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The Disaster Workforce: Tales from the Trench a Discursive paper on Missionaries, Mercenaries and Misfits in the field

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Abstract
A. Aims*: The aim of this discursive article is to discuss the often-unreported issue of the lack of standardization of health care recruitment and competence in the workplace with health care professionals in the disaster environment whilst looking at the individuals it attracts. This will be taken from my personal experiences throughout my career and supported by the available literature.*

B. Background*: The Frequency of disasters is on the increase. With the surge of disaster response and disaster relief deployed by countries wanting to help, there must be a sufficient specialized workforce ready to respond. The inadequate and lack of standardization in the recruitment of healthcare professionals in disaster response is seen repeatedly, with evidence showing incompetent, undertrained, prepared, and unsuitable healthcare workers continuing to be deployed. Which increases risk, decreases continuation of care, and works against what we are used to in first-world countries. Of course, a disaster is not an everyday occurrence and will be different, but there need to be a "middle ground" and standards met regardless.*

C. Design*: This discursive paper is based on my experience and training in disaster settings as both a military and civilian nurse. It also critically analyses and highlights a gap in the literature around evidence-based recruitment of healthcare professionals in disasters.*

D. Method*: My personal experience identifies the problems of the workforce personnel and recruitment process in disaster. Pub Med and CIANAHL databases were utilized for the literature search.*

E. Conclusion*: The need for education, training, preparation, support, and standardization in disaster and the recruitment for disasters is explored in this paper and highlighted as an area that needs to be developed further, whilst highlighting the need for further research to be undertaken in these fields.*

Keywords*: disaster, disaster nursing, disaster recruitment, disasters nurse competencies,*
standardization, recruitment, specialized, organization, Non-Government Organisation (NGO).

A. Aims

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C. Design

This discursive paper is based on my experience and training in disaster settings as both a military and civilian nurse. It also critically analyses and highlights a gap in the literature around evidence-based recruitment of healthcare professionals in disasters.

D. Method

This is a discursive paper of my own personal experience on recruitment and identified problems of the workforce personnel in disaster. Pub Med and CIANAHL were the primary databases utilized for the literature search. Keywords being "disaster nursing," "disaster recruitment," "disasters nurse competencies".

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E. Conclusion

Disaster healthcare teams, especially nursing, are still considered a new specialty (Harthi et al., 2020). Therefore, the need to develop this further is huge. Identifying the problems faced in the field allows us to build on the support, training, and preparation along with relevant competence frameworks, the workforce, and the recruitment process need in the disaster field, which is paramount for an effective outcome. The lack of literature shows the need for further research and development, and Harthi (2020) supports the exact problem in disaster in which I faced and experienced on a personal level. Those being inadequate levels of preparedness and education, the ethical issues and issues regarding the roles of health care professionals in the field. With disasters becoming more and more frequent with the need to deploy specialized teams to help with response and recovery, the need for development and research into these fields need to be taken seriously, adapted, and created to fit each disaster globally with the recognition and education to all involved in the disaster. The training of specialized disaster healthcare teams and the incorporation of disaster management in all fields should be implemented with global education and collaboration with all agencies in the disaster field. Along with governance, good communication with the country is involved.

I. RELEVANCE TO CLINICAL PRACTICE

This article has raised several ethical and practical considerations around the recruitment and governance of disaster health care professionals. Therefore, highlighting the need for further research and development.

- Education and training to all health care professionals on disaster preparedness, response, and recovery. Health care professionals who aim to be on a response team having further training by the relevant organization prior to deployment.
- Standardization and fixed criteria for those on disaster response teams, with governance and communication from the country for deployment.
- Support and guidelines for all staff involved, including employers and managers receiving staff back into their normal roles.

II. INTRODUCTION

Back in 2005, I qualified as a Registered Nurse, having always dreamed of being a nurse from a young age. Like many of my colleagues, I had always had a keen interest in science and the human body. To apply that to an individual as a whole and look at the entire person also excited me. Having been able to look after someone, help them, and be given a chance to make a difference and play a part in their life when they are at their most vulnerable, is what drew me to the profession. It takes a particular kind of person to be a good nurse, and I felt that I had these traits and the fitness to not only do this but to go into the field of disaster, which is not suitable for all individuals. I am very resilient and have a passion for emergency care and disasters. I love nature and all which she is capable of, along with humanity, the need to survive, and different cultures worldwide.

Having been a nurse for the past 16 years with experience and training in emergency, military, and disaster, I have been exposed to many different situations and complications of disaster. No disaster is ever the same, and the management of a disaster needs to be individualized to the specific area, with the people affected being the focus (McGowan, 2017). This is a field and a realization in which complications and dilemmas are seen repeatedly, yet there seem to be limited lessons learned with no plan in place and the same problems recurring around the world. The importance of preparedness reduces the impact of the disaster as “prevention is better than cure”; however, financially, not enough countries are investing and developing it as much as they should. This includes preparing and educating communities along with teams to respond to disasters.

Today’s current climate with Covid-19 may change this situation. It may take a global pandemic, where every individual around the globe has been affected, whether it be direct or indirect, to listen and take note of disasters and the need for preparedness, along with the response and recovery. It is now during this pandemic that the need for disaster response teams, with a focus on preparedness for disaster, especially in health care, has been recognized. The catastrophic effect of this pandemic we can hopefully turn into a positive by preparing globally for future disasters and taking note that we can all be affected at any time. The training of specialized disaster healthcare teams and the incorporation of disaster management in all fields should be implemented, with education in all schools and workplaces being mandatory globally.

III. THE DISASTER WORKFORCE

The health care individuals needed in a disaster need to be quick thinking, experienced, skillfully, and very competent in their roles. They need to promote, protect, save and improve the health of the people affected and the surrounding communities (US Department of Health and Human Services 2018). These individuals can be Health Care Assistants, Nurses, Doctors, laboratory personnel, etc. However, to run a hospital, you still need all the other non-clinical staff to keep the hospital running too. Although these individuals will not be covered in this paper, they are extremely important in the everyday running of the hospital, and sometimes the role in which the health care professional is working under needs to take on one of these roles too. It is the close collaboration, skills, competence, and teamwork that makes a successful workforce in a disaster.

IV. WHO IS REALLY ATTRACTS

The individuals needed in a disaster workforce need to be quick-thinking. My experience is that certain types of individuals are attracted to the disaster field. There is already a saying that it attracts Missionaries, Mercenaries, and Misfits (Schulz, 2015; Stirrat, 2008), and I can understand this. The individuals I have worked with seem to be either very experienced which want to help the most vulnerable, individuals whose standards and practice are not up to speed and current so struggle in their own countries to remain in a job and those who go for the thrill of it and collectors of “stories”. They tend to act like the martyr but do not want to participate or work whilst deployed but take photos and tell people where they have been. So, the question is, are these people the correct people for the job and deemed competent at the recruitment process? Below I will discuss three classifications of individuals disaster attracts being the Mercenaries, Missionaries, and Misfits.

V. MERCENARIES

The Mercenaries in the field, as Stirrat (2008) depicts, are those who are out for self-interest and what material benefits they can gain from working in the international disaster industry with no morality at all. These are usually people who are with international development agencies who get paid well and lack competence whilst driving around a poor third world country in flash cars advertising the agency on the side. This interpretation by Stirrat (2008) and (Chambers 1983) is definitely accurate in my experience. It is not only the high pay these individuals are after but the publicity and “hero factor”.

These individuals want to put in the bare minimum work, often bragging to people of their experience. This is often characterized by frequent deployments, usually for short periods. They collect stamps on their passport, photographs for their social media, and war stories that they have usually heard from others or experienced themselves. Some have described this as voyeurism or medical tourism (Mahrouse 2016). Their skills are usually limited due to the swift transits between postings; however, this is often not identified as they can get by for a short period of time, pretending they know things and delegating to others in times of need.

VI. MISSIONARIES

Missionaries, “the good soles,” are often volunteers or religious affiliates who feel that they have a sense of duty to the people of the country. They will work at the level of the “real people “of that country, most volunteering or receiving a low income to do so. However, some health care staff can also be considered missionaries; these are usually experienced staff that is exposed daily to their specialty full time in the community. They are usually very current and up to date with the latest techniques and training. These are the people who are the angels of the disaster and humanitarian world, setting good examples for other workers. However, due to their full-time employment in their country, getting the time off to respond to a disaster is difficult. Usually, the hospital is already short-staffed and cannot cover the staff to deploy. This staff is known to use their annual leave to attend to a disaster instead of spending their time relaxing or with their families. The annual leave obviously is not endless, and then after a short deployment, this very experienced individual needs to return to their full-time role. This leads to a high turnover in deployments and loss of information, reduced rapport, skills, and disruption for all involved.

VII. MISFITS

Skirrit (2008) explains that the misfit category includes those who do not fit into the world of their own country. Giving them a place to escape, as I have witnessed myself. These are generally incompetent staff are those who struggle in the “real world”. They move from job to job and cannot keep up with the pace, training, and standards in a first-world job. They tend not to settle in a role long enough to be exposed or move on when they are. They generally have a low work ethic and chase well-paid jobs for as little energy as they can. These individuals usually find themselves in organizations where they can hide from the real world and in an environment where there is less accountability and diminished standards. Ethical implications where incompetent professionals are involved are massive. The impression given is that third-world countries where standards and reporting methods are not so stringent, they can get away with behavior that you can’t in a first-world country. It is these people using these opportunities to get paid whilst being able to travel and get an “easy gig”.

Some of these individuals are also collectors. Unethically collecting memorabilia, photographs, stories, and stamps on their passports. In this modern world where social media is a huge factor in most people’s lives, there are some individuals wanting to be seen as the hero on social media. There was a team of basic medics who turned up on the frontline with cameras on their helmets where they would film individuals injured at the battle. They would be working out of their scope of practice and competence levels, providing the wrong care, inflicting more injury, and causing more harm due to a lack of skills and knowledge. Then upload the footage on social media to gain popularity and earn money from and a form of voyeurism. The lack of governance for these “cowboy” teams and “medical tourists” is nonexistent in these unstable countries. Their bravado and eagerness surpass their clinical competence and scope of practice. Taylor (2014) gives examples of similar stories of individuals attending disaster for their own unethical gain, along with Gayle (2018), who reported on the sexual exploitation in Haiti by Oxfam workers.

VIII. DISCUSSION

A. The disaster nursing workforce issues

The standardization of criteria for all staff members to deploy to a disaster should be recognized and set. Although it is seen as a reasonably new specialty as Harthi et al. (2020) support that there is limited control and governance over Non-Government Organisations (NGOs) and other agencies. There have been instances where two individuals have set up their own NGO, raising money in their own country. Then visit the affected country, taken a few photographs to show their attendance, then spend it in high-end hotels and use it for a holiday in that country, as Taylor 2014 also gives evidence. The lack of governance on these NGOs also results in loss and more harm in a disaster due to the lack of knowledge, experience, ethics, and lack of expertise.

The need for governance and correct management to not only NGOs but to the staff, themselves is needed in the recruiting process. For example, a clinician who was of a personality not suitable for the role in such an environment was put in a situation that quickly became a risk not only to herself but to everyone else. She lacked resilience and was clearly mentally affected by the environment and work of looking after Ebola patients in an Ebola Treatment Centre. That much so that she went to walk into the red zone (contaminated zone) with no PPE. Luckily, she was stopped beforehand and was later debriefed, where she broke down and was evacuated home due to her being unsafe to herself and others. Naushad 2019 discusses the vulnerable high-risk groups of medical responders in disaster, the adverse psychological outcomes, and how managers and health organizations have moral responsibility.

In an environment where the clinician was surrounded by health professionals, you would have thought this would have been noted beforehand. Where people work and live so closely together. The same individual was later deployed to a war zone by the same agency, where it was clear to see that she was not the right individual for the job and mentally and physically struggled. When mentioned to the management team about this, they said that she was easier to manage than those other ex-pats who think they know best and speak up and cause friction in the team. It seemed as if they did not care about the individual's health nor the risk posed to surrounding staff, even unintendedly by the individual. This kind of management was seen over and over. Why perhaps due to the suitability and difficulty of getting the correct person in for the task at hand in the disaster environment.

This shows just one of the problems of having the wrong staff in an area of the disaster, which is unsuitable, and the potential risks and knock-on effect by poor management. Also, the collaboration of multicultural and mix of internationals in place can be difficult to manage. They all want to work with "how they do it in their country" and how some NGOs' are not aware there are available protocols and a book of standards such as the Sphere standards to follow in these situations due to lack of experience, understanding, qualifications and knowledge, even governance in the field.
The setting up of specially trained health care professionals will help the process of deploying teams to disaster and resilience whilst increasing their effectiveness. Whilst education and teaching some basics to all health care professionals around disaster and part of the education curriculum in all schools by giving them some basic knowledge to respond to disasters in which they are forced such as the current situation with covid-19. The need to incorporate disaster education into all training, including the curriculum and in-service training for all health care professionals, is supported by Achara & Kamanyire 2016.

B. Structure Training and Organisation

My experience with the military in the disaster is far more positive. Individuals have regular training, and there are systems in place. Hierarchy is always present to organize and run facilities, with everyone clearly knowing their given role. This organized structure has a far more positive and efficient outcome to some NGOs who may be new to the field and entering the disaster space with little or no experience, no staff support or training, and little ethical responsibility. Obviously, not all NGOs are like this, and there is some structure in the bigger NGO's however, it is lacking, and standardization is absent in the field and along with the governance of who can enter these disasters to respond as Thobaility, Plummer & Williams (2017) suggests. The outcomes are also markable different, with good team rapport and successful healthcare outcomes being more efficient and effective in a well-structured, competent organization. Muriuki (2020) explains the importance of all donors collaborating and working together in the field for more rapid and efficient service, while Labrague et al. (2017) proves that nurses do not feel comfortable, competent, and prepared for disasters so they can be their most efficient.

The need for good standards and strict competency criteria for recruitment in the field needs to be developed and fixed in the disaster world. Fair pay needs to be given to the "Mercenaries" of the field whilst working with the employers to recognize their input in such a major field. This will allow for a bigger influx in the very experienced and competent professionals needed in the field. The support of management both in and out of the disaster field is paramount. Good management to run facilities that recognize problems with their staff and address them properly for everyone's wellbeing and safety is needed. Whilst the support from people's manager and employers in their own country need to be on board. These employees can take back specialized skills from the field and training for both in their own country and in the field, along with being current and up to date in the clinical setting. Training and education on all areas of disaster should be given to all staff in healthcare facilities, even if they have no desire to deploy to a disaster.

This helps with preparedness for unforeseen events such as COVID-19. The need for more stringent procedures and accountability globally for these professionals needs to be put in place. The recruitment process needs to be tailored to account for this enabling only a good competent workforce with good ethics to deploy to disasters. This way, everyone's well-being will be looked after.

IX. CONCLUSION

Disaster healthcare teams, especially nursing, are still considered a new specialty, as Harthi et al. (2020) explain. Therefore, the need to develop this further is huge. Identifying the problems faced in the field allows us to build on the support, training, and preparation along with relevant competence frameworks, the workforce, and the recruitment process need in the disaster field, which is paramount for an effective outcome. The lack of literature shows the need for further research and development, and Harthi supports the exact problem in disaster in which I faced and experienced on a personal level. Those being inadequate levels of preparedness and education, the ethical issues and issues regarding the roles of health care professionals in the field. With disasters becoming more and more frequent with the need to deploy specialized teams to help with response and recovery, the need for development and research into these fields need to be taken seriously, adapted, and created to fit each disaster globally with the recognition and education to all involved in the disaster. The training of specialized disaster healthcare teams and the incorporation of disaster management in all fields should be implemented with global education and collaboration with all agencies in the disaster field.

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REFERENCES

[1] Achora S. and Kamanyire J.K., Disaster Preparedness. Need for inclusion in undergraduate nursing education Sultan Qaboos University Medical Journal, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4746037/., 16 (1)(2016).

[2] Chambers R, Rural Development: Putting the Last First. Longman Scientific and Technical, UK., (1983).

[3] Gayle D., Timeline: Oxfam sexual exploitation scandal in Haiti The Guardian https://www.theguardian.com/world/2018/jun/15/timeline-oxfam-sexual-exploitation-scandal-in-haiti., (2018).

[4] Harthi MA, Thobaity AA, Ahmari WA., and Almalki M., Challenges for Nurses in Disaster Management: A scoping Review https://www.dovepress.com/challenges-for-nurses-in-disaster-management-a-scoping-reviewpeer-reviewed-article-RMHP., (2020).

[5] Labrague LJ. Hammad K., Gloe DS., McEnroe-Petitte DM., Fronda DC., Obeidat AA., Leocadio MC., Cayaban AR. And Mirafuentes EC. (2017) Disaster preparedness among nurses: a systematic review of literature 65(1) (2017) 41-53 https://onlinelibrary.wiley.com/doi/full/10.1111/inr.12369

[6] Madhouse., War-Zone Tourism: Thinking Beyond Voyeurism and Danger: An International Journal for Critical Geographies, 15(2) (2016) 330-345

[7] McGowan D.M., Not All Disasters Are the Same: Understanding Similarities and Differences https://doi.org/https://doi.org/10.1016/B978-0-12-803638-9.00006-9 (2017).

[8] Muriuki DW. (2020) Contribution of NGOs in Complex Emergencies. https://www.who.int/hac

[9] Naushad VA. Bierens J., Purayil NK., Firjeet CP., Mohammad OS., Maliyakkal A., Chalihadan S. & Schreiber MD., A Systemic Review of the Impact of Disaster on the Mental Health of Medical Responders Prehospital and disaster medicine: The official journal of the National Association of EMS Physicians and the World Association for Emergency and Disaster Medicine in association with the Acute Care Foundation 34(6)(2019) 1-12 https://www.researchgate.net/publication/336652400_A_Systematic_Review_of_the_Impact_of_Disaster_on_the_Mental_Health_of_Medical_Responders

[10] Schulz S., Desire for the desert: racializing white teachers motives for working in remote schools in the Australian desert https://www.tandfonline.com/doi/abs/10.1080/13613324.2015.1110296?src=recsys&journalCode=cree20

[11] Stirrat., Mercenaries, Missionaries and Misfits Representations of Development Personnel Citique of Anthropology 28(4) (2008) 406-425

[12] https://www.researchgate.net/publication/258129820_Mercenaries_Missionaries_and_Misfits_Representations_of_Development_Personnel

[13] Taylor EB., Missionaries, Mercenaries and Misfits Foreigners in Haiti https://popanth.com/article/missionaries-mercenaries-and-misfits-foreigners-in-haiti.

[14] Thobaity AA., Plummer V., and Williams B ., What are the most common domains of the core cmpetencies of disaster nursing? A scoping review 31 (2017) 64-71 https://pubmed.ncbi.nlm.nih.gov/28029612/

[15] US Department of Health and Human Services., Public Health Emergency https://www.phe.gov/Preparedness/news/events/NPM18/Pages/help.aspx., (2018).