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# Socio-cultural Considerations in Mass Decontamination

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It is an unfortunate reality of our era that health systems will have to deal with the stresses of patient decontamination. Whether the result of terrorism or the byproducts of industrialized society, the potential for radiological, chemical, and biological contamination is all around us. Hospitals must be prepared to deal with the operational and safety issues posed by decontamination, an issue that has been largely addressed through the allocation of government funding towards the development of guidance, training, and equipment purchasing throughout California. However, one of the most complicated aspects of decontamination operations is crowd control and one of the best ways to maintain crowd control is to take a "community-care" approach.

How does this community-care concept differ from how first responders and health systems currently deal with decontamination? It's primarily a matter of objectives. First responders have public safety as an objective – making sure the contaminated victims have the best chance at survival while containing the danger posed to the public. Hospitals similarly have the safety of their staff and patients as their primary objective. While critical, this may prove counter-productive if not balanced with consideration for the contaminated victims. Community-care is realizing that some steps mitigate harm while other steps do more harm than good.

One example of poorly executed community-care is the pesticide release incident in Earlimart, CA. In 1999 a release affected around 250 people. First responders forcibly stripped victims and sprayed them down in a field while the media cameras watched. Victims described feeling as if they were sexually assaulted, there was a massive backlash against the department by the community, and new legislation was enacted to prevent this kind of incident from recurring.

First responders have learned from these lessons, but hospitals are still struggling because of inexperience. The idea of receiving large amounts of contaminated patients is daunting enough for most hospitals that they take a very rigid approach – everyone strips all the way down, everyone gives up his/her personal effects, and anyone who doesn't cooperate gets turned away. In practice, this kind of hard-line approach may well lead to chaos.

From a practical perspective, if you remove victims' adaptive devices, such as canes, glasses, hearing aides, etc. you've further impaired your victim population. The subsequent increase of special-needs victims is now a larger strain on your hospital resources. From an emotional perspective, controlling victims in a panicked state is a difficult proposition. Compounding that by

taking their wallets, removing their wedding rings, and stripping their children in public could well turn a panicked victim into a violent assailant. The victim does not share your objective of protecting your staff and patients.

Community-care aligns the objectives of the victim with the objectives of the health system without compromising either. Looking at the patients, staff, and victims together as a community means pragmatically tailoring objectives in ways that make sense. If the ultimate goal is to protect the current patients and staff while providing care to the victims, then reasonable measures can be taken to reduce danger to patients and staff without increasing danger by agitating and/or further impairing the victim population.

History offers some great perspective on the risk / benefit analysis in situations like this. Recently the TSA discovered something important related to their full-body scan technology – people don't like to be seen naked, even if it's for their own safety, virtual, and viewed remotely. Boycotts at airports clogged up travel and people protested angrily. In October the US Supreme Court upheld a Muslim woman's right to sue Orange County because deputies jailed her and forced her to remove her hajib in the presence of men.

On the other hand, OSHA found that incidences of hospital staff being injured by contaminated patients are very low. A review of more than 2,500 hazmat incidents from the Agency for Toxic Substances and Disease Registry (ATSDR) Hazardous Substance Emergency Events Surveillance system shows that hospital workers were only injured in 0.2% of incidents and that none of those injured needed hospitalization. Even though 640 patients entered health systems without being decontaminated during the 1995 Tokyo sarin gas incident, all of the exposed health care workers were able to continue their duties.

This isn't to say decontamination should be avoided or done incompletely. It is merely to say that consideration should be given to the level of risk posed by the contaminant versus the level posed by violating social and cultural practices. Privacy, communication, and care are all critical components of a balanced and effective decontamination response.

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