SPECIAL REPORT

Emergency Physician Disaster Deployment: Issues to Consider and a Model Policy

Christopher A. Kahn, MD, MPH;[1,2] Kristi L. Koenig, MD;[2] Carl H. Schultz, MD[2]

1. Department of Emergency Medicine, University of California, San Diego, California USA
2. Center for Disaster Medical Sciences, University of California, Irvine, California USA

Correspondence:
Christopher Kahn, MD, MPH
Department of Emergency Medicine
University of California, San Diego
200 W. Arbor Drive, MC 8676
San Diego, California 92103 USA
E-mail: ckahn@ucsd.edu

Conflicts of interest: none

Keywords: disaster medicine; disasters; policy making; rescue work

Abbreviations:
ED: emergency department
EP: emergency physician
USERRA: Uniformed Services Employment and Reemployment Rights Act

Received: July 27, 2016
Revised: September 26, 2016
Accepted: October 15, 2016

Online publication: May 2, 2017

doi:10.1017/S1049023X17006409

Abstract

Disaster responders are frequently emergency physicians (EPs). Effective response is enhanced by the strong support of home institutions and clear policies for backfill of regular duties. A group of disaster medicine responders and researchers worked with an academic department of emergency medicine to create a policy that addresses concerns of deploying physicians, colleagues remaining at the home institution, and administrators. This article describes the process and content of this policy development work.

Kahn CA, Koenig KL, Schultz CH. Emergency physician disaster deployment: issues to consider and a model policy. *Prehosp Disaster Med*. 2017;32(4):462-464.

Introduction

When disaster strikes, emergency physicians (EPs) frequently find themselves at the forefront of the medical response. Through participation in federal groups such as the US National Disaster Medical System, state agencies with disaster response teams, non-governmental organizations, and individual private responses, EPs can apply their skills to support populations in need after a catastrophic event. However, EPs function within the larger context of practice groups and health systems, and consequently need the support of their administrations and colleagues for successful deployments in times of crisis.

Facilitating the sudden absence of even one physician from a busy emergency department (ED) can be difficult, and the problem is exponentially compounded when multiple physicians are asked to deploy. There are several issues that need to be resolved prior to deployment, including shift coverage, maintenance of salary, continuation of benefits including liability and workers' compensation, and assurance that employment will continue upon return from deployment. Rather than have these important discussions on an ad hoc basis after a disaster has occurred, the UC Irvine Center for Disaster Medical Sciences and Department of Emergency Medicine (Irvine, California USA) proactively created a deployment policy to provide both the department/institution and the EP with a standardized, reliable framework for successful deployment. This report describes the process used and presents the model policy developed at this academic medical center. This information should prove useful to other EP groups seeking to prepare for deployment of physician members to disasters, especially those events with limited or no notice.

Report

Development

The development of this departmental deployment policy followed a structured, iterative approach, progressing from needs assessment and stakeholder discussions through initial development for policy derivation and subsequent revisions in a validation phase, analyzing the use of the policy during disasters.

Needs Assessment (Derivation)—Prior to vetting the issues with departmental administration, senior leadership of the Center for Disaster Medical Sciences met to discuss the overall impact to critical department functions when eligible EPs were to be deployed to support disaster-response operations. At the time of policy development, model policies were solicited from a convenience sample of other programs across the US; however, none could be identified. A subsequent review of the literature identified two articles describing how academic medical centers were successful in partnering with disaster-response centers

within their institutions to facilitate deployments, as well as a description of an academic medical center partnering with a nongovernmental organization at the disaster site; however, as of the time this manuscript was prepared, there remained no publication specifically addressing the detailed issues that must be considered during the development of a disaster-deployment policy.[1-3]

Points of consideration for policy development included how many physicians the department could simultaneously support while deployed, the requirement to ensure compliance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), and practical concerns regarding the amount of time available from notification to deployment and what actions needed to be performed in that time frame. In particular, USERRA requires that civilians who serve in the uniformed services not be disadvantaged in their civilian careers as a result, that they be promptly re-employed upon completion of service, and that they not be discriminated against as a consequence of their service.[4] Based on these needs, investigators created a draft policy to help guide further discussion.

Stakeholder Discussion—After creating a list of needs and a draft policy, Center for Disaster Medical Sciences leaders met with departmental leadership to discuss the critical issues identified during the needs assessment, as well as to identify any potential issues that leadership independently recognized. The draft policy was reviewed and amended, and a final policy was adopted.

Revision in Response to Actual Events (Validation)—Over the years following adoption of the policy, it was tested during several disaster deployments. After each event, an after-action debriefing was held with department leadership, and suggestions for improvement were discussed and implemented, as appropriate.

Policy

The final policy addresses the purpose, scope, employer's responsibilities, and employee's responsibilities. Responsibilities are categorized into the areas of shift coverage, liability coverage, payment of salary, and provision of benefits. The complete policy is attached (Appendix 1; available online only).

Key Considerations

Shift Coverage—The department guarantees that at least one EP will be able to deploy to each disaster. Given the time pressure prior to deployment, the department will take responsibility for arranging shift coverage for deploying personnel. The EPs eligible for deployment are expected to coordinate with each other to determine who will be deployed. Additionally, EPs eligible for deployment, but not actually deployed, are expected to assist with shift coverage for the deployed EP. The EP being deployed will contact a specified point person in departmental administration who will handle all further notifications, shift adjustments, and other items of concern.

Liability Coverage—The policy exempts the department from providing liability coverage, placing this responsibility instead on the entity under which the EP is deploying. For federal deployments (eg, a Disaster Medical Assistance Team), the US government provides liability coverage. The EP is responsible for maintaining all documentation that the deploying agency requires as a condition of coverage.

Payment of Salary—Salary payment is maintained at the EP's usual level during deployment. Deployed EPs are expected to make up the missed clinical hours over the remaining course of the fiscal year. In case of late-year deployments, the EP has a minimum of three months to repay the hours missed. If the hours are not repaid, then salary can be adjusted downward to compensate. Compensation paid to an EP by the deploying agency is retained by the EP.

Provision of Benefits—Benefits, including years of service required for pension calculations, clinical bonus and other incentive payments, and insurance (eg, health, dental, and vision), continue without interruption during deployments. In accordance with USERRA, the deployed EP will notify the departmental administration as soon as possible to help prepare the department for the temporary absence of the EP.

Discussion

The Center for Disaster Medical Sciences developed this policy after being unable to find an appropriate model policy or key considerations in the previously published literature. Other departments, groups of disaster responders, and individual physicians responding to disasters may find it valuable to discuss this policy and associated issues with their employers prior to an imminent deployment.

Subsequent to the initial development of the policy, a substantive revision has been considered to address departmental expectations for training and safety of physicians being deployed into disaster-affected areas. This change was sparked by the deployment of physicians into West Africa during the 2014 Ebola epidemic, along with the likelihood of future emerging infectious diseases requiring specialty physician response.[5-7] The revision also discusses expectations for both the department and the physician upon return from an infectious-disease-related deployment, including potential mandated time off (quarantine) or other public health monitoring.[6]

The policy was designed within the context of an academic department, with a salary that is constant over the course of any given fiscal year. As such, although the principles remain unchanged, the policy would require modification to meet the needs of a department that instead pays its EPs on a more flexible basis, such as monthly hours worked or strictly on productivity measures. Further, the full-time EPs within the department that are covered by this policy did not work clinically in other locations at the time of its development. The policy would require acceptance and implementation among each worksite, if others exist, in order to provide the benefits of assistance with shift coverage and other assurances. The policy was specifically designed to support faculty deployment (including fellows functioning as junior faculty), and does not address several issues specific to deployment of residents, such as approval of the program director and means to assure that residents remain fully compliant with the Accreditation Council for Graduate Medical Education requirements for their specialty. Finally, many physicians volunteer with organizations that may not have the means to provide liability insurance. It is incumbent upon EPs to ensure that they have appropriate legal

protection for their work, which may require the involvement of their department or insurance administrator.

Limitations

One limitation of the policy as designed is that, while it serves as a framework for all disaster deployments, it focuses on federal/USERRA deployments. Future iterations are expected to address issues specific to non-federal deployments, such as liability protection, safety, and training.

Conclusion

Development of a disaster deployment policy has enabled the department to continue meeting its core clinical and academic functions while concurrently serving the global community by providing experienced EPs to deploy to impacted areas during disasters. Novel threats such as emerging infectious diseases make continuous review and update of the policy important, as new considerations may emerge such as requirements for quarantine after returning from deployment and prior to return to duty. Continued revision of the policy based on feedback from both deployed EPs and those who remain at the home institution to staff the ED is essential to ongoing policy improvement.

Supplementary Material

To view supplementary material for this article, please visit https://doi.org/10.1017/S1049023X17006409

References

1. Babcock C, Theodosis C, Bills C, et al. The academic health center in complex humanitarian emergencies: lessons learned from the 2010 Haiti earthquake. *Acad Med*. 2012;87(11):1609-1615.
2. Sarani B, Mehta S, Ashburn M, et al. The academic medical center and nongovernmental organization partnership following a natural disaster. *Disasters*. 2012;36(4):609-616.
3. Sklar DP, Richards M, Shah M, et al. Responding to disasters: academic medical centers' responsibilities and opportunities. *Acad Med*. 2007;82(8):797-800.
4. Uniformed Services Employment and Reemployment Rights Act of 1994. 38 USC 4301-4334. https://www.dol.gov/vets/usc/vpl/usc38.htm. Accessed July 2016.
5. Barbisch D, Koenig KL, Shih FY. Is there a case for quarantine? Perspectives from SARS to Ebola. *Disaster Med Public Health Prep*. 2015;9(5):547-553.
6. Koenig KL. Health care worker quarantine for Ebola: to eradicate the virus or alleviate fear? *Ann Emerg Med*. 2015;65(3):330-331.
7. Koenig KL. Quarantine for Zika Virus? Where is the science? *Disaster Med Public Health Prep*. 2016;10(5):704-706.