Colorado Psychiatric Society

Introduction

Do you have a "Continuity of Operations" plan for your practice in case of personal illness or a community disaster? Have you given any thought to what your role as a psychiatrist might be in a flu pandemic? Do you have a plan for yourself and your family in the event of an infrastructure break-down or an emergency declaration urging citizens not to leave home?

These are some of the questions we have been discussing with our members as part of a grant from the Colorado Department of Public Health and Environment through the Colorado Medical Society aimed at physician education about disaster preparation. As part of this effort, we have compiled this toolkit specifically for members of the Colorado Psychiatric Society. It consists of information about disaster planning including preparation for pandemic flu. It is intended to give you, your family, and your practice access to some of the informational and planning resources that are available.

We hope that you will find this information useful. In the future, our website will also include disaster preparedness information and updates. If you have any questions, ideas for future projects on this theme, or an interest in joining our disaster task force, please contact us.

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Disaster Preparedness
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Individual and Family Preparedness

READYColorado

Make a Plan. Make a Difference.

Pack a Kit:
Food Checklist

FOOD: PREPARING AN EMERGENCY SUPPLY

If activity is reduced, healthy people can survive on half their usual food intake for an extended period or without any food for many days. Food, unlike water, may be rationed safely, except for children and pregnant women.

You don't need to go out and buy unfamiliar foods to prepare an emergency food supply. You can use the canned foods, dry mixes and other staples on your cupboard shelves. Canned foods do not require cooking, water or special preparation.

Food items that you might consider including in your disaster supply kit include:

- ☐ Ready-to-eat meats (e.g., beef jerky, canned ham)
- ☐ Canned fruits and vegetables
- ☐ Canned or boxed juices
- ☐ Boxed milk
- ☐ Powdered milk
- ☐ Canned soup
- ☐ Peanut butter
- ☐ Jelly
- ☐ Granola bars
- ☐ Trail mix
- ☐ Vitamins
- ☐ Foods for infants
- ☐ Foods for persons on special diets (e.g., low sodium or gluten free)
- ☐ Cookies
- ☐ Hard candy
- ☐ Instant coffee
- ☐ Tea bags
- ☐ Cereal
- ☐ _____
- _____
- _____

FOOD STORAGE TIPS

- Keep canned foods in a dry place where the temperature is fairly cool. To protect boxed foods from pests and to extend their shelf life, store the food in tightly closed plastic or metal containers.
- Replace items in your food supply every six months.
- Throw out any canned good that becomes swollen, dented, or corroded.
- Use foods before they go bad, and replace them with fresh supplies.
- Date each food item with a marker.
- Place new items at the back of the storage area and older ones in front.

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Make a Plan. Make a Difference.

Pack a Kit:
Water Checklist

WATER: THE ABSOLUTE NECESSITY

Stocking water reserves should be a top priority. Drinking water in emergency situations should not be rationed. Therefore, it is critical to store adequate amounts of water for your household.

- ☐ **Two quarts of water/day/person for drinking.**
  Example: 2 quarts x 3 days x 5 person household = 30 quarts (about 8 gallons of water).
  Individual needs vary, depending on age, physical condition, activity, diet, and climate. A normally active person needs at least two quarts of water daily just for drinking. Children, nursing mothers, and ill people need more. Very hot temperatures can double the amount of water needed.

- ☐ **One gallon of water/day/person for sanitary purposes and cooking.**
  Example: 1 gallon x 3 days x 5 person household = 15 gallons.
  Because you will also need water for sanitary purposes and, possibly, for cooking, you should store at least one gallon of water per person per day.

WATER STORAGE TIPS

- Containers for water should be rinsed with a diluted bleach solution (one part bleach to ten parts water) before use. Previously used bottles or other containers may be contaminated with microbes or chemicals. Do not rely on untested devices for decontaminating water.
- If your water is treated commercially by a water utility, you do not need to treat water before storing it. Additional treatments of treated public water will not increase storage life.
- If you have a well or public water that has not been treated, follow the treatment instructions provided by your public health service or water provider.
- If you suspect that your well may be contaminated, contact your local or state health department or agriculture extension agent for specific advice.
- Seal your water containers tightly, label them and store them in a cool, dark place.
- It is important to change stored water every six months.

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Pack a Kit:
First Aid Supplies Checklist

Assemble a first aid kit for your home and for each vehicle

First Aid Kit Essentials

- [ ] First aid manual
- [ ] Sterile adhesive bandages in assorted sizes
- [ ] Assorted sizes of safety pins
- [ ] Cleansing agents (isopropyl alcohol, hydrogen peroxide)/soap/germicide
- [ ] Antibiotic ointment
- [ ] Latex gloves (2 pairs)
- [ ] 2-inch and 4-inch sterile gauze pads (4-6 each size)
- [ ] Triangular bandages (3)
- [ ] 2-inch and 3-inch sterile roller bandages (3 rolls each)
- [ ] Cotton balls
- [ ] Scissors
- [ ] Tweezers
- [ ] Needle
- [ ] Moistened towelettes
- [ ] Antiseptic
- [ ] Thermometer
- [ ] Tongue depressor blades (2)
- [ ] Tube of petroleum jelly or other lubricant
- [ ] Sunscreen

Prescription Medications

It may be difficult to obtain prescription medications during a disaster because stores may be closed or supplies may be limited. Ask your physician or pharmacist about storing prescription medications. Be sure they are stored to meet instructions on the label and be mindful of expirations dates—be sure to keep your stored medication up to date.

List prescription medications that you need to have on hand:

- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

Eye Wear

- [ ] Extra pair of prescription glasses or contact lens.

Other Medications

Have the following nonprescription drugs in your disaster supply kit:

- [ ] Aspirin and non aspirin pain reliever
- [ ] Antidiarrheal medication
- [ ] Antacid (for stomach upset)
- [ ] Syrup of ipecac (use to induce vomiting if advised by the poison control center)
- [ ] Laxative
- [ ] Vitamins

Other

- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

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Make a Plan. Make a Difference.

Pack a Kit:
Tools & Supplies Checklist

It is important to assemble these items in a disaster supply kit in case you have to leave your home quickly. Even if you don't have to leave your home, if you lose power it will be easier to have these item already assembled and in one place.

Tools and Other Items

- ☐ A portable, battery-powered radio or television and extra batteries (also have a NOAA weather radio, if appropriate for your area)
- ☐ Flashlight and extra batteries
- ☐ Signal flare
- ☐ Matches in a waterproof container (or waterproof matches)
- ☐ Shut-off wrench
- ☐ Pliers
- ☐ Shovel
- ☐ Other tools (screwdriver, etc.)
- ☐ Duct tape and scissors
- ☐ Plastic sheeting
- ☐ Whistle
- ☐ Small canister, A-B-C-type fire extinguisher
- ☐ Tube tent
- ☐ Compass
- ☐ Work gloves
- ☐ Paper, pens, and pencils
- ☐ Needles and thread
- ☐ Battery-operated travel alarm clock

Kitchen Items

- ☐ Manual can opener
- ☐ Mess kits or paper cups, plates, and plastic utensils
- ☐ All-purpose knife
- ☐ Household liquid bleach to treat drinking water
- ☐ Sugar, salt, pepper
- ☐ Aluminum foil and plastic wrap
- ☐ Re-sealing plastic bags
- ☐ If food must be cooked, small cooking stove and a can of cooking fuel

Sanitation and Hygiene Items

- ☐ Washcloth and towel
- ☐ Towelettes, soap, hand sanitizer, liquid detergent
- ☐ Tooth paste, toothbrushes, shampoo, deodorants, comb and brush, razor, shaving cream, lip balm, sunscreen, insect repellent, contact lens solutions, mirror, feminine supplies
- ☐ Heavy-duty plastic garbage bags and ties—for personal sanitation uses—and toilet paper
- ☐ Medium-sized plastic bucket with tight lid
- ☐ Disinfectant and household chlorine bleach
- ☐ Consider including a small shovel for digging a latrine

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Make a Plan. Make a Difference.

Pack a Kit:
Clothes, Bedding & Specialty Items Checklist

CLOTHES AND BEDDING

- ☐ One complete change of clothing and footwear for each household member
- ☐ Sturdy work shoes or boots
- ☐ Rain gear
- ☐ Hat
- ☐ Gloves
- ☐ Socks
- ☐ Underwear
- ☐ Thermal underwear
- ☐ Sunglasses
- ☐ Blankets (or sleeping bag) for each household member
- ☐ Pillows

SPECIALTY ITEMS

Remember to consider the needs of infants, elderly persons, disabled persons, and pets and to include entertainment and comfort items for children.

- ☐ For baby

_____ _____

_____ _____

- ☐ For the elderly

_____ _____

_____ _____

- ☐ For pets

_____ _____

_____ _____

- ☐ Entertainment: books, games, quiet toys and stuffed animals

_____ _____

_____ _____

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Family Communications Plan

Your family may not be together when disaster strikes, so plan how you will contact one another and review what you will do in different situations.

Out-of-Town Contact Name_____ Phone_____
E-mail_____ Phone_____

Fill out the following information for each family member and keep it up to date.

Name_____ Social Security Number_____
Date of Birth_____ Important Medical Info._____

Name_____ Social Security Number_____
Date of Birth_____ Important Medical Info._____

Name_____ Social Security Number_____
Date of Birth_____ Important Medical Info._____

Name_____ Social Security Number_____
Date of Birth_____ Important Medical Info._____

Name_____ Social Security Number_____
Date of Birth_____ Important Medical Info._____

Name_____ Social Security Number_____
Date of Birth_____ Important Medical Info._____

Where to go in an emergency. Write down where your family spends the most time: work, school and other places you frequent. Schools, daycare providers, workplaces and apartment buildings should all have site-specific emergency plans.

Home

Address_____
Phone_____
Neighborhood Meeting Place_____
Regional Meeting Place_____

Work

Address_____
Phone_____
Evacuation Location_____

School

Address_____
Phone_____
Evacuation Location_____

Work

Address_____
Phone_____
Evacuation Location_____

School

Address_____
Phone_____
Evacuation Location_____

Other place you frequent:

Address_____
Phone_____
Evacuation Location_____

School

Address_____
Phone_____
Evacuation Location_____

Other place you frequent:

Address_____
Phone_____
Evacuation Location_____

Make a note of important contacts, phone numbers and policy numbers. Dial 9-1-1 for emergencies!

Important Information	Name	Telephone #	Policy #
Doctor			
Doctor			
Pharmacist			
Medical Insurance			
Homeowner's/Rental Insurance			
Veterinarian/Kennel			
Other			
Other			
Other			

Every family member should carry a copy of this important information.

1-800-639-READY (7323)

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www.readycolorado.com

Contact Name: _____

Telephone: _____

Out-of Town Contact Name: _____

Telephone: _____

Neighborhood Meeting Place: _____

Meeting Place Telephone: _____

COMMUNICATIONS PLAN

1-800-639-READY (7323)

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Haga un Plan. Haga una Diferencia.

www.readycolorado.com

Nombre de las personas con quien ponerse en contacto: _____

Teléfono: _____

Nombre de la persona con quien ponerse en contacto fuera de la ciudad: _____

Teléfono: _____

Lugar de reunion del vecindario: _____

Teléfono del lugar de reunión: _____

PLAN DE COMUNICACIONES

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Household Plan

One of the most important steps you can take in preparing for emergencies is to develop a household disaster plan.

Simple Steps to Get Your Household READY

Step One: Types of Hazards

Learn about the natural disasters that could occur in your community from your local emergency management office or American Red Cross chapter. Make notes here.

Learn whether hazardous materials are produced, stored or transported near your area. Make notes here.

Learn about possible consequences of deliberate acts of terror. Ask how to prepare for each potential emergency and how to respond. Make notes here.

Step Two: Business and School Emergency Response Plans

Talk with employers and school officials about their emergency response plans.

Step Three: Have a Household Meeting

Talk with your household about potential emergencies and how to respond to each. Talk about what you would need to do in an evacuation. Details of evacuation plan:

4 Step Four: Complete a "Family Communications Plan"

- ☐ Download a copy of the "Family Communications Plan" from **readycolorado.com**. Plan how your household would stay in contact if you were separated. Identify two meeting places: the first should be near your home—in case of fire, perhaps a tree or a telephone pole; the second should be away from your neighborhood in case you cannot return home.
- ☐ Make sure to pick a friend or relative who lives out of the area for household members to call to say they are okay.

5 Step Five: Training!

- ☐ Download a copy of "My READY Profile" from **readycolorado.com**. Post emergency telephone numbers by telephones. Teach children how and when to call 911.
- ☐ Make sure everyone in your household knows how and when to shut off water, gas, and electricity at the main switches. Consult with your local utilities if you have questions.

6 Step Six: Take a Class

- ☐ Take a first aid and CPR class. Local American Red Cross chapters can provide information. Official certification by the American Red Cross provides "good Samaritan" law protection for those giving first aid. Visit **readycolorado.com**, "Make A Difference" for information on different volunteer opportunities.
- ☐ Reduce the economic impact of disaster on your property and your household's health and financial well-being.

7 Step Seven: Review & Copy Important Documents

- ☐ Review property insurance policies before disaster strikes—make sure policies are current and be certain they meet your needs (type of coverage, amount of coverage, and hazard covered—flood, earthquake)
- ☐ Protect your household's financial well-being before a disaster strikes—review life insurance policies and consider saving money in an "emergency" savings account that could be used in any crisis. It is advisable to keep a small amount of cash or traveler's checks at home in a safe place where you can quickly gain access to it in case of an evacuation.
- ☐ Be certain that health insurance policies are current and meet the needs of your household.
- ☐ Make copies of important documents (bank account numbers, policy numbers, etc.) and keep them in a fire-safe box, secure a set in a location other than home, and send them to an out of town relative.

8 Step Eight: Discuss Special Household Needs

- ☐ Download a copy of the "Special Needs" worksheet from **readycolorado.com**. Consider ways to help neighbors who may need special assistance, such as the elderly or the disabled.
- ☐ Make arrangements for pets. Pets are not allowed in public shelters. Service animals for those who depend on them are allowed.

Pandemic Influenza – Challenges and Preparation

As you and your family plan for an influenza pandemic, think about the challenges you might face, particularly if a pandemic is severe.

You can start to prepare now to be able to respond to these challenges. The following are some challenges you or your family may face and recommendations to help you cope. In addition, checklists and other tools have been prepared to guide your planning efforts. A series of planning checklists can be found at www.pandemicflu.gov/plan/checklists.html.

Essential Services You Depend on May Be Disrupted

- Plan for the possibility that usual services may be disrupted. These could include services provided by hospitals and other healthcare facilities, banks, restaurants, government offices, telephone and cellular phone companies, and post offices.
- Stores may close or have limited supplies. The planning checklists can help you determine what items you should stockpile to help you manage without these services
- Transportation services may be disrupted and you may not be able to rely on public transportation. Plan to take fewer trips and store essential supplies.
- Public gatherings, such as volunteer meetings and worship services, may be canceled. Prepare contact lists including conference calls, telephone chains, and email distribution lists, to access or distribute necessary information.
- Consider that the ability to travel, even by car if there are fuel shortages, may be limited.
- You should also talk to your family about where family members and loved ones will go in an emergency and how they will receive care, in case you cannot communicate with them.
- In a pandemic, there may be widespread illness that could result in the shut down of local ATMs and banks. Keep a small amount of cash or traveler's checks in small denominations for easy use.

Food and Water Supplies May Be Interrupted and Limited

Food and water supplies may be interrupted so temporary shortages could occur. You may also be unable to get to a store. To prepare for this possibility you should store at least one to two weeks supply of non-perishable food and fresh water for emergencies.

Food

- ❖ Store two weeks of nonperishable food.
- ❖ Select foods that do not require refrigeration, preparation (including the use of water), or cooking.
- ❖ Insure that formulas for infants and any child's or older person's special nutritional needs are a part of your planning.

Water

- ❖ Store two weeks of water, 1 gallon of water per person per day. (2 quarts for drinking, 2 quarts for food preparation/sanitation), in clean plastic containers. Avoid using containers that will decompose or break, such as milk cartons or glass bottles.

Being Able to Work May Be Difficult or Impossible

- ❖ Ask your employer how business will continue during a pandemic.
- ❖ Discuss staggered shifts or working at home with your employer. Discuss telecommuting possibilities and needs, accessing remote networks, and using portable computers.
- ❖ Discuss possible flexibility in leave policies. Discuss with your employer how much leave you can take to care for yourself or a family member
- ❖ Plan for possible loss of income if you are unable to work or the company you work for temporarily closes.

For the Business Checklist visit: http://www.pandemicflu.gov/plan/businesschecklist.html

Schools and Daycare Centers May Be Closed for an Extended Period of Time

Schools, and potentially public and private preschool, childcare, trade schools, and colleges and universities may be closed to limit the spread of flu in the community and to help prevent children from becoming sick. Other school-related activities and services could also be disrupted or cancelled including: clubs, sports/sporting events, music activities, and school meals. School closings would likely happen very early in a pandemic and could occur on short notice.

- ❖ Talk to your teachers, administrators, and parent-teacher organizations about your school's pandemic plan, and offer your help.
- ❖ Plan now for children staying at home for extended periods of time, as school closings may occur along with restrictions on public gatherings, such as at malls, movie theaters.
- ❖ Plan home learning activities and exercises that your children can do at home. Have learning materials, such as books, school supplies, and educational computer activities and movies on hand.
- ❖ Talk to teachers, administrators, and parent-teacher organizations about possible activities, lesson plans, and exercises that children can do at home if schools are closed. This could include continuing courses by TV or the internet.
- ❖ Plan entertainment and recreational activities that your children can do at home. Have materials, such as reading books, coloring books, and games, on hand for your children to use.

For the "Childcare, School, and University Checklist," visit: http://www.pandemicflu.gov/plan/tab5.html

Medical Care for People with Chronic Illness Could be Disrupted

In a severe pandemic, hospitals and doctors' offices may be overwhelmed.

- If you have a chronic disease, such as heart disease, high blood pressure, diabetes, asthma, or depression, you should continue taking medication as prescribed by your doctor.
- Make sure you have necessary medical supplies such as glucose and blood-pressure monitoring equipment.
- Talk to your healthcare provider to ensure adequate access to your medications.
- If you receive ongoing medical care such as dialysis, chemotherapy, or other therapies, talk with your health care provider about plans to continue care during a pandemic.

- A "Family Emergency Health Information Sheet" is provided in this guide and at: http://www.pandemicflu.gov/planguide/familyhealthinfo.html

Business Preparedness

DO YOU KNOW WHERE YOUR FIRE EXTINGUISHER IS? PLANNING FOR OFFICE EMERGENCIES

Reprinted from *Rx for Risk* Volume 10 Issue 2 (Spring 2002)

Psychiatrists and other healthcare professionals are accustomed to planning for and responding to emergencies in acute care settings. Once in an office setting, however, many professionals fail to recognize the need for emergency planning. But injuries and damages resulting from emergencies in an office setting can be just as devastating as those arising from emergencies in a hospital, and advance planning, staff training, and periodic reviews can assure an effective response in even the most modest of practice settings.

Emergency Planning

The overall goals of an emergency plan are 1) to minimize the probability of injury or loss related to patients, visitors, and or employees in an emergency; and 2) to prevent or decrease the risk of property loss (including equipment, patient and business records, etc.).

For most psychiatric office settings, an emergency plan will not be lengthy and the planning and preparation should not be time-consuming. The following suggestions may assist you with planning, constructing, and implementing an emergency plan for your practice.

1) Begin by identifying and analyzing the potential emergency risks.

a. Think about the activities in your office and the various individuals and groups who are involved in those activities. Examples: patients & families, professional staff, administrative staff, visitors, individual &/or group therapy, acupuncture, and lab work.

b. Consider the specific types of emergencies that might occur. Examples: medical emergencies, psychiatric emergencies, fire, bomb threat, hazmat exposure, flood, weather related emergencies, and power outage.

c. Consider what other factors might contribute to an emergency and your ability to respond

Examples:
- How do office hours impact potential emergency situations? For example, do some staff members work during hours when there is no one else available should an emergency occur?
- Do you own or rent the office building or facility in which your practice is located?
- What federal, state, or county regulations or codes govern or apply to your practice setting? Will they affect how you respond to emergencies?
- Do you have backup systems available if, for example, power, telecommunications, or computer networking capacities are lost? Do you need them?

2) Weigh the various effective responses to the potential emergency situations identified and decide which responses are best for your practice setting.

Examples:
- The responses must be tailored to the size and make-up of your practice. For example, is it a large group practice with a waiting room and visitors coming and going all day, or is it a solo practice in your home?
- Is it appropriate to delegate responsibility for parts of the planning and implementation to others in your office or on your staff.

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- If you are considering using medical supplies/equipment or drugs to respond to an emergency take into account the following issues:
- Can drugs be properly stored and secured?
- Who will have access? Does the system allow for quick access in an emergency but still maintain the security?
- Is there a protocol for checking expiration dates and having an adequate supply available?
- If there is personal protective equipment available in the office (e.g., gloves, masks, and resuscitation devices) is it easily accessible? Are the protocols for use defined?
- Do you and/or your staff have the appropriate credentials and training to intervene using drugs or medical devices?

It is recommended that any emergency plan include strategies for managing one of the most likely situations to arise in psychiatric practices, a patient or visitor who is agitated or who becomes out of control and may injure himself or others. "Front-line" staff (e.g., receptionists, secretaries, and administrative assistants) should be educated and trained to recognize potential emergencies and request help.

Problem behaviors to look for in a visitor or patient include: appears to be under the influence of alcohol or drugs, paces and appears agitated, talks or complains loudly, uses profanity, and makes any type of threat to others.

Staff should be trained to take some immediate steps, such as: activate the emergency system to notify other office staff of a problem, stay at least two arms' lengths away from the agitated person, separate others from the hostile person (if possible), and be prepared to call 911.

3) Consider what safety features and plans may already be in place.

Examples:
- What are the security procedures for the building?
- Does the landlord/building maintenance have an evacuation plan, fire plan, etc?
- If there are no building emergency plans, should you discuss this issue with the landlord/building maintenance?
- Who is the emergency contact if anything goes wrong in the building or if a problem is anticipated?
- Is there a sprinkler system that is functional?
- Are there fire and other alarms?
- Are fire extinguishers checked regularly?
- Are fire exits and evacuation routes unobstructed?
- Are fire doors unlocked?
- Is there a "panic button" system, or other communication system, for staff to notify others if help is needed?

4) Prepare a written emergency plan.

The plan should be readable and stored in a location that is easily accessible.

5) Educate office staff about the emergency plan.

- Everyone should know the location of the written emergency plan. Copies of emergency and evacuations plans, if any, for your building should be attached.
- Decide on a central telephone number where staff can call to get information if the office is closed or inaccessible due to an emergency.
- Emergency contact numbers should be available close to all telephones.

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- Consider an occasional impromptu “quiz” to make sure that staff know the locations of the closest fire extinguisher or fire pull station, etc.
- Have staff review the plan periodically. Hold an in-service training on responding to emergencies at least yearly.
- All staff members should be involved in identifying potential emergencies and updating the plan.

6) Periodically review the plan and update it as needed. Keep staff informed of any changes.

Real Life Examples

Potential emergency in the waiting room

Consider the following incident observed by a visiting risk manager.

Two women, a mother and her adult daughter, arrived at the waiting room of a large, psychiatric group practice. The older of the two women informed the receptionist that she had been instructed by a physician at the hospital emergency department to bring her daughter to see someone in the group practice. The receptionist told the women that the psychiatrist was not available but a message would be left for her. Although it was clear that English was not the woman’s first language, the basic information was conveyed and the two women seemed to understand that they had to wait for the doctor.

The women waited for some time, and the daughter became more and more lethargic as time passed. The mother tried to talk to the daughter (in their primary language) and get her to respond, but without much success. The mother started to become anxious and her voice became louder. The daughter did not appear to be responding coherently and was even moaning periodically. At various times, individuals who appeared to be therapists with the group practice, came through the waiting room, noticed the situation, and spoke to the receptionist who informed them that she had left a message for the psychiatrist whom the women were waiting to see. In every instance, the questioning therapist left the waiting room and went about his or her business.

Although the receptionist looked anxiously in the direction of the mother and daughter a few times; she did not seem to know what to do. After awhile, she simply stopped looking in their direction and ignored what was happening.

The risk manager approached the receptionist and stated that a professional needed to assess the situation promptly. At that moment, the psychiatrist arrived and intervened. However, the potential for a serious medical or psychiatric emergency was very real. It was not clear if the daughter was ill, was under the influence of substances, was having a reaction to medication, or had taken an overdose. Orientation of the receptionist and other staff to an emergency plan that included instructions about intervening promptly and who to contact in such a situation could have prevented this problem from escalating to the point it did.

Loss of patient and business records in a disaster

One of the most frequent property losses experienced by psychiatrists is the loss of patient and business records due to flood, fire, or theft. The loss of patient records potentially causes a variety of problems for patients and can also compromise the doctor’s defense in a malpractice suit or administrative complaint. In many cases planning and preparation can prevent or mitigate the damage.

Sometimes the damage results from the inadequate maintenance or storage of records. For example, flood damage to records stored in cardboard boxes in a home basement or garage is surprisingly common.

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In one case a psychiatrist was alerted to the potential flooding at his office in the aftermath of a hurricane. Unfortunately, there was no plan in place to mobilize the personnel and equipment needed to evacuate the records and equipment before the office was flooded.

A lack of regular backup of computer files can result in the loss of all computerized patient and business records due to the theft of computer equipment. Portable and hand-held electronic devices are particularly attractive targets.

Conclusion

Even office-based psychiatric practices should have an emergency plan in place. A prompt, effective, and confident response in the event of an emergency or an emergent situation can mean the difference between considerable damages or minimal damages.

The emergency plan for any practice will be unique to the needs of that particular practice. The information above should help you start your practice's plan. There are a variety of resources available to help in your planning process.

Resources

Federal Emergency Management Agency - www.fema.gov
American Red Cross - www.redcross.org/services/disaster/beprepared/busi_industry.html
National Safety Council – www.nsc.org
OSHA – www.osha.gov

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HOPING FOR THE BEST. PLANNING FOR THE WORST. EMERGENCY PREPAREDNESS AND CONTINGENCY PLANNING

Reprinted from *Rx for Risk* Vol. 14 Issue 1 (Winter 2006)

Both 2004 and 2005 have witnessed a series of catastrophic natural disasters - from a Pacific tsunami, to a massive earthquake, to an unprecedented Gulf coast hurricane season. In each instance, the impact on healthcare in the regions affected was immeasurable.

In the U.S. alone, over one million people were displaced by hurricanes Katrina and Rita, including thousands of doctors. All forms of communication and transportation in the Gulf region were disrupted. Healthcare facilities, physician offices, and patient medical records were destroyed.

Such disasters and their aftermath underscore the importance of emergency preparation and the need for contingency planning. However, in discussions of emergency preparedness, clinicians tend to focus solely on their response to a disaster as medical practitioners. Nevertheless, as tragically demonstrated by Katrina and Rita, one's ability to respond to a disaster and treat patients is often determined by more than simply one's competence as a clinician.

While most psychiatrists may never encounter an emergency on the scale or severity of the aforementioned disasters, the destruction of resources and records that can occur as a result of a small fire or flood, illustrates the importance of having an emergency plan in place. Having such a plan can insure your prompt, effective, and confident response in the event of an emergency.

The Purpose Behind Your Plan

While an emergency plan may not be able to protect you from disaster, it can prepare you for disaster and minimize its effects on your practice.

The overall goals of an emergency plan are to:

1) *Minimize* the probability of injury or loss related to your patients, visitors, and or employees in an emergency;

2) *Minimize*, or prevent altogether, the risk of property loss (including equipment, patient and business records, etc.)

3) *Minimize* down time and expedite your recovery from the disaster.

For most psychiatric office settings, an emergency plan need not be lengthy and the planning and preparation should not be time-consuming. The following suggestions may assist you with planning, constructing, and implementing an emergency plan for your practice.

Four Steps to Being Prepared for an Emergency

1) Compile and Consider: Identifying and analyzing your potential emergency risks.

Compile a list of the specific types of emergencies that might occur. Examples: medical emergencies, psychiatric emergencies, fire, bomb threat, hazmat exposure, flood, weather related emergencies, and power outage.

Helpful Hint: Every state and most large cities have an emergency management office tasked with providing guidance and information in case of disaster. Most, if not all of these offices have web sites with useful information that will aid you in your emergency planning. Oftentimes, these offices will have resources advising you about risks that are unique to your area. For example, the website for the New York City Office of Emergency Management can tell you whether your office is in a low-lying area at risk from flood damage during a hurricane.

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Once you compile your list you will need to prioritize your planning resources based on the likelihood of occurrence. Identifying how and where your office is most vulnerable will allow you determine where you need to focus your attention.

2) Inventory and Incorporate: Take inventory of the safety features and emergency plans already in place at your practice location for incorporation into your plan.

Before you allocate any of your own resources in developing an emergency plan, you need to determine what safety features and plans are *already* at your place at your location. For example, if your building has an evacuation plan for the building, your plan should incorporate those building procedures that are already there.

Locate and make copies of building and site maps with critical utility and emergency routes clearly marked.

- Identify and clearly mark entry-exit points both on the maps and throughout the building.
- Post maps for quick reference by employees.
- Keep copies of building and site maps with your emergency plan and other important documents and also at an off-site location.

Ask, at a minimum, the following questions:

- Is there an evacuation plan for your city, county or region?
- What are the security procedures for your building?
- Is there an evacuation plan, fire plan, etc for your building?
- Who is the emergency contact in your building if a problem arises
- Are there working fire and other alarms?
- Are fire extinguishers checked regularly?

3) Allocate Your Resources.

Once you determine what plans and procedures are already in place at your location you can allocate your resources—this can mean something as simple as collecting emergency supplies (e.g., batteries, bottled water, flashlights, and non-perishable food), developing an office evacuation plan, or it can mean a more complex response as in the case of your medical records.

For example, in the past, your building has experienced flooding during severe storms. You identify flooding as a potential risk and determine that you need to allocate resources to prevent the loss of patient and business records. You develop a plan to 1) have electronic back-up records taken weekly to a secure off-site location, 2) transport active patient records to a safe location when a severe storm is imminent, and 3) to store inactive patient records with a medical record storage company. You decide against purchasing file cabinets advertised as waterproof and fireproof due to their high cost.

4) Implement Your Plan

The first step in implementing any plan will be the act of communicating it to your office staff. Even the best plan will only be effective if your staff know it, understand it, and are able to put it into practice during an emergency. Here are some guidelines to help you in this process:

Keep it Simple. When committing the plan to writing, remember that the best plan—the plan that will be the simplest to implement—will be the one that is easy to read and understand.

Keep it Accessible. A hard copy of the plan should be stored in a location that is easily accessible. All staff should know the location of the written emergency plan. You should also keep a copy of the plan along with employee emergency contact information at a separate location such as your home. This will allow you to refer to the plan if you are away from your office and an emergency arises.

Keep in Practice. Your staff needs to know the plan and be able to implement it. Provide training and periodic walk-throughs of the plan to ensure that everyone understands their roles and responsibilities during an emergency situation.

Keep it Updated. Your office may experience changes in personnel, facilities, computer systems, and record keeping. Your plan will need to change and evolve to reflect the changes in your practice. Keep your staff involved in updating the plan and inform them of any changes to the plan.

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Plan for The Unthinkable: What if something happens to you?

One potential emergency that cannot be overlooked is if something were to happen to ***you***. Psychiatrists should prepare a set of instructions for staff, family members, and willing colleagues regarding what should be done in the event of the psychiatrist's sudden incapacity. The incapacity can be due to an accident, an illness, a family emergency, or other type of unanticipated event that takes you away from your practice on short notice. The plan need not be complex, but as with any emergency preparedness plan, it should be documented, readily accessible to those who may need to implement it, and regularly updated.

A list of suggested items to be covered in a contingency plan includes:

- Contact information: the physician's pager number, cell phone number, home phone number, e-mail address, and home address.
- Contact information for the physician's spouse, life partner, adult children, or anyone else who would likely know of the physician's whereabouts or sudden health problems.
- A statement that staff is authorized to contact these people in the event of the physician's unexplained absence from the practice.
- Instructions regarding how long staff should wait before implementing the emergency contact plan in the event of any unexplained absence. One hour is probably the longest period of unexplained absence the plan should allow.
- Instructions regarding who is authorized to have access to patient records in the physician's unexplained absence. These instructions also should specify what information can be released from the records.
- Instructions regarding prescription refills and release of information to third parties.
- Instructions regarding how to deal with patients who become upset, either physically or emotionally, in the event of a crisis.
- Names, addresses, and phone numbers of psychiatrists who have agreed to act as emergency backups. There should be more than one. Staff should be trained on proper referral procedures and proper termination-of-care procedures.

Helpful Hint: Hurricane Katrina displaced both doctors and patients and destroyed medical facilities and countless medical records. Many mental health patients were displaced to other states and unable to contact their psychiatrist or gain access to their records. Katrina illustrates the importance of encouraging your patients to document their own medications and treatment history.

In Conclusion

Psychiatrists and other healthcare professionals are often accustomed to planning for and responding to medical emergencies in acute care settings. Once in an office setting, however, many professionals fail to recognize the need for emergency planning. But injuries and damages resulting from disasters in an office setting are often just as devastating as those arising from emergencies in a hospital. Advance planning, staff training, and periodic reviews can insure an effective response in even the most modest of practice settings and prepare both your staff, and your patients for the unthinkable, so that when an emergency does occur, you can confidently maintain your focus on patient care.

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Resources

These resources will help you develop your practice's emergency plan.

American Health Information Management Association – www.ahima.org
See "Practice Brief: Disaster Planning for Health Information":
http://library.ahima.org/xpedio/groups/public/documents/ahima/pub_bok1_019242.html#contingency

Federal Emergency Management Agency - www.fema.gov
FEMA also has a webpage listing links to your local state Emergency Management Agency - http://www.fema.gov/fema/statedr.shtm

The Department of Health and Human Services along with the CDC have compiled a form whereby patients can document their own medical care -
http://www.bt.cdc.gov/disasters/hurricanes/katrina/kiwy.asp

American Red Cross - www.redcross.org/services/disaster/beprepared/busi_industry.html

U.S. Department of Homeland Security has a website that provides information and resources including a common-sense framework for planning an emergency/disaster plan for any business http://www.ready.gov/business/index.html

At the following website there is a cost estimator for emergency plan expenses: http://www.ready.gov/business/over-cost.html

The National Partnership for Workplace Mental Health
http://www.workplacementalhealth.org/

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Business Preparedness Planning for Psychiatrists

Outline from July 19, 2007 presentation to members

Laura Michaels, J.D.

Decision Making

- Need to plan both as a business and as a provider of health care.
- Considerations:
  Close practice? Focus on personal, family, community care in non-professional role.
  Continue practice? Business planning to anticipate decrease in workload, decrease in workforce.
  Expand practice to provide pandemic flu care? Treatment of mental health consequences, including issues among caregivers. (May require affiliation with other clinical entities)
  Suspend practice and participate as volunteer in county, state, federal disaster efforts? (Likely will require prior registration and training.)
- If you are employed by a health center, hospital or other agency, you should be a part of your agency's practice preparation.

Develop Written Plan

- Determine what would trigger closing of office.
- Identify your practice's essential functions and the individuals who perform them.
- Determine which outside activities are critical to maintaining operations and develop alternatives in case they cannot function normally, e.g. deliveries, inventory, contracted work.
- Consider scenarios likely to result in increase or decrease for services.
- If you have employees or contractors, create policies on:
  Absences due to personal illness, family member illness, community containment measures and quarantines, school/business closures.
  Flexible worksite (telecommuting)
  Flexible hours
  Compensation
  Create plan to recruit temporary personnel, if needed.
- Determine which business functions are critical and whether they can be done offsite:
  Treating patients
  Payroll, bills due, accounts receivable
  Medical insurance claims and documentation
  Medical record management
  Communications
- Plan accordingly for interruptions of essential governmental services like sanitation, water, and power supply.

Communications

- Establish emergency communications plan and revise periodically.
- Create list of names, addresses, and phone numbers of psychiatrists who have agreed to act as emergency backups. There should be several. If you have staff, be sure they are trained to do proper referrals.
- Create list of key contacts with back-ups.
- Enhance infrastructures as needed to support telecommuting and remote patient access.
- Create list or database with contact information on patients who have regularly scheduled visits and may need to be contacted for rescheduling or another method of care.
- Have contingency plans for ensuring communications and networking in the event of power failures, e.g. battery powered cell phone chargers.

Financial Issues

- Plan for cash flow shortage, income disruption
- Consider the levels of accessible cash that may be required to maintain business operations.
- Review insurance coverage
- Understand what your policy covers
- Look into business interruption insurance
- Find out what records your insurance provider will want to see after an emergency and store them in a safe place.

Infrastructure and Supplies

- Identify what equipment, computers are needed to keep practice open.
- Ensure that you have proper equipment to work from outside the office.
- Make sure home system can access work system; look at compatibility issues.
- Improve cyber security
- Use anti-virus and anti-spyware software and keep them up-to-date.
- Back up your computer data.
- Review access privileges and security.

Infection Control

- Provide infection control supplies in office (e.g. hand-hygiene products, tissues, and receptacles for their disposal)
- Establish policies for preventing influenza spread at the worksite (e.g. promoting respiratory hygiene/cough etiquette, and prompt exclusion of people with influenza symptoms).
- Create guidelines to modify frequency and type of face-to-face contact (hand shaking, office layout, seating).
- Shift arrival times to limit contact.
- Consider personal protective equipment (e.g. surgical masks, N95 masks), understanding significant issues re hand-to mask and mask-to-surface contamination, reuse.

Impact on Patients

- Create system for triage of patients to determine who requires care, possibly limiting office visits to those that are medically necessary.
- If decision is made to close office, decide on your availability by phone or e-mail and back-up physicians.
- Care for patients who are isolated or quarantined.
- Access to Medications
- Where possible and safe, provide longer medication refills.

Medical Records and Medical Practice Data

- Back up critical records including electronic medical records, accounting systems, and other electronic data regularly in a different location, preferably offsite.
- If using on-line Electronic Medical Record services, contact providers and find out how to access records during a communication outage or other failure.
- Ensure that security requirements mandated by HIPAA are followed

Coordinate with External Organizations and Agencies

- Collaborate with insurers and health plans to understand their capabilities and plans, e.g. emergency coding.
- Collaborate with public health agencies and/or emergency responders to participate in community activities.
- Collaborate with the Colorado Psychiatric Society and the Colorado Medical Society about services you might contribute to the community, i.e. coverage for ill colleagues, staffing hotlines, hospital back-up.

Monitor Public Health Advisories

- Sign up for Alerts:
  National Flu Activity: www.cdc.gov/flu/weekly/fluactivity.htm
  Avian Influenza: Current Situation:
  www.cdc.gov/flu/avian/outbreaks/current.htm
  Colorado Avian Influenza Update: www.cdphe.state.co.us/dc/influenza/avian/

The Colorado Medical Society recently prepared a comprehensive document, "Guidelines for Medical Office Pandemic Readiness," which can be viewed and downloaded at: http://www.cdphe.state.co.us/epr/Public/medicalpanready.pdf

Pandemic Influenza

Facts:

from the Colorado Department of Public Health and Environment

Fight fear with Facts

Avian Influenza (bird flu): questions and answers

What is avian influenza?

- Avian influenza, or "bird flu," is an illness caused by influenza viruses that naturally occur in birds, especially wild waterfowl like ducks and geese.

Are there different kinds of avian flu?

- There are two main kinds of avian flu viruses, "high pathogenic" and "low pathogenic."
- High pathogenic avian influenza (HPAI) means that the virus causes severe disease and death in poultry such as chickens and turkeys. Waterfowl like ducks and geese are better able to resist the virus. The same high pathogenic viruses that cause no signs of disease in waterfowl can kill domestic poultry like chickens and turkeys quickly.
- Low pathogenic avian influenza (LPAI) causes milder disease and many fewer deaths in poultry. It is common among wild and domestic birds in many countries.
- The type of avian flu that has been spreading since October 2003 is high pathogenic H5N1. Wild birds carrying the HPAI H5N1 strain can spread the virus to domestic birds.

Can people catch avian flu viruses?

- People usually do not become infected with avian flu viruses, but a small number of high pathogenic avian flu infections from H5N1 have been reported. Many of those infected have died.
- Most people who were infected with high pathogenic avian flu had very close contact with sick birds.

How does avian flu spread?

- Infected birds spread particles of the virus from mouth and nose fluids, and from their droppings. Birds that do not show signs of illness from the disease can spread the virus.
- People can be infected with the virus from contact with infected birds or their droppings. This includes contact during plucking, handling or playing with infected birds, or contact with surfaces contaminated with droppings from infected birds.

What are the signs of avian flu in people?

- Many of the human cases reported had typical flu symptoms, including fever, cough, sore throat, headache and muscle aches. Some people developed severe pneumonia and some died from respiratory failure.

Food safety tips for poultry and eggs

- Avian flu is not spread through properly cooked food.
- Poultry and eggs in the U.S. are safe to eat. There are strict regulations that prevent countries that have avian flu outbreaks from sending poultry products to the United States.
- Those who prepare poultry for people to eat should follow the normal rules for handling raw meat:
  - ✓ Keep raw meat, poultry, fish and their juices away from other foods.
  - ✓ After cutting raw meats, wash your hands, cutting boards or dishes, knife and counter tops with hot, soapy water.
  - ✓ Sanitize cutting boards and counter tops with a solution of 1 tablespoon chlorine bleach in 1 gallon of water.
  - ✓ Cook poultry in an oven temperature of at least 325 °F.
  - ✓ Use a meat thermometer to check the temperature of cooked foods in the deepest part of the dish. Cook whole birds and parts to 165°F.
  - ✓ Do not eat raw eggs.
  - ✓ Cook eggs until the yolks and whites are firm.
  - ✓ Only use raw eggs in foods that are cooked to 160°F after adding eggs. Use pasteurized egg products in recipes that are not cooked, such as egg nog.
  - ✓ Do not thaw meat at room temperature. Thaw meat in the refrigerator.
  - ✓ If you are sick, do not prepare or serve food for other people.

Is there a test for avian flu?

- There are tests for low pathogenic and high pathogenic avian flu in birds. Colorado has tested birds for avian flu since 2004, including private and commercial poultry flocks.
- No birds in Colorado have tested positive for either low pathogenic or high pathogenic H5N1 avian flu.
- There is no routine testing for avian flu in humans in Colorado at this time, since there is no avian flu risk.
- If a person becomes ill after traveling to an area with known avian flu, the doctor will try to find out whether he or she has been exposed to sick birds. If the person may have been exposed to infected birds, the doctor can request testing at the state public health laboratory.

Avian Influenza (bird flu): questions and answers

Is there a flu shot to prevent avian flu?

- Not yet. Scientists in several countries are working together to make an effective vaccine to prevent avian flu.
- Vaccines are made to prevent certain viruses. The flu shot you got in the fall is a formula that prevents the specific types of human flu that are circulating this year -- not avian flu.

What is the treatment for avian flu in people?

- Just like most other infections caused by viruses, there is no medicine to cure avian flu.
- If the illness is caught early, prescription antiviral medicines that are used for the common flu may help shorten the length and decrease the severity of the illness.

Is it safe to travel to Asia?

- The U.S. Centers for Disease Control and Prevention has not warned Americans to avoid travel to Asia or any other areas where there have been outbreaks of avian flu.
- Travel recommendations are updated as needed at **www.cdc.gov/travel**.
- Travelers to countries with high pathogenic avian flu should avoid live or dead birds; live bird markets; poultry farms; and bird cages and poultry cooking equipment.

Why is public health watching the avian flu so closely?

- Changes in flu viruses are common. So far, the H5N1 virus has not changed enough to spread easily from person to person.
- Whenever an avian flu virus infects people, there is a chance that the virus could mutate, or change, to a new virus that spread easily from person to person.
- Our immune systems would not recognize a new virus, and could have problems fighting it off. That means the new virus could cause serious illness and death.
- When a new virus is not controlled easily, it could be able to spread rapidly around the world and cause a pandemic.

What is the difference between an epidemic and a pandemic?

- An epidemic is an outbreak of disease that occurs in one or several limited areas, like a city, state or country.
- A disease that spreads beyond the borders of several countries around the world is called a pandemic.

Can pet birds get avian flu?

- Yes. But there is no high pathogenic H5N1 in the U.S., so there is no risk to pet birds at this time.

Is it safe to hang wild bird feeders in the yard?

- Yes. There is no high pathogenic H5N1 in the U.S.

Is it safe to hunt and eat game birds?

- Yes. There is no high pathogenic avian flu in the U.S. As always, hunters should use disposable, waterproof gloves when handling game birds, and should wash their hands afterwards.

Is working in a restaurant with poultry products safe?

- Yes. There is no high pathogenic H5N1 in this country, so there is no risk of being infected with avian flu from working or eating in a restaurant.

What should I do if I find a dead wild bird?

- If you find multiple dead waterfowl in the wild, such as ducks or geese, contact the Colorado Division of Wildlife at 303-297-1192.
- If you are concerned about possible exposure of domestic birds to sick or dead wild birds, contact your local veterinarian.
- Avoid contact with dead birds. If you must handle them, use waterproof gloves and wash your hands well afterwards.

Additional sources of information

Colorado HELP hotline
www.cohelp.us
1-877-462-2911 (toll-free)
M-F 7 a.m. – 11 p.m.; S-S 9:30 a.m.–8 p.m.

Centers for Disease Control and Prevention (CDC) and U.S. Department of Health and Human Services
www.cdc.gov/flu/avian/index.htm and www.pandemicflu.gov
1-800-311-3435 (toll-free)

Colorado Department of Public Health and Environment
www.cdphe.state.co.us/dc/influenza
303-692-2700
1-800-866-7689 (toll-free)

World Health Organization (WHO)
www.who.int/csr/disease/avian_influenza

Colorado Division of Wildlife
www.wildlife.state.co.us
303-297-1192

Colorado Department of Public Health and Environment

02/07

Colorado

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PANDEMIC FLU
GET READY

Frequently Asked Questions: Colorado's Preparations for Pandemic Influenza

What is Colorado's plan in the event of a pandemic influenza?

Colorado's pandemic influenza plan is available on the Web site of the Colorado Department of Public Health and Environment at **www.cdphe.state.co.us/bt/HealthProviders/PandemicPlanDraft.pdf**. The plan helps support agencies throughout the state in the event of a pandemic influenza. The state provides funding from federal grants to help local public health agencies prepare their communities. It often is said that all disasters and all emergencies are local. The state is prepared to activate and mobilize its resources to assist throughout Colorado as needed. In addition, in the event of a statewide pandemic, the state also can call on federal resources for assistance.

Who is in charge in Colorado in the event of a pandemic?

The governor has the ultimate authority. A 2000 state statute called for creation of a 22-member advisory committee, the Governor's Expert Emergency Epidemic Response Committee, to advise the governor in the event of an public health emergency. The committee's priorities include:

- Protecting human life (the committee's highest priority)
- Controlling the further spread of disease
- Meeting the immediate emergency needs of people (specifically medical services, shelter, food, water and sanitation)
- Restoring and continuing operations of facilities and services essential to the health, safety and welfare of people and the environment
- Preserving evidence for law enforcement investigations and prosecutions

This committee of health and medical experts would convene rapidly in the event of a disaster emergency, assess all available information and make recommendations to the governor.

Other than allocating state resources, what can the Colorado governor do in the event of a pandemic?

The governor has broad powers to responde to the needs of an emergency (see C.R.S. § 24-32-2104(7)). In any disaster, the governor may suspend "the orders, rules, or regulations of any state agency, if strict compliance with provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency."

Executive orders have been drafted for the governor to use in a public health emergency. The orders are not in effect now; they would have to be signed by the governor at the time of the emergency.

Colorado Department of Public Health and Environment

Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Denver, CO 80246-1530
www.cdphe.state.co.us 303.692.2700 800.886.7689

Colorado Governor's draft executive orders

- **Executive Order 0.0** - Declares a state of disaster emergency
- **Executive Order 1.0** - Orders hospitals to transfer or stop admitting patients
- **Executive Order 2.0** - Concerns the procurement and taking of certain medicines and vaccines
- **Executive Order 3.0** - Suspends certain statutes and regulations to allow rapid distribution of medicines or vaccines
- **Executive Order 4.0** - Suspends physician and nurse licensing statutes to allow out-of-state health care workers to respond to emergencies
- **Executive Order 5.0** - Suspends certain licensing statutes to enable supervised, licensed physician assistants and emergency medical technicians to assist with the emergency
- **Executive Order 6.0** - Authorizes the state to isolate or quarantine individuals
- **Executive Order 7.0** - Orders facilities to transfer or receive patients with mental illness to help respond to the emergency
- **Executive Order 8.0** - Suspends certain statutes pertaining to burial practices to allow for rapid burial of epidemic victims
- **Executive Order 9.0** - Authorizes the governor to cancel public events and close certain public buildings and schools

What is a pandemic?

You may have heard the term "epidemic," referring to an outbreak of a contagious disease that spreads rapidly and widely. A flu "pandemic" happens when a new flu virus appears around the world. Because it is new, there is little natural immunity to the virus, and the disease can spread easily from person to person.

What is Colorado's approach to anti-viral medications such as Tamiflu?

There are more than 600,000 10-day treatments of Tamiflu, or oseltamivir, reserved for Colorado through the Strategic National Stockpile. While the Colorado Department of Public Health and Environment is supporting local public health agencies that want to purchase additional antivirals at the federal contract price, the department has decided not to purchase additional courses of Tamiflu through the federal government for the following reasons:

- Any Tamiflu purchased through the federal contract must be used only to treat influenza; it cannot be used to protect the uninfected from getting influenza.
- There is little evidence regarding the effectiveness of Tamiflu in treating a novel pandemic influenza such as H5N1.
- Any Tamiflu purchased through the federal contract that is not used by the drug's expiration date must be discarded and cannot be rotated.

In light of the above, Colorado will be purchasing a smaller quantity of Tamiflu on its own, so that there will be flexibility in having some pre-positioned antiviral drug available. This pre-positioned supply can be maintained without expiring and can be used to support local decisions about the most effective use of the drug in response to a pandemic or other influenza-related event.

How will antivirals such as Tamiflu be used in Colorado?

First, as directed by the federal government, the 600,000 10-day treatments available to the state from the Strategic National Stockpile will be used to treat the sick in the event of a pandemic. These courses cannot be used to protect others from a possibility or likelihood of contracting the virus.

Second, the Tamiflu purchased directly by the state can be used to protect those individuals most at risk of contracting the virus. In the event of a pandemic, Colorado will use its Tamiflu to help protect individuals, such as health care workers, emergency response personnel and others, who are most directly responsible for working with the already sick and who, therefore, are most at risk of contracting and spreading the virus.

What should individuals do to prepare for an emergency like pandemic flu?

Be healthy. Be ready. Be informed. These simple statements represent three things all Coloradans should do to prepare for any emergency.

- **Be healthy** - practice basic self-care: get plenty of rest, exercise and eat a balanced diet. Cover your cough. Wash your hands. Stay home if you are sick. Avoid large crowds in the event of a pandemic.
- **Be ready -** prepare a home emergency kit with enough food, water, medicine and first aid supplies to last at least a week.
- **Be informed -** tune to radio and TV broadcasts and check the Web sites of the Colorado Department of Public Health and Environment at **www.cdphe.state.co.us**, READYColorado at **www.readycolorado.com** and the federal government's site at **www.pandemicflu.gov** for the latest developments.

How has Colorado used the federal funds received for emergency preparedness?

Colorado has received approximately $16 million to fund public health emergency preparedness activities this year. The majority of that money has been distributed to local health agencies to lead and support planning at the local level. The remaining funds are being used by the state to provide the state level preparedness needed for any response. The Colorado Department of Public Health and Environment also received one-time federal funding of nearly $5.2 million to further develop pandemic plans and preparations. Of these pandemic flu funds, $3.3 million has been awarded directly to local public health agencies.

How many patients could be accommodated by Colorado's health care system? What is Colorado's "surge capacity" in the event of a pandemic?

Colorado has more than 10,000 hospital beds. Of those, only about 10 percent are available at any one time. In addition to the beds already in place through the state's many health care providers, Colorado has an additional 6,500 emergency medical beds in strategic locations around the state. The issue in Colorado is not available beds; rather, it will be medical personnel to staff the beds.

What is Colorado doing to help increase the number of medical staff members available?

The state has contracted with the Disaster Medical Assistance Team of Colorado to manage a statewide Colorado Public Health and Medical Volunteer System database. Marketing and public information efforts are underway to help attract additional volunteers to register in the database. The primary purpose is to have a single database of qualified, trained medical volunteers who can be called upon in the event of medical necessity. The system also will allow non-medical volunteers to sign up for logistical or administrative support assistance.

Who decides when to close schools?

Ultimately, the Colorado's chief medical officer at the Department of Public Health and Environment is charged with offering recommendations to the governor regarding closing schools statewide. However, local public health agencies and local mayors and county commissioners have the authority to do the same in their jurisdictions.

Will Colorado have a hotline number for people to call for information?

Yes, the CoHELP line at 1-877-462-2911 has public health information every day. During a public health emergency, the Colorado Department of Public Health and Environment will work with CoHELP staff to provide updated information about any large-scale, health-related emergency such as pandemic flu.

Learn more about pandemic flu

www.cdphe.state.co.us/epr

www.pandemicflu.gov

CSTS

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Understanding the Effects of Trauma and Traumatic Events to Help Prevent, Mitigate and Foster Recovery for Individuals, Organizations and Communities

A Program of Uniformed Services University, Our Nation's Federal Medical School, Bethesda, Maryland • www. usuhs.mil/csts/

Mental Health and Behavioral Guidelines for Response to a Pandemic Flu Outbreak

Background on the Mental Health Impact of Natural Disasters, including Epidemics

It is only relatively recently that attention has been focused on the mental health impact of disasters. Previously, concerns related to immediate physical health and community infrastructure risks in the aftermath of disasters such as storms, earthquakes, or floods had overwhelmed considerations of the short and long-term mental health consequences of disasters, or the extent to which mental health played a role in the impact of a disaster (1).

In the arena of the health impact of natural disasters, the majority of data available relate to weather or geologic events (1). For example, there is some data on the long-term mental health impacts of such disasters as the Gujurat and Turkey earthquakes (2); the 2004 Asian tsunami (3); a number of large impact disasters in South America and Asia; and soon, there will be published data on Hurricanes Katrina and Rita (4-5). We know that severe stress reactions are common; that front-line health and human services workers are at high risk for PTSD; and that in general, even in relatively developed countries, there is very little existing infrastructure in place that can adequately address the mental health needs of victims (5).

In contrast, there is almost no data on the mental health impacts of outbreaks of disease. This is largely because there have been few pandemic health threats in the last century. Since the highly lethal pandemic outbreak of influenza in 1918, there have been few global threats from infectious agents. The recent outbreaks of SARS in Asia and Canada, which caused global concern but fortunately did not result in large-scale outbreaks nor a global pandemic, gives us the most recent data on the mental health concerns that are relevant in a pandemic outbreak situation.

There is almost no data on the mental health impacts of outbreaks of disease.

The data from the SARS outbreaks indicated that upwards of 40% of the community population experienced increased stress in family and work settings during the outbreak; 16% showed signs of traumatic stress levels; and high percentages of the population felt helpless, apprehensive, and horrified by the outbreak (6). In another community survey 30% of those surveyed thought they would contract SARS, while only a quarter believed they would survive if they contracted the disease, despite an actual survival rate of 80% or more, indicating a fairly high rate of perceived risk that might have preceded widespread panic had the outbreak been either more widespread or more lethal (7). Community residents were diligent about adopting appropriate person-to-person transmission precautions; however, precautions were adopted differentially based upon anxiety levels and perceived risk of contracting the disease, indicating the importance of stress and anxiety levels, as well as baseline mental health, on a public response to taking necessary precautions (7).

We also know from the SARS outbreak that front-line health workers may be particularly vulnerable to negative mental health sequelae of treating outbreak victims. Studies of the nurses who treated SARS patients indicated high levels of stress and about 11% rates of traumatic stress reactions, including depression, anxiety, hostility and somatization symptoms (8).

While there have been relatively few large outbreaks to inform an appropriate response to a potential pandemic flu, the existing data on infectious disease outbreaks, data from natural disasters, and public mental health principles can

be brought to bear on the development of such a response. Public mental health measures must address numerous areas of potential distress, health risk behaviors, and psychiatric disease. In anticipation of significant disruption and loss, promoting health protective behaviors and health response behaviors will be imperative. Areas of special attention include: (1) the role of risk communication; (2) the role of safety communication through public/private collaboration; (3) psychological, emotional, and behavioral responses to public education, public health surveillance and early detection efforts; (4) psychological responses to community containment strategies (quarantine, movement restrictions, school/work/other community closures); (5) health care service surge and continuity; and (6) responses to mass prophylaxis strategies using vaccines and antiviral medication.

The first step in preventing undesirable psychological, emotional, and behavioral response is an effective public health program of risk assessment and communication, public health prevention, and consequence management. These are necessarily premised on having effective political and community leadership, appropriate pre-event organization, and staffing and funding.

Being alert to the interrelationship between psychological, emotional, and behavioral responses and their effect on other elements of the response plan must also be emphasized. While planning can be based on assumptions that public health efforts to stop an outbreak will be successful, the importance of managing the consequences of failure and the subsequent behavioral response to failure is crucial. This can extend from failure to deliver support and services, to failure of a vaccine to prevent illness, to failure of therapies to work.

Recommended steps in response to a pandemic flu outbreak are divided into four phases: preparedness, early outbreak response, later response and recovery, and mental health intervention planning.

PREPAREDNESS

1. **Education**. Public education must begin immediately, before a pandemic occurs, and be embed into existing disaster public education campaigns, resources, and initiatives (e.g. HLS's www.ready.gov , Red Cross, CDC public education and preparedness http://www.hhs.gov/pandemicflu/plan/, and HHS www.pandemicflu.gov). This should focus on facts, to include what is known, what is not known, and how individuals, communities, and organizations can prepare for a potential outbreak.

   As we know from the SARS outbreak, public education impacts threat awareness, threat assessment, and preparedness behaviors in every phase of an event. Public education in advance of an outbreak should be inclusive of the varying degree of threats, to include those of reasonably low threat potential to those with the highest potential.

2. **Leadership preparation**. Leadership preparation includes ensuring that public officials understand which members of the population will be most vulnerable and who will need the highest level of health services, including mental health services. This includes identification of those groups who may be at greatest risk for problems related to contagion, such as those with psychiatric illness, children, elderly, homeless, and those with losses. Ongoing negative life events also increase one's risk for mental health problems, and may place certain people at higher risk for negative mental health impact of an outbreak. In addition, health risk behaviors such as smoking, drug use, and alcohol use may increase in times of stress, putting some people at increased risk.

3. **Sustaining Preparedness Measures**. Maintenance of motivation, capital assets, equipment, and funding to continue preparedness efforts over the long term must be considered, not just to focus on immediate needs. It is also important to remember that if responses are under-supported and fail, the community anger and lowered morale may complicate the ability of a community to respond to an outbreak, as well as the recovery process once an outbreak has ended.

4. **Leadership Functions**. Leadership functions require identification of community leaders, spokespersons, and natural emergent leaders who can affect community and individual behaviors and who can endorse and model protective health behaviors. Special attention to the workplace is imperative as corporations have public education resources to potentially reach large populations. The media and celebrity groups constitute important leaders in most modern societies and have a critical role in providing leadership in communication.

EARLY PANDEMIC RESPONSE

1. **Communication**. Wide dissemination of uncomplicated, empathically informed information on normal stress reactions can serve to normalize reactions and emphasize hope, resilience, and natural recovery.

   Recommendations to prevent exposure, infection, or halt disease transmission will be met with skepticism, hope, and fear. These responses will vary based on the individuals' and the local community's past experiences with government agencies. In addition, compliance with recommendations for vaccination or medication treatment or prophylaxis will vary greatly and will not be complete. The media can either amplify skepticism or promote a collaborative approach. Interactions with the media will be both challenging and critical.

The public must clearly and repeatedly be informed about the rationale and mechanism for distribution of limited supplies (e.g., Tamiflu). Leadership must adhere to policies regarding such distribution, as abuses of policy will undercut public safety and public adherence to other government risk reduction recommendations.

2. **Tipping points**. Certain events, known as 'tipping points', will occur that can dramatically increase or decrease fear and helpful or health risk behaviors. Deaths of important or particularly vulnerable individuals (e.g., children), new unexpected and unknown risk factors, and shortages of treatments are typical tipping points. The behavioral importance of community rituals (e.g. speeches, memorial services, funerals, collection campaigns, television specials) are important tools for managing the community wide distress and loss.
3. **Surges in demands for health care**. Those who believe they have exposed (but have not actually been) may outnumber those exposed and may quickly overwhelm a community's medical response capacity. Planning for the psychological and behavioral responses of the health demand surge, the community responses to shortages, and the early behavioral interventions after identification of the pandemic and prior to availability of vaccines are important public health preparedness activities.

LATER RESPONSE AND RECOVERY

1. **Community structure**. Maintenance of community is important. Community social supports — formal and informal — will remain important. In-person social supports may be hampered by the need to limit movement or contact due to concerns of contagion. Virtual contact – via web, telephone, television, and radio – will be particularly important at these times. At other times local gathering places – religious, schools, post offices, and groceries — could be points of access for education, training and distribution. In as much as allowed, instilling a sense of normalcy could be effective in fostering resiliency. In addition, observing rituals and engaging in regular activities (such as school and work) might manage community and organizational distress and untoward behaviors. Providing tasks for community action can supplement needed work resources, decrease helplessness and instill optimism. Maintenance and organization in order to keep families and members of a community together is important (especially in event of relocation).
2. **Stigma and discrimination**. Under conditions of continuing threat, the management of ongoing racial and social conflicts in the immediate response period and during recovery takes on added significance. Stigma and discrimination may marginalize and isolate certain groups, thereby impeding recovery.
3. **Management of fatalities**. Mass fatality and management of bodies, as well as community responses to this, must be planned for. Containment measures related to bodies may also be in conflict with religious, rituals of burial, and the usual process of grieving. Local officials should be aware of the potential negative impact of disrupting normal funeral rituals and processes of grieving in order to take safety precautions. Public health announcements should include (if known) how long the virus remains in the corpse and what should be done with the bodies. In a pandemic, funeral resources will be overwhelmed and mortuaries may not want to handle contaminated bodies. Careful identification of bodies must be insured and appropriate, and accurate records maintained.

MENTAL HEALTH INTERVENTION PLANNING

1. **Efforts to increase health protective behaviors and response behaviors**. Individuals under stress will need reminders to take care of their own health and limit potentially harmful behaviors. This will include taking medication, giving medications to elderly and children, and when to go for vaccination.
2. **Good risk communication following risk communication principles**. The media can either amplify skepticism or promote a collaborative approach. Interactions with the media will be both critical and challenging.
3. **Good safety communication**. Promoting clear, simple, and easy-to-do measures can be effective in helping individuals protect themselves and their families.
4. **Public education**. Educating the public not only informs and prepares, it enlists them as partners in the process and plan. Education and communications will need to address fears of contagion, danger to family and pets and mistrust of authority and government. The tendency to expect or act as if these are not present can delay community wide health protective behaviors.
5. **Facilitating community directed efforts**. By organizing communal needs and directing action toward tangible goals, this will help foster the inherent community resiliency toward recovery.
6. **Utilizing evidence-informed principles of psychological first aid**. These basic principles include:

   —Establish safety; identify safe areas and behaviors

   —Maximize individuals' ability to care for self and family and provide measures that allow individuals and families to be successful in their efforts

— Teach calming skills and maintenance of natural body rhythms (e.g., nutrition, sleep, rest, exercise)

—Maximize and facilitate connectedness to family and other social supports to the extent possible (this may require electronic rather than physical presence)

—Foster hope and optimism while not denying risk.

7. **Care for first responders to maintain their function and workplace presence**. This will require assistance to ensure the safety and care of their families. First responders will be comprised of a diverse population, to include medically trained personnel to bystanders with no experience.
8. **Mental Health Surveillance**. Ongoing population level estimates of mental health problems in order to direct services and funding. Surveillance should address PTSD, depression and altered substance use as well as psychosocial needs (eg housing, transportation, schools, employment) and loss of critical infrastructure necessary to sustaining community function.

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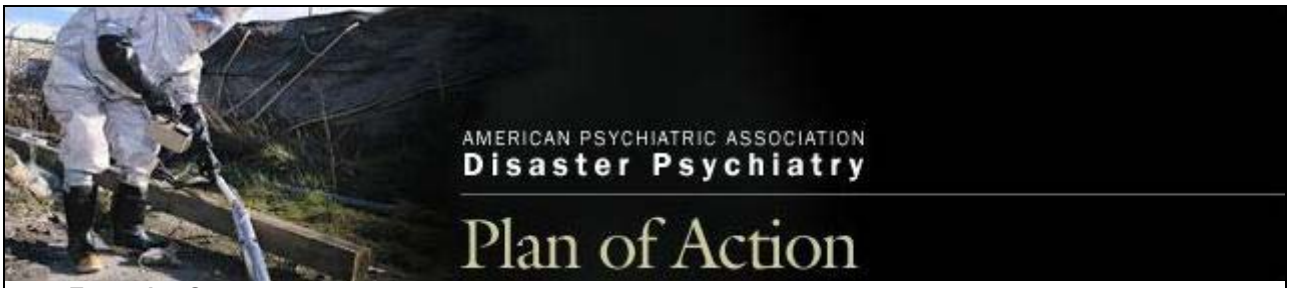
Disaster Psychiatry



Executive Summary

Psychiatrists bring a wide range of skills and expertise useful for preparing for and responding to disasters. In the aftermath of a disaster, the medical skills of the psychiatrist are very valuable.

- Basic first aid and CPR can prove lifesaving.
- A calm, professional approach can help prevent panic.
- A psychiatrist's leadership to coordinate an organized response and assistance at triage stations promotes accurate prioritization of medical/surgical dispositions and effective allocation and matching of resources to need.
- The ability to distinguish between common reactions of hyperarousal from pathological ones can ensure appropriate management of individuals.

Medical training prepares psychiatrists for recognizing disease and developing differential diagnoses. This fund of knowledge is helpful in:

- Identifying the etiology(ies) of altered mental status, especially in the aftermath of trauma where medical illness or injury can be inappropriately diagnosed as psychiatric and vice versa.
- Responding to toxic chemical exposures, whether delivered from terrorists' weapons or through industrial accidents, knowledge of pharmacology and experience with anticholinergic agents.
- Facilitating communication across a wide range of professional boundaries: interacting with community officials, disaster response agencies, police, fire and rescue, school systems, hospital staff, and medical personnel to name but a few.

The psychiatrist's familiarity with an epidemiological approach to understanding disease in a group context is invaluable in the context of disasters. This model is a useful tool in identifying:

- High risk groups for psychological distress based on exposure to trauma (e.g., body retrieval workers).
- Vulnerable groups such as the elderly and children.
- "Vectors" of disease such as communication of fear via rumor or media.

The psychiatrist's knowledge of developmental models for human behavior matches interventions to individuals incorporating knowledge of their vulnerabilities and resilience throughout the life cycle. Similarly, knowledge of the natural history and epidemiology of disease is helpful in correctly identifying all factors contributing to an individual's physical and/or emotional distress.

In addition to general medical assessment and interventions, the psychiatrist brings a number of specialized medical skills. The psychiatrist is knowledgeable of the assessment and differential diagnosis of disorders of cognition, affect, and behavior. He/she is especially helpful in situations in which psychiatric disorders are co-morbid with medical conditions. Facility with medical, psychological and socio/cultural interventions allows the psychiatrist to choose from a broad

armamentarium of treatments. Psychiatrists can:

- Prescribe medications for psychiatric disorders.
- Provide symptomatic relief as appropriate for sleep problems and hyperarousal.
- Recognize and treat substance intoxication and withdrawal syndromes.
- Screen carefully for the presence of organic brain disorders and suicidal/homicidal ideation.

Psychiatrists have a number of educational experiences which provide them with expertise in disaster consultation.

- Child training in the general residency or in fellowship provides a background in consulting to non-medical organizations and leaders such as school principals, teachers and guidance counselors.
- Consultation/liaison training provides a firm foundation in working with the medically ill and their primary treatment team, chaplains, families and others in a hospital setting. It also exposes psychiatrists to experience with acute emergencies and a broad range of organic brain disorders.

Psychiatrists are well-suited to provide consultation to disaster organizations such as the Red Cross, FEMA and emergency systems as well as community leaders. The physician's medically based connections with these institutions are very helpful in gaining entree. The medical identity also facilitates participation across international boundaries.

Psychiatrists enjoy special psychotherapeutic skills useful in disasters.

- Experience in working with injured patients and the management of associated hyperarousal.
- Ability to deal with issues of death and dying are prominent in disaster work.
- Facility in sleep management and the judicious use of medications is an important contribution.
- Increasingly, disasters are an all-too-common feature of modern life. Education in the unique features of Disaster Psychiatry, as well as adaptation of traditional interventions, ensures that psychiatrists are prepared to make significant contributions to the prevention and mitigation of psychiatric morbidity resulting from disasters.

DISASTER PSYCHIATRY: PRINCIPLES AND PRACTICE

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INTRODUCTION

A wide host of traumatic events can surprise and stun communities. Natural disasters that strike without much notice, such as tornadoes or earthquakes, represent such traumas. In addition, man-made traumas such as transportation disasters, factory explosions and school shootings have become part of life. Many believe that the probability is high that terrorists will use biological or chemical agents at some point here in the United States.

Psychiatrists have many skills that can assist individuals and communities recover from disasters. The term, "disaster psychiatry", has been coined to describe an epidemiological approach to understanding and treating the effects of mass casualty situations.

The goals of psychiatric intervention are to: minimize exposure to traumatic stressors; educate about normal responses to trauma and disasters; provide consultations to other health care professionals and community leaders; advise people on when to seek professional treatment; assist in resolution of acute symptomatology; reduce secondary morbidity; and identify those who are at higher risk for the development of psychiatric disorders and to treat those who develop them. This article will review basic principles of disaster psychiatry and suggest ways in which psychiatrists can intervene following community catastrophes.

DEFINITION OF DISASTER

The term "disaster" derives from the Latin dis, "against", and astrum "stars" and is translated as "the stars are evil" (1). While there are many definitions of disaster, a common feature is that the event overwhelms local resources and threatens the function and safety of the community.

Disasters are frequently divided into the categories of "natural" / "acts of God" (hurricanes, floods, earthquakes) or "manmade" / "acts of man". However, this distinction is somewhat arbitrary - often the impact of natural disasters is very heavily shaped by humans. Common examples of this include building homes in unsafe areas such as flood plains or upon steep hill-sides where mudslides have occurred. Poor construction and high-density buildings can increase the number of people injured and killed exponentially following an earthquake. Man's inter-actions with his environment have also been postulated to contribute to natural disasters through poor land management policies and through practices that contribute to global warming (2).

PRINCIPLES OF DISASTER PSYCHIATRY

Paradigm shifts

Disaster Psychiatry entails a number of paradigm shifts for psychiatrists involved in clinical practice. The first major paradigm shift involves a focus on health rather than disease. Most clinicians' practice entails treating people who are identified as ill (patients). In disaster situations, the vast majority of people will experience transient psychological and behavioral symptoms that

represent normal responses to an abnormal event. In disaster settings, then, care is given to avoid the use of diagnostic labels prematurely. In the acute phase, the psychiatrist primarily educates and facilitates the natural recovery process rather than treating pathology. The final major departure from one's usual practice in the acute phase of a disaster is that one leaves the office.

In disaster psychiatry, outreach is key. The overarching goal is to facilitate normal recovery processes and prevent or diminish psychiatric morbidity. The psychiatrist practices primary prevention, often through consultation to primary care providers and disaster agencies, reducing the number of individuals who will develop psychiatric morbidity.

The Preventive Medicine model of an infectious disease outbreak investigation and intervention provides a familiar organizing structure for conceptualizing behavioral and psychological responses to a disaster (3,4). In this model, one identifies the pathogen, its source, and those exposed to it. To adapt this for psychiatric responses to disasters, one thinks of the psychological, physiological, and social stressors associated with the disaster as the pathogens. One then identifies groups of people that are most highly exposed to these stressors. Detailed reconstruction of the event in space and time and examination of the subsequent cascade of actions taking place in its aftermath ensures that traumatized groups are not overlooked. This is an iterative process. In the course of interactions with those involved in the disaster, one learns of additional traumatic stressors and additional groups who were exposed to them.

Familiarization with Responses to Trauma and Disasters

Adults

A host of psychological and behavioral responses are seen in adults following trauma and disaster. These include anger, disbelief, sadness, anxiety, fear, irritability, arousal, numbing, sleep disturbance, and increases in alcohol, caffeine, and tobacco use. For most individuals, acute post-traumatic psychiatric symptoms resolve over time. For others, however, the psychological and behavioral changes persist and may meet the criteria for psychiatric diagnoses. For some, disasters may have beneficial effects. More attention is being given to the possibility of severe traumas serving as organizing events and providing individuals with a sense of purpose as well as other positive growth experiences (5-9).

In the acute aftermath of a disaster or trauma, the psychiatrist must be alert to organic mental disorders secondary to head injury, toxic exposure, illness, and dehydration. When communities are hit by large-scale disasters, it is always important for the psychiatrist and other physicians to consider that behavioral symptoms may also be due to the simple loss of the patient's usual medications.

Persistence of symptoms over time, accompanied by a high level of severity and impaired function, can lead to a wide variety of psychiatric diagnoses. Post-traumatic Stress Disorder (PTSD) is, perhaps, the best-known psychiatric diagnosis that is associated with trauma response. It is characterized by exposure to a serious event in which threat to life or physical injury (to self or others) is accompanied by intense feelings such as terror, helplessness, or fear (10). In addition to the threat criterion, the individual must have experienced distressing symptoms of intrusive thoughts of the event, avoidance of reminders, and physiological arousal (such as exaggerated startle). Symptoms must have been present for more than one month. Delayed onset PTSD has been described but "true" delayed PTSD (rather than subthreshhold that later meets criteria) appears to be much more uncommon than previously reported. Clinically, in cases of late-onset PTSD or reactivation of previously resolved PTSD, it is important to explore current life events

(11). At symbolically charged times, such as receiving a diagnosis of cancer or retiring from a long military career, emergence of PTSD symptoms may be thought of as the mind's way of expressing metaphorically in the present significant traumatic events in the past that evoked intense feelings. In such cases, exploration of the patient's current situation is generally more productive than focusing on the past.

Acute Stress Disorder (ASD) was introduced into our diagnostic nomenclature in DSM-IV (10). ASD is a constellation of symptoms very similar to PTSD but persists for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the trauma. The only difference in symptom requirements between the two diagnoses is that dissociative symptoms must be present in order to diagnose an individual as having ASD. The dissociative symptoms can occur during the traumatic event itself or after it.

Other psychiatric diagnoses are also seen in the aftermath of significant trauma. These include adjustment disorders, substance use disorders (including increased tobacco use), major depression, complicated bereavement, and generalized anxiety disorders. Importantly, injured survivors may have psychological factors affecting their physical condition (12-16). Psychiatrists and physicians should also be alert to the occurrence of family violence in disaster situations that bring significant stressors to families (17).

Children and Adolescents

Child and adolescent development can be significantly altered as a consequence of traumatic exposure. The onset of a wide range of symptoms and behaviors has been noted in children exposed to disasters and other traumas (18,19). As in adults, the greater the traumatic stressor, the more likely children are to develop persistent psychiatric difficulties. Posttraumatic stress disorder, depression, and separation anxiety disorder have been noted (20). The reactions of significant adults, e.g., parents and teachers, affect children's responses to trauma (21).

Children may develop avoidant behavior to specific reminders of the tragedy (e.g., avoiding areas of the playground where someone has been killed). Other reactions commonly seen include fear of recurrence, grief reactions, guilt, and worries about the safety of others. Children's reactions to trauma are affected by the developmental stage they are in. Preschool children through second graders commonly experience, fear, helplessness, confusion, sleep disturbance, separation anxiety, and regressive symptoms. They may have difficulty identifying and talking about what is troubling them. Third through sixth graders may have sleep disturbances, difficulty concentrating, somatic complaints, and concerns about their safety and the safety of others (22). They can be preoccupied with their actions during the shooting and reenact and retell the event through traumatic play (22). Adolescents' responses more closely approximate adults. They may experience profound changes in their attitudes towards life and their future. Of special concern are increased risk-taking behaviors sometimes seen in adolescents following trauma (22).

It is important to prevent secondary complications stemming from disaster exposure. For example, chronic disturbed sleep may interfere with school performance. The child then can experience further blows such as school failure and its attendant damage to self-esteem.

Communities

With the advent of instantaneous communication and media coverage, word of the disaster is disseminated quickly. The community is soon flooded with outsiders: people offering assistance,

curiosity seekers, the media, etc. This sudden influx of strangers affects the community in many ways. Probably the most visible change is the presence of large numbers of media representatives.

Aggressive news reporters can be experienced as intrusive and insensitive. Hotel rooms contain no vacancies, restaurants are crowded with unfamiliar faces, and the normal routine of the community is shattered. At a time when, traditionally, communities have turned inward to grieve and assist affected families, the normal social supports are strained and disrupted by outsiders.

Inevitably, after any major trauma, there are rumors circulated within the community about the circumstances leading up to the traumatic event and the government response. Sometimes there is a heightened state of fear. For example, a study of a school shooting in Illinois noted that a high level of anxiety continued for a week after the event, even after it was known that the perpetrator had committed suicide (23).

Another common response is outpourings of sympathy for the injured, dead, and their friends and families. Impromptu memorials of flowers, photographs, and memorabilia are frequently erected. Churches and synagogues play an important role in assisting communities' search for meaning from such tragedy and in assisting in the grief process.

Over time, anger emerges in the community. Typically, there is a focus on accountability, a search for someone who was responsible for a lack of preparation or inadequate response. Mayors, police and fire chiefs, and other community leaders are often targets of these strong feelings. Scapegoating can be an especially destructive process when leveled at those who already hold themselves responsible, even if, in reality, there was nothing they could have done to prevent adverse outcomes.

There are many milestones along the way which affect the community. There are the normal rituals associated with burying the dead. Later, energy is poured into creating appropriate memorials. Memorialization carries the potential to cause harm as well as to do good. There can be heated disagreement about what the monument should look like and where it should be placed. Special thought must be given to the placement of memorials. If the monument is situated too prominently so that community members cannot avoid encountering it, the memorial may heighten intrusive recollections and interfere with the resolution of grief reactions. Anniversaries of the disaster (one week, one month, one year) often stimulate renewed grief.

Assessment of the Traumatic Stressors

Just as its virulence and mode of transmission can characterize an infectious agent, disasters can be characterized by generic traumatic elements that are most likely to engender psychiatric morbidity. To understand the nature and degree of patients' traumatic experience, psychological stressful dimensions of the disaster should be assessed (24).

Threat to life has been shown to be associated with perhaps the highest risk of psychiatric morbidity (25,26). Those persons who actually sustain injuries are at greater risk of developing psychiatric sequelae than those not injured. Exposure to the dead and mutilated increases the potential for adverse psychiatric events (27-29). Groups routinely exposed to the dead and injured: first responders (fire, police, and EMT's), hospital workers, and mortuary volunteers, should be remembered in designing assessments and interventions.

Increasingly, traumatic bereavement is recognized as posing special challenges to survivors (30,31). While the death of loved ones is always painful, an unexpected and violent death can be

more difficult to assimilate. Family members may develop intrusive images of the death based on information gleaned from authorities or the media.

Witnessing or learning of violence to a loved one also increases vulnerability to psychiatric disorders. The knowledge that one has been exposed to toxins (e.g., chemicals or radiation) is a potent traumatic stressor (32,33). Often times these events are clouded in uncertainty as to whether or not exposure has taken place and what the long-term health consequences of exposure might be. Living with uncertainty can be exceedingly stressful. This particular stressor dimension is the focus of much concern in the medical community preparing for responses to terrorist attacks using biological, chemical, or nuclear agents (34,35).

Causing death or severe harm to another is a risk factor for the development of psychiatric illness. This dimension is often examined when evaluating military personnel. However, it is often forgotten that there are many cases in civil life where human error costs lives. Transportation accidents, hazardous spills, and construction mishaps are common situations in which blame and guilt arise.

The deliberate infliction of pain and suffering is a particularly potent psychological stressor. The Oklahoma City bombing vividly demonstrated strong psychological and social responses engendered by terrorism and other criminal acts (12,36,37).

Delineation of "At-Risk" Populations

The psychiatrist must begin to prioritize those who should be assessed. A guiding principle should be that the greater the "dose" of traumatic stressors, the more likely an individual is to develop psychiatric morbidity. While each disaster has its unique aspects, certain groups are routinely exposed to the dead and injured and, therefore, are at risk for psychiatric sequelae. Adults and children who were in danger and those who witnessed the events should be identified and given high priority in subsequent interventions. Similarly, police, paramedics and other first responders who assist the injured and evacuate them to medical care, and hospital personnel who care for the injured are all groups that should be offered opportunities to process what happened and provided education on normal responses and when to seek further help. Those who are charged with cleaning up the site of the tragedy are also vulnerable to persistent symptoms. Inevitably, each disaster situation will contain individuals who are "silent" victims and often overlooked. By paying close attention to the response process, the psychiatrist may identify these individuals and ensure that they receive proper care, too. Other vulnerable populations include the elderly and the very young.

THE PRACTICE OF DISASTER PSYCHIATRY

Disaster Preparedness

Involvement in pre-disaster planning in the school system and at the broader community level pays an important dividend critical to successful intervention in the aftermath of tragedy. Psychiatric involvement in developing disaster response plans in the schools and in the community is an ideal way to develop working relationships with local government, police, fire and school officials. As in other types of disasters, entrée to key decision-making officials is critical to influencing immediate responses following a mass casualty situation in a school shooting.

As in other areas of medicine, the best prevention is primary prevention -avoiding the disaster or limiting the numbers affected by it. At the community level, the psychiatrist can work with local government agencies responsible for developing a disaster response plan. Since every hospital must have and exercise a disaster response plan in order to meet JCAHO requirements, psychiatrists should ensure that plans include psychiatric considerations. Another primary prevention effort is providing grand rounds talks on psychiatric aspects of trauma and disaster to other health care providers, especially primary care providers. Psychiatrists can also make major contributions to community recovery by offering to speak in non-medical venues such as PTA meetings and to the media.

Child psychiatrists, in particular, can make important contributions to preparations for responding to traumas and disasters that affect schools. A major intervention is to help school officials "think the unthinkable" by asking about disaster preparedness plans and ensuring that they address potential scenarios. Such plans should include ways to protect oneself, evacuation protocols, a system for tracking people, a plan for notifying and educating parents, a plan for reducing traumatic reminders at the school, and a plan on how to handle the media (21). The psychiatrist can also stress the importance of realistic disaster drills as training is an important protective factor in preventing or mitigating physical and psychiatric sequelae (21).

Emergent Interventions

Emergent interventions take place in the minutes to hours following a cataclysmic event. Activities generally focus on the disaster site, hospitals to which the injured have been evacuated, and areas where survivors and family members congregate. A psychiatrist's basic medical skills in the provision of acute aid to the injured may be the most critical contribution in the first minutes to hours of the disaster.

The psychiatrist may be asked to assist at the scene of a disaster. At this early stage, the psychiatrist should remind those in charge that it is important to limit and minimize exposure to the dead and to other images that are disturbing, thereby, reducing the number of individuals exposed to traumatic stressors. Efforts should be made to gather survivors in areas where evidence of the tragedy is not visible. It is also important to establish order and restore a sense of safety (38).

The psychiatrist can assist school personnel in delivering information to the children about what has happened in a fashion that is appropriate to their stage of development. It is important to tell the truth. Lying, in an attempt to protect people, only serves to destroy trust and will complicate efforts to develop a supportive recovery environment. It is prudent to recommend to parents that they limit children's exposure to television until news coverage of the story has subsided. A growing number of studies have found that exposure to graphic depictions of trauma heightens children's distress (39,40).

Another important intervention during this early stage is providing victims and their families' privacy from onlookers and, more importantly, the media. At this very vulnerable time, it is important to create a holding environment in which emotions can be expressed without worries that they will later be broadcast nationwide. The assessment process begins at this emergent stage. While the sychiatrist is at the disaster site, he should begin to gather data about who has been exposed to the trauma. The identification of "at risk" individuals in an essential element of successful interventions.

Psychiatrists can also provide important interventions at the hospital since the injured are at higher risk for the development of psychiatric disorders in the long term. All injured in a disaster should have a psychiatric assessment and follow-up. Often, merely, "come back in a month and let's be sure all is on track," is the right prescription after an assessment of high-risk individuals with no present symptoms. It may be helpful, for example, to recommend that survivors be placed together in rooms to reduce their isolation and to facilitate natural debriefings. Even among very experienced rescue workers and hospital personnel, exposure to dead and injured children is universally described as being especially difficult to cope with. Psychiatrists need to remember that people assisting injured children will likely experience significant distress. Special attention should be given to ensure that no group is overlooked in the provision of emotional first aid.

Acute Interventions

Acute interventions begin after the emergent activities have resolved. They begin within hours after a disaster and can last for several months. Goals of acute interventions include decreasing exposure to secondary stressors (e.g., struggles to obtain insurance monies, difficulties in obtaining housing), encouraging return to school and work, education of teachers and parents so that they can better support children, and encouraging the media to shift attention to stories focusing on recovery and rebuilding rather than the disaster itself.

Obtaining consultation from experienced disaster psychiatrists is an exceptionally helpful tool. Even for seasoned disaster psychiatrists, it is invaluable to talk with a colleague. While it is ideal to have this exchange take place in person, telephone consultation can be highly effective. Consultation over the course of the disaster can guide intervention efforts and address unique challenges and dilemmas. As a member of the impacted community, the local psychiatrist is also affected by the trauma. The opportunity to reflect on the experience with an empathic psychiatrist who has been in similar situations can be extraordinarily reassuring and helpful. The consultant can also remind the psychiatrist to attend to his own needs for sleep and respite and the importance of making himself available to his own family.

One means of obtaining consultation is to contact the American Psychiatric Association's Committee on Psychiatric Dimensions of Disaster. Many committee members are experienced in responding to a wide variety of disasters. In addition, they can recommend other psychiatrists who have expertise in particular areas that are most relevant to the disaster at hand. The Committee can also facilitate a telephonic consultation. There are a wide range of publications that can be tailored to the traumatic event and mailed out. Overview articles on disaster psychiatry, recommended readings, and links to other websites are available through the Committee's page on the American Psychiatric Association's website (www.psych.org).

In the aftermath of highly publicized mass casualties, there is usually an outpouring of mental health professionals offering pro bono or fee-for-service assistance. This can require active community management to ensure this help does not become an additional stressor or prematurely label feelings of fear as a diagnosis of Anxiety Disorder. Another valuable outcome of consultation can be the accumulation of information about experienced organizations and mental health care providers who are well regarded in the field of trauma management. The local psychiatrist can then advise local leaders on choosing who should have access to schools, hospitals, and first responder organizations in the community.

Often requests are made by mental health experts to research the impact of the trauma and subsequent interventions on longer-term mental health outcomes. The consultant can provide advice on how to assess proposals from researchers. Carefully designed studies that are conducted

in a sensitive fashion can assess the effectiveness of interventions and increase knowledge about how to intervene more effectively in similar situations.

Community Interventions

Consultation to community leaders

The psychiatrist may provide interventions himself or may serve in a consultant role to assist decision-makers about what sort of interventions should be provided and who should conduct them. The psychiatrist can make important contributions to disaster responders and critical incident management teams by reminding leaders to ensure that their subordinates get sufficient rest and respite. A more difficult task is convincing the leaders, themselves, to make sure they take time to eat, sleep, and stay in touch with their families. Overdedication can lead to poor decisions as well as fatigue, irritability, and errors.

When small communities are targets for national and international media, it becomes important to protect leaders from misadventures with the media. Generally, it is helpful to advise the mayor and other visible leaders, such as the principal or superintendent, to use spokespersons to brief the press at regular intervals rather than to attempt to do so themselves. The use of a spokesperson frees up the key leaders to continue to prioritize and respond and diminishes the opportunity of saying something they will later regret due to fatigue and stress.

Public education and outreach

Psychiatrists can use media opportunities such as radio, television, and newspapers to educate the public on normal responses to traumatic events such as school shootings. This is a good time to draw upon the materials that have already been prepared by the American Psychiatric Association and other organizations. The Center for Mental Health Services website lists a large number of available materials. (Go to www.mentalhealth.org, click on the "publications/catalog" icon, select the "KEN's publication list", and, finally, select "Disaster Relief and Crisis Counseling.") Review of these prior to a disaster can identify the "wheat from the chaff."

Reassuring the public that a wide range of feelings and thoughts are common can diminish individuals' fears that they're "going crazy." The sense that one's experience is not abnormal facilitates discussion with others and promotes the use of social supports.

Interventions with "At-Risk" Populations

Generally, early interventions for "at-risk" children and adults focus on providing an opportunity to review what happened and their responses to the event. Their behavioral and psychological responses to the event are "normalized" through education that explains their reactions as "normal responses following abnormal events." Interventions also are used to identify individuals that seem to be especially disturbed and should be offered further assessment on an individual basis. Expectancy is conveyed that over weeks and months disturbing thoughts and feelings will dissipate for most people. The format of interventions differs somewhat between adults and children. Often, early interventions are conducted in a group format. This offers the advantage that participants can gain validation for their symptoms and potentially have cognitive distortions corrected. Group interventions also afford the most efficient use of resources for those most in need.

Adults

A wide range of interventions can be offered. These range from group interventions such as debriefings and educational meetings to individual treatment.

Debriefing is a group intervention although the same principles can be applied in individual meetings. Debriefing is specifically designed to be used with persons who have been exposed to a trauma. While it is in common use, there are mixed conclusions regarding debriefing's efficacy in preventing or diminishing psychiatric disorders (41). However, many practitioners and researchers note that debriefings are generally well received by voluntary participants who find it emotionally rewarding and educational.

Debriefings are usually held within several days of an event. This enables the participants to have a chance to recover physiologically. Debriefings generally proceed from a more cognitive, factual level to a review of feelings, thoughts, and behaviors at the time of the event and since then. Most debriefings include an educational component that prepares individuals for common feelings, behaviors, and thoughts people have following trauma. The educational portion is reinforced by group members talking about their own experiences. The sharing of such thoughts and feelings normalize common experiences and diminish the individual's fears about "going crazy" or "falling apart".

Debriefings can help correct cognitive distortions especially in situations when many people have witnessed or participated in a common experience. Gathering multiple perspectives can be helpful in correcting unrealistic beliefs. For example, time distortions are quite common. The common experience of time moving more slowly than it does in real life can cause individuals to believe that they failed in making a critical intervention when in real time it would have been impossible. Feedback from other group members that can provide a more accurate depiction of the events may help reduce a group member's misplaced feelings of culpability.

There are many models of debriefing that have slightly varying goals and methods. Often they are composed of members of a work group such as EMTs or police. There is some difference of opinion as to whether it is better to include supervisory individuals in groups with their subordinates or to have two separate groups. Some argue that putting both in the same group allows exploration of issues that can facilitate future work together. Others point out that this may hinder the debriefing because leaders may fear appearing "weak" to employees, while supervisees may fear jeopardy to their careers if they are candid.

Although debriefing's role in prevention of PTSD may be limited, it may serve to decrease disability by maximizing an early return to one's social and work groups (42). Debriefings also serve an assessment function. They enable the early identification of individuals who may be especially vulnerable to longer-term sequelae. Gaining a sense of the "dose" of trauma that members may have been exposed to as well as the coping strategies they employ may help in such predictions.

Eye Movement Desensitization and Reprocessing (EMDR) has received a great deal of publicity. It has been proposed as a technique for working with trauma patients. At present, EMDR is not a standard part of disaster psychiatry. Recent reviews have indicated that what is new in EMDR does not appear to be helpful, and what is helpful is what we already know about relaxation, education, and psychotherapy (37,43).

Children

Grouping children by classrooms is an ideal way to begin assessment and intervention. Psychological first aid and therapeutic consultation to children's classrooms are very successful interventions. Importantly, models for working with teachers and school systems are critical following natural disaster as well as school traumas (18,19). A drawing-and-story-telling technique has been described (44) that facilitates children's discussion about the traumatic experiences and facilitate children's work on issues relating to grief and mourning (22). Death is discussed in an age-appropriate fashion and children are helped to understand death's finality (22). It is important to avoid the exploration of deeply disturbing material in the classroom setting. For example, rather than helping a child elaborate on a highly charged drawing as would be done in an individual session, the child's anxiety can be reduced by encouraging him to draw another picture that is more calming (22). Similarly, for the class as a whole, it is important to diminish anxiety and foster closure. Children should be encouraged to draw or enact reparative scenes after they have explored the anxiety-ridden materials associated with the trauma. As with adults, early identification of those in need of extra attention is an auxiliary goal.

Longer-term Interventions

In the long-term, disaster psychiatry more closely resembles a typical psychiatric practice. For some individuals, psychiatric disorders will have developed that will need treatment. Psychotherapy of PTSD is an active area of empirical research (45). Across all studies, ongoing exposure/discussion of the traumatic event in a safe environment is a major component of all successful treatment. It is still valuable, however, to perform outreach in the community to increase the likelihood that those who are suffering psychiatric sequelae from the disaster seek appropriate assistance. Once again, grand rounds to primary practitioners and consultations to school nurses can be helpful reminders to consider psychiatric issues in patients with somatic complaints.

Ways to Learn More about and Get Involved in Disaster Psychiatry

Each District Branch of the American Psychiatric Association (APA) has received mailings from the Committee on Psychiatric Dimensions of Psychiatry. The packets have contained key readings, videotapes, audiotapes and slides relating to Disaster Psychiatry. There are many excellent books covering disaster response, in general, and psychiatric responses and interventions, in particular. The Disaster Committee's page at the APA's website (www.psych.org) is also a valuable resource. There are also courses and workshops offered at the Annual Meeting of the American Psychiatric Association which can increase understanding of both theoretical and practical issues involved in disaster response.

Psychiatrists offer unique expertise for responding to biological and chemical terrorist attacks. The Army provides a website that contains a wealth of information on chemical and biological agents. It would be well worth a few minutes browsing it (www.nbc-med.org).

In addition to educational activities sponsored by professional organizations, there are non-government organizations that provide education. The National Organization for Victims Assistance (NOVA) offers training programs on mental health aspects of disasters. For those wishing to volunteer with the American Red Cross, where one serves as a disaster counselor but not a psychiatrist, a two-day course for mental health providers is available. The focus of this course is learning the Red Cross organization and its rules on how to work within the American Red Cross to help its staff and volunteers as well as to assist disaster survivors. The Red Cross

relies on local practitioners to provide long-term assistance to the community. Psychiatrists, dually trained in a primary care specialty, can play a role in local chapters of the Red Cross by seeking the role of Medical Director or Associate Medical Director where the issues are broadly on the medical health of volunteers.

The American Red Cross provides assistance at all major disasters within the United States. Recently, it has been charged with providing for the psychological needs of victims and their families following transportation disasters. It should be noted that the charter of the Red Cross prohibits the dispensing of medications. Suggestions have been made that in times of disaster local APA district branches could locate psychiatrists near Red Cross shelters to be available for medical and psychiatric consultation. This can facilitate referral of persons needing further assessment and treatment and offer a means of prescribing medications.

CONCLUSION

Psychiatrists have many important skills that can assist communities and individuals in the wake of catastrophe. The epidemiological outbreak investigation model is a useful tool for modifying standard psychiatric practice to more effectively meet the demands of communities overwhelmed by disasters. Involvement in disaster planning is an excellent way for psychiatrists to help their communities prepare for the unthinkable.

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Ethical and Liability Considerations

Virulent Epidemics and Scope of Healthcare Workers' Duty of Care

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The phrase "duty of care" is, at best, too vague and, at worst, ethically dangerous. The nature and scope of the duty need to be determined, and conflicting duties must be recognized and acknowledged. Duty of care is neither fixed nor absolute but heavily dependent on context. The normal risk level of the working environment, the healthcare worker's specialty, the likely harm and benefits of treatment, and the competing obligations deriving from the worker's multiple roles will all influence the limits of the duty of care. As experts anticipate the arrival of an avian influenza pandemic in humans, discussion of this matter is urgently needed.

Epidemiologists are warning against an impending pandemic of avian influenza that could kill several million people (*1*). This possibility raises an urgent and thorny ethical question: Are healthcare professionals obligated to care for patients during virulent epidemics of infectious disease?

Duty of Care

Duty of care, in the medical context, is often invoked as a sort of quasi-biblical commandment, akin to "do not lie" or "do not murder." In a document submitted to the Severe Acute Respiratory Syndrome (SARS) Expert Panel Secretariat, Godkin and Markwell suggest that policy guidelines on the duty of care (which they term duty *to* care) should state that healthcare professionals' duty to care extends to a public health emergency in outbreak conditions (*2*). The authors however suggest that healthcare employers have a set of reciprocal responsibilities toward their staffs, which include duties to inform, protect, and support healthcare personnel. Singer et al., in an article on the ethical issues raised by SARS in Toronto, briefly discuss the duty to care before concluding that the 9 authors "could not reach consensus on the issue of duty of care, particularly regarding the extent to which healthcare workers are obligated to risk their lives in delivering clinical care" (*3*). The term "duty of care" (which I take to be synonymous with duty to care) is, at best, too vague and, at worst, ethically dangerous. For these reasons, the phrase should be modified in favor of more specific descriptions of the obligations of healthcare workers.

Special Obligation of Doctors to Benefit Their Patients

By virtue of their profession, doctors and nurses have more stringent obligations of beneficence than most. They have obligations to a specified group of persons (their patients) that nonmedical personnel have no obligation to help. The term "duty of care" refers to these special obligations. In its bare form, however, the phrase gives no indication of the precise nature of the duty, nor of its limits. Its definitional vagueness, combined with its rhetorical appeal, may be used to justify actions without the need for rational deliberation. During the SARS outbreaks in Toronto, the phrase was often used as a self-standing argument for active involvement on the part of medical staff, without any critical examination of its meaning. Used in this manner, the term may become a subtle instrument of intimidation, pressuring healthcare workers into working in circumstances that they consider morally, psychologically, or physically unacceptable. The phrase duty of care can thus be ethically dangerous by giving the illusion of legitimate moral justification.

To be of any use, the phrase needs to be fleshed out. Are there limits to the duty? Should doctors do everything in their power to benefit their patients? The answer, surely, is no. Doctors are under no moral obligation to donate one of their kidneys to one of their patients, for example. They may, of course, choose to do so, but their act would exceed the demands of everyday morality. What distinguishes normal duty from acting beyond the call of duty, however, is not always clear-cut; the boundary between the 2 categories is fuzzy (*4*).

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Contingency of the Limits of Duty of Care

Defining the limits of the duty of care is a daunting task, strewn with philosophical and logistical difficulties. As the example of the kidney-giving doctors shows, the duty is not absolute but, rather, constrained by several factors. First, the limits of the duty should be a function of the normal risk level. A doctor practicing in Kinshasa, Democratic Republic of Congo (DRC), for instance, is going to incur more risk than a doctor in rural Dorset, England. The diseases are many and the facilities few in DRC. Every nurse or doctor, by accepting a post, is usually aware of the perils of treating infected patients. The appearance of an exotic, highly virulent disease, however, challenges healthcare workers to question their interpretation of the duty of care, in particular, its limits. This challenge was apparent both in the HIV/AIDS epidemics of the 1980s in the United States and in the 2003 SARS outbreaks in Toronto, in which doctors and nurses refused to treat afflicted patients on the grounds that they presented too great a danger (*2,5*). This phenomenon is also likely to occur if the anticipated avian influenza epidemic affects Western hospitals. In light of these historical precedents, hospitals may want to inform prospective staff members of what is expected in crisis situations before, rather than in the midst of, an emergency. By using comparisons and statistics, hospitals could indicate the sorts of risks healthcare staff are expected to handle.

Another factor in defining acceptable risk levels relates to the healthcare worker's specialty. Within the same hospital, an emergency care physician, as a first responder to many critically ill or injured persons, is obviously more at risk than, for example, a dermatologist. By entering into a specialty, doctors implicitly consent to a range of risks and responsibilities associated with the job. The outer limit of acceptable personal risk will fall further along the continuum of risk for some specialists (e.g., infectious disease physicians) than for others (e.g., dermatologists or rheumatologists). During the SARS outbreaks in Toronto, the persons most at risk were nurses and infectious diseases (ID) specialists. As a result of their specialist training, they may have felt a stronger obligation to participate than doctors in other areas of medicine.

Doctors as Multiple Agents

Doctors, although they belong to their own professional community and adhere to its set of rules, are also part of the broader community and therefore subject to the same rights and duties as other members. The 2 spheres of obligation, professional and personal, are both separate and overlapping. They are separate in that the obligations of doctors toward their patients give them rights that nonmedical members of the society do not possess, such as opening someone's abdomen to remove an appendix. The spheres are overlapping, however, in that their role as doctors does not completely absolve their responsibilities as members of the broader community. The immunity from sanction is specific, not general. A gynecologist may legitimately examine intimate parts of his or her patient but cannot drive beyond the speed limit or steal apples from the market stall. With the acquisition of additional duties and rights conferred by the profession, the doctor also agrees to relinquish certain rights enjoyed by others. By entering into the profession, a doctor agrees not only to abide by new rules but also to accept dangers that would be unacceptable to many (e.g., performing a delicate, invasive procedure on a patient with hepatitis or HIV/AIDS).

In times of crisis, the duties deriving from doctors' multiple roles may come into conflict. Doctors, for instance, may have a duty to care for their SARS or avian influenza–infected patients as well as a duty to care for their own children by protecting them (and hence themselves) from infection. So a further problem with the duty to care, aside from its vagueness, is that it fails to consider the holder of the duty as a multiple agent belonging to a broader community. Doctors, in such situations, play several incompatible roles—doctor, spouse, parent, for example—and they must deal with them as best they can. The limits of the duty of care are thus also defined by the strengths of competing rights and duties.

Virtues of Patients and Their Duty of Care

Whereas much has been written on what makes a good doctor, scant attention has been devoted to the good patient (*6,7*). Pellegrino and Thomasma, in For the Patient's Good, devote a chapter to the "good patient" (*8*). "Patients," they write, "must relate to physicians in all of the virtuous ways that govern human interrelationships and social conduct" (*8*). The authors identify 4 key virtues for the good patient: truthfulness, compliance, tolerance, and trust. The virtue most pertinent to this discussion is tolerance. In their examination of tolerance, Pellegrino and Thomasma mention the patients' need to understand the limitations and fallibility of medicine and to care for the well-being of their fellow patients (*8*).

The virtue of tolerance should also require patients to acknowledge healthcare workers' plurality of roles, as well as their fears and concerns in the face of severe risk. If these fears are well founded and reach such a level that medical staff are worried for their life or that of their loved ones, the virtuous patient ought to allow them to step down from their role as caregivers. In such cases, insisting that they continue in this role would reflect a lack of compassion and understanding. Patients should be entitled to ask for a replacement who is less anxious or prone to panic, but they cannot force other persons to undergo extreme stress against their wishes.

When a physician visited the 1995 Ebola virus outbreak in Kikwit (DRC), he found 30 dying patients in an abandoned hospital, left to care for themselves amid rotting corpses, sometimes in the same bed (*9*). Was the last doctor justified in leaving the patients, or should he or she have been obliged to single-handedly treat the highly and dangerously infectious Ebola patients? The answer depends, at least in part, on the actual risk to the doctor and the potential benefits (including the alleviation of pain and distress) that his or her presence will bring to the patients. If the actual risk for serious illness or death for the doctor is low and the benefits of treatment substantial, then he or she may have an obligation to remain. If, however, the lack of protective equipment means that the chances of infection are high and no, or trivially small, benefits will result for the patients (as is often the case with Ebola), then the doctor may justifiably abandon the doomed patients. Virtuous patients, aware of the high risk and the futility of treatment, would not force a doctor to care for them in such circumstances. Patients too have a duty to care for healthcare workers. Part of this duty is not to require doctors to transcend the bounds of reasonable risk during treatment and to respect and acknowledge their roles outside the realm of medicine.

As potential participants in the drama and as holders of a duty of care toward healthcare workers, the general public also should be involved in setting limits to duty. Some form of dialogue between the public and the medical profession, through the media, public consultations, and educational establishments, could help establish a mutually acceptable set of limits.

Impact on Patient Trust

The justified abandonment of patients by doctors arguably will result in the harm or even death of these patients. Moreover, public trust in doctors will diminish as persons realize that they, like the 30 forsaken Ebola patients at Kikwit General Hospital, might be left on their own as soon as the risk reaches a certain level. The patients at Kikwit died alone, abandoned by both medical staff and their own frightened relatives. So tragic is the situation that it seems counterintuitive to justify the actions of the nurses and doctors. Yet, before passing judgment, comparing this situation with another hypothetical situation may be useful.

If a swimmer in an isolated but supervised beach starts to drown 50 meters from the shore, the lifeguard may reasonably be expected to attempt a rescue. This, after all, is the lifeguard's duty as a qualified professional. If, however, the person is drowning 2 miles out and is surrounded by a school of hungry, man-eating sharks, then one cannot expect the solitary lifeguard to dive among the sharks to save the swimmer, even if that means the swimmer will certainly die and even if the lifeguard has a small chance of saving him or her (at great personal risk).

The lifeguard cannot be criticized for not interfering, even though his or her prima facie duty is to rescue drowning persons. Likewise, the fact that doctors can, in exceptional circumstances, refuse to treat patients does not necessarily entail a moral wrong, no matter how serious the consequences to the abandoned patients. As long as patients hold realistic expectations of the limits of doctors' duty of care, no trust should be lost when these limits are transgressed.

Urgent Need

In the last 20 years, various outbreaks of severe infectious diseases, from Ebola virus infection to SARS, have highlighted the need for a more precise account of the duties and obligations of healthcare professionals. The impending avian influenza epidemic makes such an account urgent. The concept of duty of care, in its bare form, is too vague to be helpful. Its limits are not fixed, but contingent on various factors, from the working environment's normal risk level to the healthcare worker's specialty and the range of other obligations that derive from his or her multiple roles. To clarify this overlooked topic, empirical social science research should be conducted to illuminate the views and reasoning of physicians, patients, and members of the public on the limits of the duty of care. Philosophical reflection on the issue as well would do much to clarify this overlooked topic. As dramatic as it may sound, delineating the limits of the duty of care may prevent large numbers of doctors from abandoning their patients in a crisis. Such abandonment has happened in the past and may occur again.

In light of the potentially catastrophic impact of avian influenza on human health and economic well-being, this topic should engender a burst of activity and debate in hospitals, universities, and medical journals. We should explore not only the nebulous limits of the duty of care but also infection control measures, staff training and involvement, the role of medical students and volunteers, the triaging of incoming patients, and the logistics of treatment, depending on the severity of the epidemic, as well as the lessons learned from past epidemics. However difficult the task, these issues should best be tackled now, in times of relative calm, rather than in times of pandemic turbulence.

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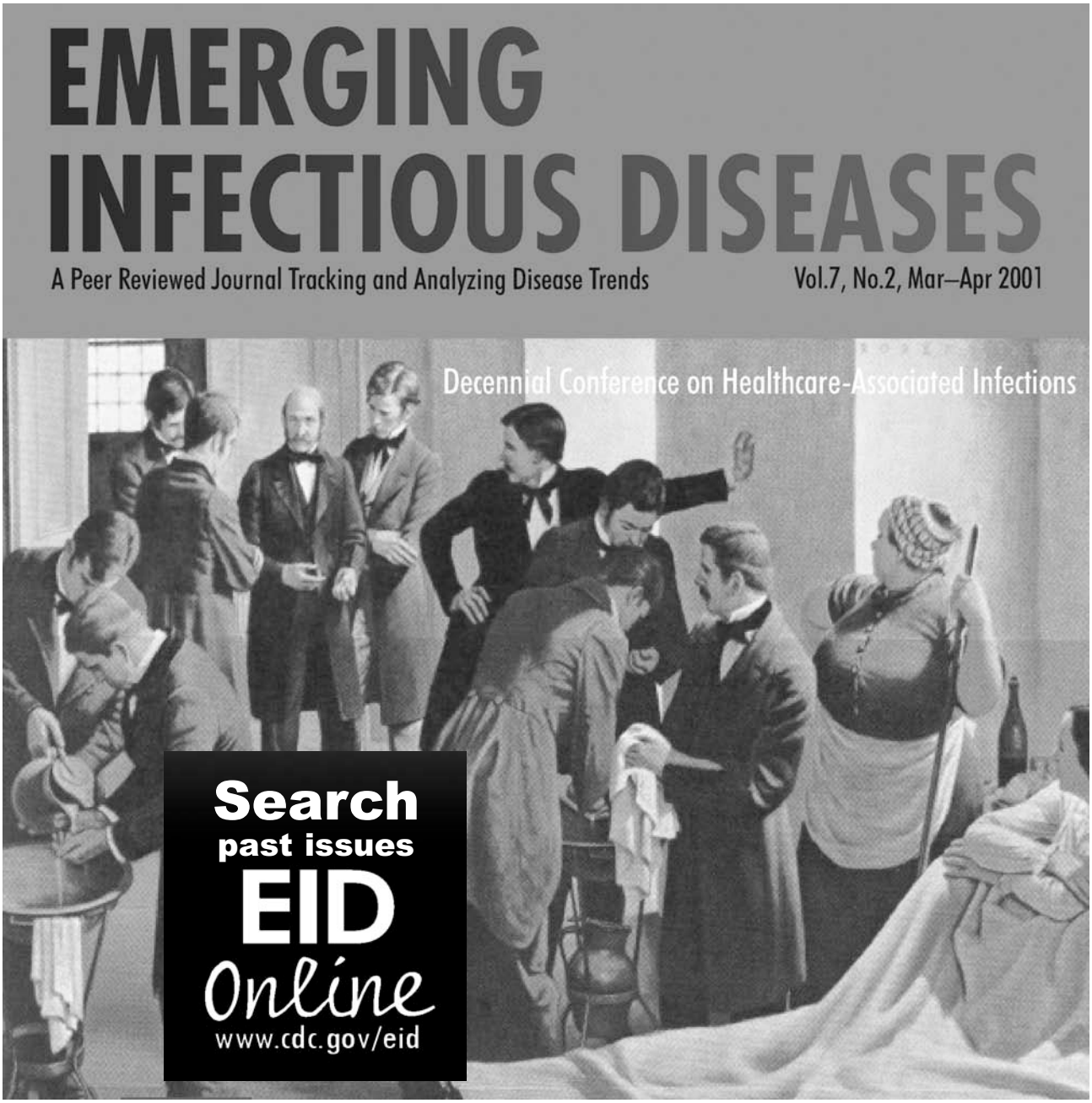

Physician Volunteer Liability FAQ

- When responding to an actual disaster, you may be covered by the Good Samaritan Law.

- Be part of a group that has a cooperative agreement or Memorandum of Understanding (MOU) with the state Division of Emergency Management, local emergency managers, sheriffs, police, fire departments or local emergency planning committees. You may be covered under the Colorado Immunity Statute.

- Know exactly how you will be called out and how your services will be used and/or documented.

- Participating in training and exercises is a source of liability. To ensure you are fully covered, contact your medical liability carrier.

Resources:

Colorado Good Samaritan Law
http://home.mesastate.edu/~jerry/gmnc/Colorado%20Good%20Samaritan%20Law.htm
Colorado Statute 24-32-2605. Immunity.
http://www.gcgllc.com/LEPCHandbook/SectionA/A1a.pdf
COPIC Insurance
http://www.callcopic.com/home/what-weoffer/coverages/medical-professional-liability-insuranceco/volunteer-physician-liability

References and Resources

References and Resources Used in this Publication

- Colorado Department of Public Health and Environment Office of Emergency Preparedness and Response: http://www.cdphe.state.co.us/epr/index.html
- Colorado Medical Society Physician Disaster Preparedness Community Website: http://www.cms.org/DisasterPrep.html
- American Psychiatric Association: http://www.psych.org/disasterpsych/
- Ready Colorado Campaign: http://www.readycolorado.com/
- CDC Emergency Preparedness and Response: http://emergency.cdc.gov/
- US Department of Health and Human Services pandemic flu information: http://www.pandemicflu.gov
- Professional Risk Management Services, Inc: http://www.psychprogram.com
- Center for the Study of Traumatic Stress: http://www.centerforthestudyoftraumaticstress.org
- American Red Cross Disaster Preparedness: http://www.redcross.org/services/disaster/

CPS is in the process of updating our website to include resources and links on disaster preparedness. These will be available at http://www.coloradopsychiatric.org