Haiti Disaster Tourism—A Medical Shame

Daniël J. Van Hoving, MMED;[1] Lee A. Wallis, MD;[1] Fathima Docrat, MBBCh;[2] Shaheem De Vries, MPhil[1]

1. Division of Emergency Medicine, Stellenbosch University/University of Cape Town, Cape Town, South Africa
2. Product Physician (Pain and CNS), Pfizer, South Africa

Correspondence:
D.J. van Hoving
PO Box 897
Bellville 7535 South Africa
E-mail: nvhoving@gmail.com

Keywords: disaster; disaster tourism; earthquake; Haiti

Abbreviations:
NGO = non-governmental organization

Received: 15 March 2010
Accepted: 15 March 2010

Web publication: 03 June 2010

Abstract

The devastating Haiti earthquake rightly resulted in an outpouring of international aid. Relief teams can be of tremendous value during disasters due to natural hazards. Although nobly motivated to help, all emergency interventions have unintended consequences. In the immediate aftermath of the earthquake, many selfless individuals committed to help, but was this really all in the name of reaching out a helping hand? This case report illustrates that medical disaster tourism is alive and well.

Van Hoving DJ, Wallis LA, Docrat F, De Vries S: Haiti disaster tourism—A medical shame. *Prehosp Disaster Med* 2010;25(3):201–202.

Introduction

On 12 January 2010, a 7.0 magnitude earthquake crumbled the capital of Haiti to the ground. The world watched as this devastating event resulted in an outpouring of international aid and well-intentioned disaster relief teams raced to Port-au-Prince to help. But was this really all in the name of reaching out a helping hand, or were we witnessing disaster tourism?

Three authors were volunteers who responded in the immediate aftermath of the earthquake, where, among the many selfless individuals committed only to doing the right thing, we experienced disaster tourism first-hand. Our ordeal illustrates that medical disaster tourism is alive and well; we wonder whether the medical fraternity should hang its head in shame.

Disaster Tourism—Alive and Well

Our team arrived in Port-au-Prince on 20 January, one week after the initial earthquake. Once in Haiti, the South African contingent joined forces with their Mexican counterparts. The combined group of experienced practitioners included an anesthetist, a general surgeon, emergency physicians, general practitioners, and advanced life support paramedics. We worked together through a local relief agency, and assisted at a hospital in Port-au-Prince where we helped the local doctors in the out-patient clinic, did rounds on the in-patients (who were lying outside), and set up a makeshift surgical theatre (used mainly for wound debridement). While we make no presumptions that our contribution was flawless, we followed best practices and worked in conjunction with the local health system.[1]

One afternoon, out of the blue, two other international medical teams arrived in our location. While we welcomed the prospect of additional hands, the attendant media group was unexpected. Without any consultation with any parties on-scene, the new medics started to see patients, leading to unnecessary re-assessments, duplicating painful wound checks, and so on: all in the glare of the television cameras. Often stopping to be interviewed by the television crew or to pose for photographs, they eternalized their humanitarian deeds. The patients, unable to communicate due to language barriers, appeared to accept the care (after all, these foreigners are experts who travelled thousands of miles just to help them: who wouldn't be thankful?).

Just then, an elderly man arrived with a badly injured leg. After our assessment, it was clear that his prognosis was very poor, and we suggested conservative management due to the extremely limited local resources. The other team, however, demanded that the man be operated on and that they will assist because of their "extensive surgical experience". The television crew captured

every moment, including a dramatic last minute interview with the new "surgeon". As may be expected, everything that could go wrong went wrong, and the patient died. The "surgeon" subsequently informed us that he is actually a general practitioner who did some surgery about 20 years ago.

The bus arrived, the medical crews got onboard with the media entourage, and—after a last "did-what-I-could" shrug of the shoulders—we had our last view of the medical disaster tourists. Then, the deceased man's family arrived, being (understandably) very upset and angry. They demanded an explanation from us; what could we tell them? We had no reasonable answers to provide.

Humanitarian Aid versus Disaster Tourists

Humanitarian aid is the perfect opportunity to fulfil the deepest desire of any healthcare worker—the desire to help others in need.[1] On the other hand, a *disaster tourist* may be defined as a person heading to the site of a disaster to see the destruction, take pictures, obtain bragging rights, and get the shoulder badge. Man has forever been a curious being, and with television desensitizing us to tragedy, people want a true taste of authenticity. Everyone wants to experience everything firsthand.[2]

Surely medical professionals are not like that! We strive to practice evidence-based medicine. We improve patient safety through regular morbidity and mortality meetings and continuous quality improvement programs. We strive to respect and protect our patients' rights. Furthermore, our profession is governed by strict ethical rules, with healthcare councils quick to reprimand anyone who steps out of line. But does the same set of rules apply in disasters?

International Relief—Hindrance or Helping Hand?

Aid from all over the world starts to pour in as soon as a disaster strikes. This is fuelled even more when the media focuses the world's attention on it.[3] Massive relief efforts were seen after the earthquake in Iran (2003), the Asian tsunami (2004), and again with the Haiti earthquake (2010). Help is offered mainly as donations, but there also is an influx of dedicated and experienced people volunteering their time and skills. These include government teams, non-governmental organizations (NGOs), and even individuals pitching up on their own to assist those in need. These volunteers are nobly motivated to help, but all emergency interventions have unintended consequences.[4]

Professional humanitarian workers have mixed feelings about the influx of "foreign disaster relief experts". Sometimes, the responders are poorly suited to help, with little or no experience in international relief, poor understanding of the local culture, and usually have no relationship with either local agencies or the affected population. This influx phenomenon has been described as "disaster tourism" or "parachuting".[4] This has an adverse impact on relief efforts, and may dim local receptiveness to foreign help.[4,5] Disaster tourists may cause harm by depleting scarce resources (like food and water), using culturally inappropriate methods, or by violating security precautions.

The Achilles' heel of most emergencies remains poorly coordinated efforts. This results in an uneven allocation of support and sub-optimal care that do not always satisfy the local needs.[1,4,6–8] This view is supported by survivors of the Bam earthquake who scored the medical care provided only as "moderate".[9] Poor coordination further results in duplicate assessments leading to assessment fatigue of those in need, as well as increasing feelings of frustration and resentment.[4] The lack of accountability and credentialing from independent relief teams are further areas of concern.[10]

- Non-governmental organizations are eager to provide urgent support and impatiently bypass governmental bureaucracies and politics.[4] This may be the result of the constant battle between NGOs as they compete for funding for their cause.[1] They have diverse goals and often create a parallel service that may serve to weaken the capacity and credibility of combined efforts.[4,10] Competitive humanitarianism is not only destructive but also leads to poor utilization of skilled resources.[1] Furthermore, their services usually are unsustainable: they may raise expectations, but then leave after a short period, resulting in feelings of abandonment by the local population.[1,4]

However, disaster relief teams can be of substantial value when they are fully self-sustained and capable of delivering definitive care as well as managing the day-to-day cases that are unrelated to the disaster. This can be accomplished by erecting fully-equipped field hospitals while working with the United Nations and local government.[6,7,11,12]

Good Intentions Aren't Enough

International relief teams have a role in disasters, but must be careful not to become a hindrance. Make sure of your personal intentions before packing your bags. Put yourself in the victim's shoes, and ask yourself if this is the best way to help those in need. Work with an experienced relief agency and leave the media at home.

If you crave media attention and the world's spotlight, do disaster victims a favor and stay at home; disaster relief is hard enough for everyone involved. We plead to medical relief workers to embrace our medical code and strive to provide the best medical care possible at all times, even during disasters.

References

1. Welling DR, Ryan JM, Burris DG, *et al*: Seven sins of humanitarian medicine. *World J Surg* 2010;34(3):466–470.
2. Disaster tourism: Vulgar voyeurism or honest altruism? Available at: http://www.women-on-the-road.com/disaster-tourism.html. Accessed 25 February 2010.
3. Sondorp E, Bornemisza O: Public health, emergencies and the humanitarian impulse. *Bull World Health Organ* 2005;83(3):163.
4. Wessells MG: Do no harm: Toward contextually appropriate psychosocial support in international emergencies. *Am Psychol* 2009;64(8):842–854.
5. Seyedin SH, Aflatoonian MR, Ryan J: Adverse impact of international NGOs during and after the Bam earthquake: Health system's consumers' points of view. *Am J Disaster Med* 2009;4(3):173–179.
6. Abolghasemi H, Radfar MH, Khatami M, *et al*: International medical response to a natural disaster: lessons learned from the Bam earthquake experience. *Prehosp Disaster Med* 2006;21(3):141–147.
7. Lee VJ, Low E: Coordination and resource maximization during disaster relief efforts. *Prehosp Disaster Med* 2006;21(1):s8–s12.
8. Cumberland S: Groundbreaking approach to disaster relief. *Bull World Health Organ* 2008;86(9):661-663.
9. Saghafinia M: Survey of the Bam earthquake survivors' opinions on medical and health system services. *Prehosp Disaster Med* 2008;23(3):263–268.
10. Zoraster RM: Barriers to disaster coordination: health sector coordination in Banda Aceh following the South Asia Tsunami. *Prehosp Disaster Med* 2006;21(1):s13–s18.
11. Owens PJ, Forgione A, Briggs S: Challenges of international disaster relief: use of a deployable rapid assembly shelter and surgical hospital. *Disaster Manag Response* 2005;3(1):11–16.
12. Redmond AD: Natural disasters. *BMJ* 2005;330:1259–1261.