The PA in Disaster Response: Core Guidelines

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information, and may lose nuance of policy.
You are highly encouraged to read the entire paper.

- AAPA believes PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts.
- AAPA supports educational activities that prepare the profession for participation in disaster medical planning, training and response.
- AAPA will work with all appropriate disaster response agencies to update their policies, in order to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.
- AAPA believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for all disasters that affect our communities, nation and the world.
- AAPA supports the concept of photo IDs to identify qualified medical personnel during a disaster response.
- AAPA recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response.
- AAPA supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state or local emergencies and public health crises.

Introduction

Natural and man-made disasters, such as tornadoes or terrorist attacks, typically result in an urgent need for medical care in the affected areas. PAs may well be called upon to provide immediate healthcare services during times of urgent need.

In recent years, large-scale disasters like 9/11 and Hurricane Katrina have raised concerns about our ability to respond in an effective and coordinated manner to the medical (and other) needs created by these disasters. These catastrophic disasters can result in a high number of casualties, create chaos in the affected community and larger society, and drastically affect local and regional healthcare systems.

The definition of disaster adopted by the World Health Organization and the United Nations is “the result of a vast ecological breakdown in the relationships between man and his environment, a
serious and sudden disruption on such a scale that the stricken community needs extraordinary efforts to cope with it, often with outside help or international aid.”  

The most common medical definition of a disaster is an event that results in casualties that overwhelm the healthcare system in which the event occurs. A health disaster encompasses the compromising of both public health and medical care to individual victims. It is possible to evaluate the changes that a disaster has caused by measuring these against the baselines established for the affected society or community before the disaster event.

From a medical or public health standpoint, a disaster begins when it first is recognized as a disaster, and is overcome when the health status of the community is restored to its pre-event state. Responses to disasters aim to:

1. Reverse adverse health effects caused by the event
2. Modify the hazard responsible for the event (reducing the risk of the occurrence of another event)
3. Decrease the vulnerability of the society to future events
4. Improve disaster preparedness to respond to future events.

Because disasters can strike without warning and in areas often unprepared for such events, it is essential for all PAs to have a solid foundation in the practical aspects of disaster preparedness and response.

All disasters follow a cyclical pattern known as the disaster cycle, which describes four reactionary stages:

1. Preparedness
2. Response
3. Recovery
4. Mitigation and prevention.

The emergency management community is faced with constant changes, such as demographic shifts, technology advances, environmental changes and economic uncertainty. In addition, all facets of the emergency management community can face increasing complexity and decreasing predictability in their operating environments. Complexity may take the form of additional incidents, new and unfamiliar threats, more information to analyze, new players and participants, sophisticated (but potentially incompatible) technologies, and high public expectations. These combinations can create very difficult and challenging environments for all healthcare providers, especially those with little background or experience in disaster medicine.

One of the major areas of uncertainty surrounds the evolving needs of at-risk populations. As U.S. demographics change, we will have to plan to serve increasing numbers of elderly patients and individuals with limited English proficiency, as well as physically isolated populations. There is the
possibility of pandemic victims; and in the event of either single or large multi-casualty events, large numbers of injured or ill patients attended to by a fractured infrastructure made up of healthcare responders with little training and/or resources.

Disaster medicine evolved out of the combination of emergency medicine and disaster management. The PA profession is well qualified to function in the field of disaster medicine. PAs come from diverse backgrounds and are very capable of working in communities affected by natural and man-made disasters. Our profession was “born” from those serving our country and returning from combat situations, and we are as a profession well known as being resourceful and capable of meeting and exceeding professional expectations.

AAPA recommends that all PAs become more familiar with the tenets and challenges of disaster medicine and working in austere environments.

This paper provides basic guidelines for those PAs who are able and willing to assist in a disaster relief effort.

**Preparation Through Education**

In addition to understanding the principles of critical event management, effective disaster response requires training and preparation for austere practice conditions and unanticipated assignments. Unless absolutely necessary, disaster medicine should not be practiced by PAs who do not possess the knowledge and skills needed to function effectively in the specialized environment of the disaster scene. PAs should therefore prepare in advance of disasters or mass casualty events. Preparation should be done through an established relief organization and should address healthcare and non-healthcare aspects of disaster response. Disaster response competencies for healthcare workers have been developed by several organizations, including the Association for Prevention Teaching and Research and the National Disaster Life Support Foundation (see Resources).

The following are core competencies that all PAs should have regarding disaster medicine:

1. Basic knowledge of the National Incident Management System’s Incident Command System, along with local and state emergency services and management.
2. Recognize the importance of safety in disaster response situations, including protective equipment, decontamination and site security.
3. Have a working knowledge of the principles of triage in a disaster setting.
   a. Do the greatest good for the greatest number and maximize survival.
4. Learn how to develop the clinical competence to provide effective care with extremely limited resources.
a. Maintain certifications in BLS, ACLS, and PALS, and, if possible, specialty training such as Advanced Disaster Life Support, Advanced Trauma Life Support, and Advanced Disaster Medical Response.

b. Stay up to date with ever-changing disaster medical information from various AAPA-approved web sites like the Centers for Disease Control (CDC), National Disaster Medical Systems (NDMS), National Incidence Management System (NIMS), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), and others.

5. Learn how to prescribe treatment plans along with an understanding of psychological first aid and caring for patients and responders during and after mass casualty events.

6. Understand the ethical and legal issues in disaster response for PAs. These include:
   a. Their professional and moral responsibility to treat victims
   b. Their rights and responsibilities to protect themselves from harm
   c. Issues surrounding their responsibilities and rights as volunteers
   d. Associated liability issues.

7. Always keep the protection of public health as a professional core responsibility, regardless of education or training.

**Credentials and Roles**

Verification of certification, licensure or qualifications is nearly impossible at a disaster site. Yet it is certainly in the best interests of the afflicted to receive care from legitimate, competent clinicians. AAPA supports the concept of voluntary state or national medical photo IDs to identify all qualified medical personnel during disaster response. States such as New York have implemented such programs in the wake of recent major disasters.

Most medical relief workers participate via nongovernmental organizations (NGOs), on Disaster Medical Assistance Teams (DMATs) through the U.S. National Disaster Medical System (NDMS), or through other teams organized by charities or state and local governments. Volunteering through established emergency response organizations helps to ensure verification of all responders’ credentials in advance. In addition, all workers should carry copies of their license and certification to present when needed.

Response teams often include healthcare providers who have not trained together and are not familiar with one another’s background, skills and scope of practice. They also may find themselves in austere conditions with few medical resources available. Team members should explain their training and skills to one another and talk about how they will share responsibilities. PAs need to be able to articulate the PA role and scope of practice educating other team members about PA
capabilities while facilitating consensus regarding their respective disaster roles and who will supply what levels of emergency care. For example, who is best prepared to suture lacerations? Set a broken arm? Insert an emergency chest tube? Participants should discuss these kinds of issues as their team begins working together.

There will be situations when PAs are the most qualified healthcare providers available to serve as medical officers for a disaster-stricken area. In these situations, PAs should recognize the need for their skills and abilities and be willing to assume the required responsibility for the benefit of the team. PAs who find themselves in such situations should seek out additional medical resources as needed.

**State Laws/Federal Exemptions**

In some cases, governors waive state licensure requirements during disasters, but this is not always the case. In the aftermath of Hurricane Katrina in 2005, the governors of Louisiana and Missouri waived licensure requirements for all healthcare professionals for a period of time, but the governors of Texas and Mississippi did not. Texas and Mississippi streamlined their application processes, but still required licensure by their state boards. PAs should not assume that disaster response organizations either understand or ensure compliance with licensure requirements. PAs should research the steps necessary to practice in the affected area before assisting with domestic response initiatives. PAs should also keep in mind that Good Samaritan laws do not provide either authorization to practice or, in most cases, liability protection when they are working in disaster relief situations.

One way to ensure both proper authorization to practice and protection from liability is to participate through established federal response organizations. DMAT members, for example, are required to maintain appropriate certifications and state licensure. However, when a DMAT is federally activated, its members become federal employees and are exempt from state licensure requirements. In addition, as federal employees they are protected by the Federal Tort Claims Act, under which the federal government becomes the defendant in the event of a malpractice claim. It should be noted that DMATs are primarily a domestic asset and, with the exception of the International Medical-Surgical Response Team (IMSuRT) component of NDMS, their preparedness, training and credentialing is limited to the United States. In contrast, members of the Medical Reserve Corps may be deployed internationally or domestically.

The AAPA Guidelines for State Regulation of PAs and the AAPA Model State Legislation both include model language regarding PA licensure during disaster conditions. This language reads:

*PAs should be allowed to provide medical care in disaster and emergency situations.*

*This may require the state to adopt language exempting PAs from supervision provisions*
when they respond to medical emergencies that occur outside the place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees. Physicians who supervise PAs in such disaster or emergency situations should be exempt from routine documentation or supervision requirements. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

Responding to International Crises

Outside of the United States, government programs and NGOs must ensure that U.S. providers have permission to offer medical care in the disaster area. Well-prepared response organizations should be able to prevent in advance any licensing problems that can thwart efforts to deploy to the disaster area. Even so, it remains incumbent upon PAs to ensure that they are properly authorized to practice medicine in the region where they have assumed patient care roles. The international arena presents a myriad of issues that may not exist on the domestic front. Cultural beliefs, governmental regulations, political instability, and lack of established standards of healthcare may all present complications. PAs need to investigate international disaster relief standards and response organizations before volunteering. PAs also need to consider the possibility that host countries may refuse foreign assistance, and should be respectful of that decision.

Beware the Ill-prepared Relief Worker

Research substantiates two categories of resource problems that typically arise during disaster response: needs that are a direct result of the disaster, and those resulting from the additional demands placed on resources by relief workers themselves.

Ill-prepared relief workers can compound disaster situations by increasing demands on potentially limited resources. They may need water, food and shelter; have incompatible radio systems that complicate communications; or be unwilling to accept unexpected assignments. These responder-generated demands can be somewhat alleviated through foresight, preparedness courses and individual preparation for the new roles often encountered found in complex situations. Responders may need to be fully self-sufficient so as to not drain precious, limited resources and further deplete supplies for survivors.

Each group that responds to a disaster brings its own logistical capabilities, priorities, goals and expectations. Coordinating this sudden ad hoc network of organizations can be a very big challenge. As a rule, in a multi-organizational response to a disaster, the more unfamiliar responders are with their tasks and with their co-workers, the less efficient and the more resource-intensive is the response. PA relief workers should be aware of the efforts and objectives of these other response operations, and ensure that
efforts to provide medical care don’t hamper efforts to provide clean water, electrical power or other necessities.

**Disaster Response Standards**

In preparation for the multifaceted aspects of disaster response, clinicians should become familiar with generally accepted standards for re-establishing basic societal functions. The Sphere Project (www.sphereproject.org), an international coalition that includes the International Red Cross/Red Crescent and other experienced response organizations, has developed a comprehensive set of standards setting forth what they believe people affected by disasters have a right to expect from humanitarian assistance. The Sphere Project aims to improve the quality of assistance provided to people affected by disasters and to enhance the accountability of the humanitarian system in disaster response.

The standards outline the basic societal functions that should be addressed, the degree to which organizations should strive to restore them, and minimum goals that should be seen as interim steps to complete recovery. According to the Sphere Project, these basic functions are:

- Clothing, bedding and household items
- Water supply, water quality, latrines, and other sanitation facilities
- Supply and security of food stores, nutrition, and monitoring of vitamin deficiencies
- Healthcare, including preventive and surveillance measures.

The Sphere Project and other medical relief organizations also emphasize that, in addition to meeting acute medical needs, effective relief includes health promotion measures such as vaccinations and hand-washing, as well as monitoring programs for early detection of disease outbreaks.

Nutrition monitoring is also essential to the health of disaster survivors. Malnutrition can be the most serious public health problem caused by a disaster, and may be a leading cause of death from it, whether directly or indirectly. Food aid has an immediate impact on human health and survival and, while it may not be a formal part of a medical team’s role, the need for adequate nutrition reinforces the importance of coordinated disaster response.

Finally, the provision of aid following a disaster should be free of political, cultural, religious or ideological restrictions. The need for organizational policies reflecting cultural tolerance and for individual workers to be sensitive to the population they serve should go without saying. Unfortunately, relief efforts are often derailed by basic misunderstandings of local customs. Failure to recognize cultural healthcare beliefs in the affected population may also result in some patients choosing not to visit disaster medical facilities. Medical care should not be offered in such a way that patients must put aside their beliefs to receive it. Participation through established organizations can help to minimize cultural offense. Individuals also should commit to a personal effort at cultural understanding.  

**Standards for Crisis Care**
A recent Institute of Medicine (IOM) report proposed guidelines for the standard of care in disaster situations. In that report, the IOM defines crisis standards of care as:

“A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.”  

The care available to a community during a time of disaster will vary based on the resources available. There will typically be a continuum of care from “conventional” to “contingency” and “crisis” levels. In “conventional” care, health and medical care conforms to the normal and expected standards for that community. “Contingency” care develops as a response to a surge in demand and seeks to provide patient care that remains functionally equivalent to conventional care while taking into account available space, staff and supplies. The overall delivery of care may remain fairly consistent with community standards. A community may be able to stay in either conventional or contingency modes for a longer period through disaster planning and preparedness.

“Crisis” care occurs when resources, personnel and structures are stretched or nonexistent and conventional or contingency standards are no longer possible. Implementation of the crisis standard of care is not an optional decision but is forced by the circumstances. The move to crisis care mode is an attempt to adjust resources in the hope of preserving health, reducing loss of life, and preventing or managing injuries for as many members of the community as possible. Communities that are well prepared for disasters should be able to return quickly to either a conventional or contingency level of care once the restricted resources are resupplied.

Many communities may not automatically recognize this continuum. Therefore, preparations should include discussions that help define the continuum that would exist during a crisis situation. During the response to a surge in needed care, communities would need to be able to evaluate their changing needs and to communicate their situation to others to aid in their response. The crisis standard of care seeks to provide a basis for such evaluation and communication of changing needs during evolving disasters.

It is also important to have in place a process for allocating resources to address the most compelling interests of the community. This process requires certain elements to prevent general misunderstanding and an erosion of public trust, including fairness, transparency, consistency,
proportionality and accountability. These can only be achieved through community and provider engagement, education and communication. A formalized process also requires active collaboration among all stakeholders. Actions to be taken during crisis management need the force of law and authoritative enforcement to preserve the benefit to the challenged community.

**Guidelines for PAs Responding to Disasters**

1. PAs should participate in disaster relief through established channels
   a. Consider joining non-governmental organizations, government agencies, State Medical Assistance Teams, Disaster Medical Assistance Teams, or other organized groups with a focus in providing disaster services. AAPA’s Disaster Medicine Association of PAs can help provide direction as well.
   b. Participate in workplace disaster planning.
   c. Stay current with information from reliable resources.
   d. Make every effort not to become a victim of the event or to cause harm to others.

2. PAs should support comprehensive, team-based healthcare.
   a. Become proficient in the National Incident Management System’s Incident Command System.
   b. Learn to be flexible in working in unfamiliar places and circumstances – many times you have to become comfortable with “hurry up and wait” scenarios.

3. PAs should prepare for and expect the possibility of coping with scarce medical resources and nonmedical assignment in disaster situations.
   a. Participate in local disaster planning events.
   b. Participate in various webinars, table top drills, etc…
   c. Bookmark federal and state websites that have an abundance of current information for medical providers, which might include:
      i. Centers for Disease Control (CDC)
      ii. Federal Emergency Management Agency (FEMA)
      iii. Department of Homeland Security (DHS)
      iv. Health and Human Resources (HHS)
      v. State Medical Assistance Team (SMAT)

4. PAs should be prepared to provide documentation of their qualifications at any disaster site.
   a. Always have access to a portable file containing hard copies of your driver’s license, medical license, DEA license, and any specialty certifications.

5. PAs involved in medical relief efforts should be familiar with standards of disaster response and develop printed and electronic quick reference resources, including
a. Disaster triage guides (i.e., Start, Jump Start, and others)
b. Triage coding guides
c. Decontamination principles
d. Treatment guidelines for victims of biological, chemical, radiological, or natural disasters (e.g., hurricanes, tornadoes, floods, cold/heat emergencies, pandemics.)

6. PAs should maintain a high degree of cultural sensitivity when working with all populations.

**Principles of Disaster Triage:**

- The fundamental difference between disaster triage and normal triage is in the number of casualties. Care is aimed at doing the most good for the most patients (assuming limited resources).
- Definitive care is not a priority.
- Care is initially limited to the opening of airways and controlling external hemorrhage; no CPR in mass casualty events.
- The disaster triage system (US) is color coded: red, yellow, green and black, as follows:
  - Red: First priority, most urgent. Life-threatening shock or airway compromise present, but patient is likely to survive if stabilized.
  - Yellow: Second priority, urgent. Injuries have systemic implications but not yet life threatening. If given appropriate care, the patients should survive without immediate risk.
  - Green: Third priority, non-urgent. Injuries localized, unlikely to deteriorate.
  - Black: Dead. Any patient with no spontaneous circulation or ventilation is classified dead in a mass casualty situation. No CPR is given. You may consider placement of catastrophically injured patients in this category (dependent) on resources. These patients are classified as “expectant.” Goals should be adequate pain management. Overzealous efforts towards these patients are likely to have deleterious effect on other casualties.

**Summary**

AAPA endorses the following statements to promote and support disaster preparedness and response activities and the integration of PAs as key personnel in mitigating the impact of disasters:

- AAPA believes PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts.
- AAPA supports educational activities that prepare the profession for participation in disaster medical planning, training and response.
- AAPA will work with all appropriate disaster response agencies to update their policies in order to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.
AAPA believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals and practices in preparation for all disasters that affect our communities, nation and the world.

AAPA supports the concept of photo IDs to identify qualified medical personnel during a disaster response.

AAPA recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response.

AAPA supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state, or local emergencies and public health crises.

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