

EDITORIAL

Playbill

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*All the world's a stage,
And all the men and women merely players;
They have their exits and their entrances;
And one man in his time plays many parts.*
William Shakespeare, *As You Like It*

Shakespeare was not the first to describe the world as a stage and men and women as but players who over time assume many roles, depending on the nature of the play itself and its requisite needs. He did, however, certainly capture the many vagaries inherent in this “life” model better than any other, and underscored the ensemble nature of social activities. For us who are involved in preparedness and response, many useful analogies can be derived from this construction. First and foremost for me is that a play consists of acts that take place over a continuum of time—much like the disaster cycle of mitigation, preparedness, response and recovery. Within these acts, or stages, different individuals play different roles, and these roles vary with the specific play or event.

Frequently, I have been asked what is the primary focus of *Disaster Medicine and Public Health Preparedness* in relation to the disaster cycle. As with most simple questions, the answer can become quite confusing and complex, especially in a field that does not enjoy a common lexicon and is beset by semantic conflicts over its very definition. These difficulties aside, I will give my simplified perspective. *Disaster Medicine and Public Health Preparedness* focuses on all stages of the disaster cycle but in a disproportionate manner, depending on the relative role of the public health and health care system in a particular stage for a given event type.

A second closely related analog pertains to individuals over time. As an actor, one may have an area of specialization but also must be prepared to play a variety of roles depending on the demands of a given script. Most importantly, to prove successful, the individual parts must be integrated into a coherent production—the ensemble is greater than its individual members. These factors represent 2 of the hallmarks we strive to achieve—a preparedness and response workforce that has individual or specialized skills and a secondary skill set that allows them to

effectively function in other roles. And, of course, in our environment true success comes not from individual roles but from the capabilities of an integrated team.

The global response to the Haitian earthquake stands as the poster child for a lack of integration of resources in the early stages of the response.¹ Also, the lack of integration is often best exemplified and commonly the result of volunteers, as spontaneously responding individuals or units, often uninvited by a responsible authority. Even when invited volunteers tend to arrive independent of any systematic response. This very predictable occurrence after a major event was addressed in a recent article by Jessica Alexander in the *Washington Post*, entitled “Five myths about helping the Philippines” (December 5, 2013). The fifth myth was volunteers on the ground are always a help.

Well-meaning volunteers who arrive to help can complicate matters further. After the earthquake in Haiti, a few medical teams from the United States came to perform surgeries. More often than not, they did not connect with other groups and were unable to coordinate long-term care for their patients. The results were devastating: Patients left clinics without knowing when to get their sutures removed, how often to put on clean bandages, or where to go for follow-up treatment. Many people developed infections ... unskilled volunteers can burden aid agencies that need to ensure their security, shelter, and transportation. Further, they compete with disaster survivors for housing, food, and clean water. Many volunteers showed up in Haiti without any food for themselves, diverting time and resources from disaster response. In Tacloban, agencies are setting up tents for their staff members near the airport, because there is no space for them in the city. Volunteers who come to assist take up space that experienced, professional aid workers should occupy; those who want to clear rubble take jobs that Filipinos can do better, if only because they speak the language and can navigate the local environment without mishap.

Although there is certainly some truth here, we need to be very careful of discrediting well-meaning and capable professionals who indeed can and do make valuable contributions, most especially in the initial response to a disaster.

This month's cover addresses 2 events; the first is with respect to Typhoon Haiyan and its devastating effects on the Philippines. In relation to this there is a letter from Dr. Eduardo Dolhun, from Stanford University Medical Center who was a volunteer responder to the disaster and the second is the tornado in Hattiesburg, Mississippi, and this issue includes an excellent lead article by Cates et al, which addresses this event. What is most instructive about this article is its demonstration of new communications modalities to include social media that can contribute to decreased morbidity and mortality resulting from devastating events. This represents the increasing importance of ehealth applications in preparedness and response activities and represents another area which would be well served by a special issue of Disaster Medicine and Public Health Preparedness. Dr Dolhun does not indicate the presence or lack of an affiliation for him and his team, or whether the team was requested or spontaneously responded. However, more to the point, his team's contributions and observations, as detailed in the letter are being brought to our attention. Although not research in the purest sense, this type of empirical observation can substantively inform future research activities.

Also, as noted by Dr Frederick Burkle, Jr. one of the letter's reviewers noted,

Eduardo Dolhun's observations of his small medical team arriving in the storm-ravaged Philippines represents the shared experiences of what all foreign medical teams, large and small, will find. It is instructive and confirms that soon after the "direct" consequences of any disaster takes its toll, "indirect" public health emergencies predictably result in major, and preventable,

morbidity and mortality, especially for the most vulnerable of populations. Disaster responders, who are well trained in acute trauma care, must refocus their attention toward preventable disease arising from destroyed public health infrastructure and protections. This task is often more daunting, and represents the broad requirements expected of every responder. While Dr. Dolhun has sounded the alarm for a potential outbreak of endemic cholera, and rightly so, most outbreaks arise from common everyday pathogens that we all have in our own countries. Today, recovering the preventable tools that functionally mimic protective public health infrastructure such as clean water, safe sanitation, vaccine-preventable disease coverage, adequate shelter and reestablishing primary health care become emergent priorities. It is here that any alerts of a more critical outbreak will be first sounded.

As with so many issues in our discipline that concern volunteers and responders, this is an extremely complex one. There are no simple or obvious answers, and no simple set of policies to address this; each major event in terms of its ideology, geographic location, and health and socio-impacts will define the context that allows the best application of volunteers and responders. Looking to the future, this is an area that would be well served through a special issue of the journal. After all, the role of the journal and its parent society is to help ensure (1) a capable response; (2) that responders are ready, willing and able; and (3) that information provided from them will help provide the translational research so needed in this arena.

REFERENCE

1. Chu K, Stokes C, Trelles M, Ford N. Improving effective surgical delivery in humanitarian disasters: lessons from Haiti. *PLoS Med.* 2011; 8(4):e1001025. doi:10.1371/journal.pmed.1001025.