EDITORIAL

DISASTER PREPAREDNESS

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During the past decade, our country has faced several disasters requiring large-scale medical responses. Some of these disasters have been from such terrorist acts as the bombing of the Murrah Federal Building in Oklahoma City in 1995 and the terrorist attacks of Sept. 11, 2001. Some have been from such natural disasters as Hurricane Katrina in summer 2005. Regardless of the initial cause, mass displacements and injuries have required influx of medical providers, raising many issues for licensure boards.

We may not be facing the same crises now, at the time this editorial is written, as we did in the fall of 2005, but we will face future crises. Now is the time for us to consider the lessons we have learned from these events and to plan now for the next disaster.

The charge of licensure boards is to protect the public's safety by ensuring the individuals who practice under our auspices are capable and competent to perform the requisite tasks. In a time of a large-scale disaster, we need to define "public safety." Is public safety an absolute, or is it relative? What are the parameters? Can we maintain the same parameters for public safety in times of disaster and mass casualties, where the need is incrementally so much greater than we do at other times?

Typically, after a disaster, there is a large influx of people wanting to help. Experience has taught us, for various reasons, individuals pretend to be physicians. Medical licensing boards issue cards to their licensees, but these cards vary in appearance, design and resistance to counterfeiting. Even a robustly-designed card, though, does no good if the disaster occurs at the other end of the country, and local people do not know the appearance of a "valid" card from a distant board. People have discussed some form of national provider identification. Recognizing such a unique card would be easier, but the card would only indicate credentials possessed by an individual at the time the card was issued. Things may take place in the interim where individuals lose their licenses for cause, but this would not be indicated by their card.

Another suggestion that has been made is to create and advance some type of national provider list of privileged individuals. Again, such a list can be made, but how is one placed on the list and how is one removed? Members of medical boards know from experience hospitals will remove an individual's privileges, yet it may be many months, if not years, before such information is passed on to the medical boards for them to take action against someone's license. The question is: How do you maintain an accurate and current list? It is possible to create mechanisms to put somebody on the list, but how do you remove people from that list in a timely fashion?

A further complication is the issue of granting individuals privileges. While individuals may have licenses, these licenses for medical professionals typically cover the broad range of activities a physician and surgeon can perform. Being licensed as a physician and surgeon does not make me competent to perform certain types of surgery or treat other types of conditions. These decisions typically are addressed not by medical boards but by hospital privileging committees. Making these decisions will be a critical part of the disaster response.

Boards in affected areas face these problems plus additional ones. There maybe an influx of physicians willing to help. If the physicians come in under federal auspices, licensure may not be an issue. However, there may be a desire to bring in other physicians who will urgently and rapidly need licenses. Boards are limited in the actions they can take by their empowering statutes, and often these statutes do not provide means for such a response. These

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are considerations legislatures will need to address as we anticipate how to best prepare our nation for response to future disasters — either natural or manmade.

Another issue boards in affected areas may face is licensure of international physicians. Just as the United States often sends physicians to areas affected by mass disasters, other unaffected countries likewise offer assistance to the United States in times of crisis. The physicians who offer to come may be well-trained and qualified, but have no track record of licensure in the United States. As they may be totally trained abroad and do not have Educational Commission for Foreign Medical Graduates (ECFMG) certification, they may not qualify for licensure in a United States jurisdiction. However, they are skilled, caring, compassionate, competent and want to help. What mechanisms do we have for ensuring individuals who are capable and competent can assist?

A problem boards in affected areas may face is their very existence. If the board office is in the disaster area, it maybe unreachable. Is the board information available and can that information be utilized? Many boards back up their information, but if the board office cannot be used, can the board set up operations in a different location? Many boards back up their information and store it offsite, but the offsite location may be in the same city as the board office. We have seen recent natural disasters where entire cities become uninhabitable. It does not take much imagination to conceive of a terrorist act that could result in the same situation. Boards need to consider, based on their own unique situations, where backup copies of their information must be kept.

Lastly, terrorism comes in many guises, and electronic terrorism is now recognized to be one of them. Have boards reviewed all the possible scenarios for protecting their data and operations from electronic terrorist attacks? Boards need to consider the entirety of their security arrangements. Boards may have admirable protection, but if part of that protection depends upon the presence of a firewall within a state system and a hacker is able to gain access to another state computer in a less-protected agency, boards themselves may be left vulnerable. Large corporations with far more expertise than boards in electronic counter-measures, and with far larger information technology budgets than boards, have succumbed to electronic attacks. We struggle even knowing where to turn for information and guidance. Technological expertise is so highly-specific our support staff and our normal contractors may be unaware they lack sufficient knowledge.

These questions are difficult and complex. None have easy answers. The problems will remain and we will face these challenges in the future. The only uncertainty is to when they may occur. Let us take the opportunity now to shape our own agendas and develop our own plans for addressing these issues.

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