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Palliative Care Needs of People Affected by Natural Hazards, Political or Ethnic Conflict, Epidemics of Life-Threatening Infections, and Other Humanitarian Crises

Chapter: Palliative Care Needs of People Affected by Natural Hazards, Political or Ethnic Conflict, Epidemics of Life-Threatening Infections, and Other Humanitarian Crises

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Introduction

Traditionally, humanitarian healthcare response has focused primarily on saving lives and has lacked a concerted focus on preventing and relieving suffering. Yet the principles of humanitarianism explicitly require prevention and alleviation of human suffering,^{1,2} and the imperative of saving lives does not conflict with the imperative of relieving suffering in most situations.³ Patients deemed “expectant” (expected to die) often suffer severely before they die, and failure to endeavor to relieve their suffering constitutes unethical abandonment (see Chapter 15). During comfort-oriented care, triage should be repeated because it may reveal that a patient deemed expectant could be saved, either because the patient’s condition unexpectedly stabilizes or because additional life-saving resources arrive. Humanitarian crises may be triggered by natural hazards (earthquakes, major storms, tsunamis, floods, droughts), violent political or ethnic conflict, epidemics of life-threatening infections, release of radiation, or other disastrous events. However, humanitarian crises rarely are caused by a single factor and are usually the result of mixed natural, human-made, environmental, political and economic causes and vulnerabilities.³ The consequences may vary greatly depending on the causes, location, and vulnerability of the population they affect, but the consequences often include extensive loss of life and physical, psychological, social, and spiritual suffering on a massive scale (Table 2.1). The poor, the displaced (refugees and internally displaced persons), and those living in low-income settings generally are most vulnerable to unnecessary suffering and death because healthcare and social support systems in their areas may be weak, dysfunctional, inaccessible, unaffordable, overburdened, or destroyed.

Table 2.1. Common Symptoms and Forms of Distress Caused Directly by Humanitarian Emergencies *

	Ebola Epidemic	Earthquake	Genocide/War	Influenza Pandemic[†]
Pain	X	X	X	X
Dyspnea	X	X		X
Nausea/vomiting	X			

Diarrhea	X			
Fever	X			X
Fatigue/weakness	X			
Delirium	X			
Cough	X			X
Dizziness	X			
Conjunctivitis	X			
Oedema	X			
Acute stress reactions	X	X	X	X
PTSD	ND	X	X	
Other anxiety disorders	X	X	X	
Depressive symptoms	ND	X	X	
Stigmatized/social isolation	X			X
Complicated grief	ND	X	X	X

ND, no data; PTSD, post-traumatic stress disorder.

*Light gray indicates acute symptoms or distress, medium gray indicates chronic symptoms or distress, and dark gray indicates acute or chronic symptoms or distress, or both.

† Hypothetical.

Sources: WHO (2018);³ Leong et al. (2004);⁴ Rieder and Elbert (2013);⁵ MacNeil et al. (2010);⁶ Schieffelin et al. (2014);⁷ Dallatomasina et al. (2015);⁸ Mollica et al. (2004);⁹ Angeletti et al. (2012);¹⁰ Downar and Seccareccia (2010);¹¹ Roy et al. (2005);¹² Wu et al. (2014);¹³ Kristensen et al. (2012);¹⁴ Li et al. (2015);¹⁵ Caffo and Belaise (2003);¹⁶ Catani et al. (2008);¹⁷ West and von Saint André-von Arnim (2014);¹⁸ Teodorescu et al. (2015).¹⁹

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Natural Hazards: Earthquakes, Major Storms, Tsunamis, Floods

Sudden-onset disasters due to natural hazards commonly cause suffering and death on a large scale and also may devastate the social and medical infrastructure needed to care for the sick and injured (Table 2.2). In these situations, palliative care is needed:

1. By patients actively dying from acute injury;

2. By patients who may live for days or weeks with injuries or illnesses that are nonsurvivable in a disaster context or who develop nonsurvivable complications;
3. By patients not in immediate danger of dying but with moderate or severe symptoms;
4. By patients with pre-existing serious illness, disability, or frailty who have lost access to healthcare;^{20,21,22}
5. By family members of patients with any of the preceding conditions; and
6. By the severely psychologically traumatized or socially vulnerable.

Table 2.2. Types of Suffering of People Affected by Sudden-Onset Disasters, War, Political Conflict, or Ethnic Violence and Recommended Steps to Integrate Palliative Care into Humanitarian Responses

Type of Suffering	Recommended Palliative Care Responses to Suffering
Physical Suffering	
<p>Symptoms due to acute injury or illness</p> <p>Symptoms due to injury-related complications and subacute or chronic illnesses</p>	<ul style="list-style-type: none"> • Put in place policies clarifying that humanitarian medical assistance aims to both save lives and relieve suffering • Develop protocols for a minimum standard of symptom assessment and treatment, and for care of expectant patients, by international and national emergency medical teams (EMTs) and local healthcare providers. • Train and equip EMTs and local healthcare providers to reach a minimum standard of symptom assessment and treatment and care of expectant patients. • Include the essential package of palliative care medicines and equipment for humanitarian emergencies and crises in all emergency health kits; ensure that oral and injectable morphine are included in all kits and are both secured and accessible in adequate quantities by EMTs and local healthcare providers. • Include in all type 1 EMTs at least one physician and nurse with at least basic palliative care training. • Include in all type 2 and 3 EMTs at least one physician with at least intermediate palliative care training and that all anesthetists and anesthesia technicians have at least basic palliative care training.
Psychological Suffering	
<p>Acute psychological effects (including acute anxiety, acute depressed mood, acute grief)</p> <p>Chronic psychological effects (including PTSD, chronic anxiety disorders, chronic depression, complicated grief, survivor's guilt, substance use disorders)</p>	<ul style="list-style-type: none"> • Train EMT staff members and local healthcare providers in psychological first aid (PFA) • Train and equip EMTs and local healthcare providers with protocols for psychological symptom assessment and treatment • Include the essential package of palliative care medicines and equipment for humanitarian emergencies and crises in all emergency health kits; include oral fluoxetine, injectable diazepam, and oral and injectable haloperidol in all kits so that they are accessible in adequate quantities to EMTs and local healthcare providers.²¹ • Train and equip all EMTs in palliative care as described earlier. • Seek partnerships with local community and spiritual leaders for advice on cultural values and beliefs relevant to mental illness and to inform the local community about the EMTs' activities.

	<ul style="list-style-type: none"> • Recruit local mental health care providers who can provide culturally and linguistically appropriate care and advise foreign team members on cultural values and beliefs relevant to mental illness. • Offer training to local volunteers to provide basic mental health interventions as appropriate. • Organize support groups for patients and survivors who may wish to share experiences and challenges. • Include mental health care providers in humanitarian response teams that are likely to encounter many patients with mental health consequences.
Social Suffering	
<p>Loss of access to shelter, clothing, food, sanitation, protection from violence, school (for children)</p> <p>Extreme vulnerability (including frail older people, unaccompanied children, people with mental or physical disabilities, people living in extreme poverty)</p>	<ul style="list-style-type: none"> • Ensure access to shelter, clothing appropriate to climate and culture, food, sanitation, school. • Seek to arrange protection from physical or psychological abuse. • Organize support groups for patients and survivors who may wish to share experiences and challenges.
Spiritual Suffering	
<p>Loss of sense of meaning of life</p> <p>Loss of faith or angry with God</p>	<ul style="list-style-type: none"> • Seek partnerships with local spiritual counselors willing to visit patients and family members on request.

Sources: WHO (2018).³ Adapted from IASC (2007);²⁸ Smith and Aloudat (2017);²⁹ Knaul et al. (2018);³⁰ Krakauer (2018).³¹

In the immediate aftermath, surgical and life-sustaining resources often are inadequate to the need.²³ However, emergency medical teams (EMTs) always should be equipped to provide palliative care. The essential package of palliative care medicines and equipment needed for safe and effective symptom control is small and inexpensive (see Chapter 13),³ and WHO has published model guidelines to enable transport of controlled medicines such as morphine across international borders for emergency medical care.²⁴ Governments and humanitarian organizations also should help ensure that local healthcare providers in hospitals and in the community have adequate palliative care training and supplies, particularly in areas most at risk for sudden-onset disasters.

Earthquakes

Earthquakes commonly cause collapse of buildings with resultant crush injuries and associated symptoms of pain, dyspnea, and psychological trauma, among others. Immediate and ongoing pain relief and psychological support should accompany surgical, critical, and rehabilitative care. Many rescued victims of earthquakes die weeks later of complications, such as local or systemic infection related to wounds, renal failure due to rhabdomyolysis, or sequelae of lacking food, shelter, or medicine for chronic conditions. Patients may suffer from any number of physical and psychological symptoms depending on their specific medical, psychological, and social situation.

Tsunamis

Tsunamis often cause both traumatic injuries and health problems distinct from those caused by other natural hazards.^{25,26} These include the following:

- Aspiration pneumonitis

- Respiratory infections, often with rare or drug-resistant pathogens
- Respiratory failure due to pneumonitis or infection
- Soft-tissue infections with rare or drug-resistant pathogens
- Tetanus

Integrated critical care and palliative care is needed for patients with respiratory failure or tetanus.

Major Storms and Floods

Major storms and floods may not only destroy or incapacitate healthcare facilities but also cut them off from resupply. Hospitals and long-term care centers in areas commonly affected by storms and floods should have evacuation plans in place, a backup generator, and at least a 10-day supply of oxygen, food and water, basic antibiotics, essential medicines for noncommunicable diseases, and all items that constitute the essential package of palliative care (see Chapter 13).^{3,22}

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War, Political Conflict, and Ethnic Violence

War, political conflict, and ethnic violence commonly cause many types of suffering on a vast scale due to injuries (Table 2.2).²⁷ Beyond acute physical and psychological trauma, destruction of local infrastructure and services and mass displacement can result in exposure to still more violence and to harsh climates. These conditions also may result in malnutrition and in infectious outbreaks among the population. Often, most displaced persons are women, children, and older adults, who are especially vulnerable to exploitation, sexual abuse, rape, and torture.³²

Pain should be treated aggressively in any patient. Acute and chronic anxiety, depression, post-traumatic stress disorder (PTSD), and complicated grief are common sequelae that humanitarian responders should be prepared to diagnose and treat (Table 2.1). Basic training in mental health and psychosocial support (MHPSS) should be included in palliative care training for humanitarian responders, as it equips them to provide focused, nonspecialized psychological support, such as psychological first aid (PFA) and treatment of uncomplicated adjustment disorder and mood disorders, for affected persons and for responders.³³ Psychiatrists and psychologists can be helpful in planning and implementing specialized mental health care for affected persons and responders.²⁸ Spiritual counselors with experience in palliative care or disaster response also can be helpful in planning and implementing psychological and spiritual support (Table 2.2).

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Epidemics of Life-Threatening Infections

During epidemics of life-threatening infections, suffering may result from both the disease and the medical or public health response. Thus, it is important to train EMTs and local healthcare providers to anticipate adverse effects of treatment and to apply preventative measures as appropriate.

Disease symptoms vary depending on the infection (Table 2.1). Some epidemic infections result in physical, psychological, social, and spiritual suffering. Physical symptoms of Ebola infection typically include nausea, vomiting, diarrhea, body aches, fever, and, in late stages, bleeding, respiratory distress, and encephalopathy.³⁴ Aggressive control of nausea, vomiting, and diarrhea not only relieves unnecessary suffering but also can protect against volume depletion and electrolyte derangements and hence may improve survival. It also can reduce contamination of enclosed, shared spaces within Ebola treatment units with virus-laden body fluids, hence lessening the risk of transmission to healthcare workers. In some widespread life-threatening infections, such as multidrug-resistant tuberculosis, adverse reactions to treatment commonly cause significant suffering and make adherence to treatment difficult.³⁵ Thus, pain and symptom control is crucial for a variety of reasons.³

Quarantine of people exposed to an epidemic life-threatening infection and isolation of those with active infection may be necessary from a public health perspective. However, the benefits and harms should be considered carefully because quarantine and isolation typically exacerbate psychological and social suffering.^{28,36} Quarantined and isolated patients often feel anxious, sad, and dehumanized. Thus, patients' time in isolation wards should be kept to the minimum time necessary for infection control, and the wards should be organized to enable patients to communicate with family members and friends at a distance or with mobile phones. Patients should be informed regularly about their condition and prognosis in a way appropriate for their culture and education and literacy level. Voluntary psychosocial support groups can be organized for patients, survivors, and bereaved family members, psychosocial supporters, local spiritual counselors, and mental health staff members should receive infection control training and equipment necessary to safely visit infected patients. Psychosocial supports should remain accessible to survivors and family members (especially orphans) who may continue to suffer from mental health problems, stigmatization, social isolation, and extreme poverty.³⁷ Community education can be conducted to reduce fear and stigma and improve infection control, and community reintegration programs for survivors can be organized with community or religious leaders.

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Nuclear Detonation

A nuclear war would result in sudden and prolonged suffering and death on an unprecedented scale owing to physical and psychological trauma, burns, radiation sickness, epidemic disease, starvation, and exposure to the elements. Thus, all healthcare providers should advocate intensively for abolition of nuclear weapons and prevention of war.³⁸ To advocate effectively, and to prepare to respond as effectively as possible to this suffering, it is important to anticipate what specific needs would arise. Acute radiation syndrome (ARS) typically involves three phases. The duration of each depends on the total radiation dose and the rate at which it is delivered. After initial radiation exposure there may be a prodromal phase, with symptoms such as nausea, vomiting, and lethargy. During the latent phase, a person feels relatively well before developing the phase of organ system dysfunction. The organ systems most susceptible to radiation injury are, in order of vulnerability, the hematological system, the gastrointestinal tract, the skin, and cerebrovascular system. Patients who receive a high level of exposure typically develop severe organ system failure, have a very poor prognosis, and should receive comfort-oriented care.³⁹ The psychological trauma of a nuclear detonation may result in acute stress disorder, PTSD, anxiety disorders, major depression, complicated bereavement, unexplained physical symptoms, sleep disturbance, family conflict and violence, and substance use disorders.⁴⁰

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Triage

Regardless of the types of humanitarian crisis or the types of suffering it causes, several principles apply to the triage process (Table 2.3):

1. Palliative care and life-saving treatment should not be regarded as distinct. Palliative care should be integrated as much as possible with life-saving treatment for patients with acute life-threatening conditions (triaged red).
2. Palliative care must be provided for all patients deemed expectant (triaged blue) and should commence immediately.⁴¹
3. Palliative care should commence immediately, as needed, for patients with non-life-threatening conditions whose injury- or disease-specific treatment may be delayed (triaged yellow).
4. Repeat triage should be practiced, especially for patients triaged blue and yellow, to make sure that important changes in the patient's condition that should result in a change in triage category are not missed.

Table 2.3. Recommended Triage Categories in Humanitarian Emergencies and Crises

Color

Category	Code	Description
1. Immediate	Red	Survival possible with immediate treatment. Palliative care should be integrated with life-sustaining treatment as much as possible.
2. Expectant	Blue	Survival not possible given the care that is available. Palliative care is required.
3. Delayed	Yellow	Not in immediate danger of death, but treatment needed soon. Palliative care and/or symptom relief may be needed immediately.
4. Minimal	Green	Will need medical care at some point after patients with more critical conditions have been treated. Symptom relief may be needed.

Source: WHO (2018).³

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