled away predicting futility, it happened that this patient arrived at our handover during shift change, and we hence had 4 trainees and 2 consultants present. We resuscitated aggressively, managed to get blood transfusions started early, pushed for theatre, and a few hours later heard the news from post-op recovery that the young man had survived. This 'win' elevated the mood and ambition of staff for weeks, acknowledging what could be achieved should systems and performance be strengthened. Similarly, the emotive and tragic death of a paediatric burns patient provided us the right opportunity to launch mortality and morbidity meetings, and involve staff in guideline development. In order to balance our demands and expectations as expatriate clinicians, we organised a day trip to a lakeside resort for staff who had never before been afforded such an opportunity to get together as a team. The photos still adorn the Sister's desk in the emergency dept office.

Conclusion

Global Health and Humanitarian Medicine are evolving disciplines and concepts which encompass a range of skills, many of which are aligned with existing specialty curricular components, such as time and workload management, ethical research, teaching and training, health promotion and public health to name but a few. While it has been recognized that staff who have worked overseas bring back valuable skills to their place of employment, there has been limited formalized development of such experience in the UK, which has often been voluntary, and not always structured or supervised (14). Clearly, we have an opportunity and need to develop a cadre of global health practitioners and specialists to help tackle the clinical and leadership challenges of both national and international contexts, in addition to nurturing the spirit of altruism with which many of us began our journey in medicine.

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