Emerging Horizons of Clinical Engineering in Disaster Preparedness and Management: Proposal for an expanded professional identity

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ABSTRACT

The COVID-19 pandemic of 2020 has exposed a wide range of systemic deficiencies in public health strategy, poor alignment of global health and economic institutions, insufficient budgeting, and the urgent need for real-time management of scientific resources, rapid-cycle clinical innovations, competent political decision-making, and supply chain logistics under disaster conditions. This article proposes that a new model of multi-disciplinary professional skills is needed globally to re-engineer existing public and private healthcare systems for both normal and disaster conditions. Clinical engineers are recommended to play a growing role in future global disaster management and systems integration activities, owning in large part to their multifunctional expertise in technology assessment, hospital operations, and as stakeholders in healthcare innovation. Twenty-six recommendations are presented as foundational strategies to create a 21st century model of globally aligned healthcare systems, centered on the growing role of clinical engineers as subject matter experts in both normal and disaster conditions.

Keywords – disaster preparedness, clinical engineering, systems engineering, alternate sites of care, health technology design, dual-use infrastructure.

INTRODUCTION

GLOBAL DISASTER UNPREPAREDNESS

The global COVID-19 crisis of 2020 has thrown a global spotlight on the many ways in which healthcare systems, medical industries, markets, and healthcare professions have been unprepared, under-resourced, tragically slow and uncoordinated in responding to the most disruptive medical disaster of our times. Despite numerous threat-analysis studies, detailed pandemic scenarios, and simulations by state and federal agencies, despite trillions of dollars spent on post-9/11 international disaster preparedness, and repeated top-level’s warnings by epidemiological and public health experts, the world’s governments, markets, and healthcare systems have failed to prepare and prevent a health disaster from exploding into a multidimensional catastrophe.

The fragmentation of plans and competencies across sectors – complicated by political decision-making – clearly demand mission-critical reorganization among the institution players, with more coordinated, integrated, and systems-oriented professional approaches worldwide, and active cultivation of public health intelligence. For the reasons that follow, clinical and biomedical engineers are among the best-suited health professionals to assume an expanded and more comprehensive leadership role as subject matter experts in this urgently needed transformation, particularly following the recent adoption of the recommendations of the UN High-Level Commission on Health Employment and Economic Growth, the WHO Global Strategy on Human Resources for Health, and the establishment of national health workforce accounts. In particular, the WHO analysis and recommendations in “Human Resources for Medical Devices” provide a transformational vision for Biomedical and Clinical Engineering worldwide that strongly harmonize with the recommendations contained in this article.

WHY CLINICAL AND BIOMEDICAL ENGINEERS?

Traditionally, Clinical Engineers and Biomedical Engineers are professionally prepared to perform a very broad range of overlapping clinical, technical and operational tasks – working from bench innovations to bedside care, including the design and assessment of medical devices and their internal components, to the management of complex hospital infrastructures and supply chains, encompassing possibly hundreds of device families, models, network interfaces and “care-anywhere” services via telehealth and telemedicine. For the purposes of this article, the term “Clinical Engineer” (CE) will be used to encompass both biomedical and clinical engineers, because clinical engineers (and clinical systems engineers) typically have the widest, multi-systems professional orientations and skillsets that are well-suited to the often improvisational complexities of disaster preparedness and management in healthcare systems.

Beyond individual hospital operations, CEs may also be involved extramurally in standards development and technology assessment organizations, research and clinical trials, innovation consortia, startups, professional associations, and consultations to ministries of health and the World Health Organization. As such, they can have wide-ranging, inter-institutional experiences that are directly relevant to the multi-systems challenges of disaster preparedness and management. Although they may work with different job titles and tasks different professional education and certifications around the world, CEs share a common mission to optimize safety, efficiency, cost controls, and healthcare quality through the application of systems-oriented engineering expertise that encompasses not only devices, but processes, human resources, procurement, risk management, and strategic planning. These integrative skillsets take on even greater importance in disaster circumstances. Compared to many other vertically-specialized professions in healthcare, the multi-disciplinary, intersectoral span of professional relationships in CE provides a unique foundation to bring a more coherent, rapid-cycle integration of science, technology, standards, regulation, institutional strategy planning, and execution.

As science and technology have advanced with increasing velocity and scope, these life-saving engineering professions are also evolving and expanding to incorporate new tools and processes into increasingly complex healthcare systems. The successful incorporation of emerging knowledge and urgent innovations under disaster circumstances requires new categories of professional expertise and institutional alignments. Because of their wide-ranging organizational knowledge and technical skillsets, CEs are uniquely prepared to become the next generation of multi-disciplinary experts who can help cultivate the systemic organizational intelligence and planning that is increasingly indispensable for modern healthcare, as well as for disaster preparedness and management.

PROPOSAL FOR AN EXPANDED PROFESSIONAL IDENTITY

THE GROWING NEED FOR SYSTEMS EXPERTISE FOR BOTH NORMAL AND EMERGENT CONDITIONS

As innovators in the medical device industry, CEs may be involved in highly specialized research aimed at diagnosing or improving diagnostic devices, monitoring, or therapeutic devices that are technically complex, multifunctional, networked, and designed for “precision medicine” that may disrupt traditional clinical and business practices. As managers of a clinical operations infrastructure, CEs may be responsible for the 24 x 7 hospital requirements for maintenance and repairs, for health experts, the world’s governments, markets, and as stakeholders in healthcare innovation. Twenty-six recommendations are presented as foundational strategies to create a 21st century model of globally aligned healthcare systems, centered on the growing role of clinical engineers as subject matter experts in both normal and disaster conditions.

INTERNATIONAL CLINICAL ENGINEER ASSOCIATIONS

As innovators in the medical device industry, CEs may be involved in highly specialized research aimed at diagnosing or improving diagnostic devices, monitoring, or therapeutic devices that are technically complex, multifunctional, networked, and designed for “precision medicine” that may disrupt traditional clinical and business practices. As managers of a clinical operations infrastructure, CEs may be responsible for the 24 x 7 hospital requirements for maintenance and repairs, for
assessing new technologies, managing installations and upgrades, project and team coordination, scheduling maintenance and repairs, coordinating IT integration, facility design consultation and new facility provisioning, cross-functional troubleshooting with IT, end-user training, vendor and supply chain management, surge capacity planning, replacement planning, service-level agreements, budgeting, technology assessment, risk management, hazard alerts and recalls, and emergency preparedness.

Because CE's may span such vast areas of expertise26-28 that are essential to the quality and reliability of day-to-day healthcare services, they are at the same time uniquely positioned to be recognized as systems-oriented, subject matter experts who can help repair and re-engineer the prevailing fragmentation in disaster preparedness and management.

AN ACTION PLAN FOR THE FUTURE

This article provides a very condensed compilation of technological, organizational and professional recommendations that will enable CE's, clinical systems engineers, and biomedical engineers to build upon their existing system lifecycle expertise and assume wider institutional roles in disaster preparedness (DP) and disaster management (DM). Although the current global concerns are for pandemic response, the following topics will be equally relevant for all-hazards disaster conditions, as well as for improving normal strategic and operational efficiencies and resilience of clinical systems, ensuring a more robust, integrated infrastructure for future events. Because of the inherent complexities of normal healthcare operations, where it is necessary to work in a 3-to-5-year planning window to make significant changes, it is likewise necessary to begin planning now during the 2020 COVID-19 pandemic, to deliver the global systems improvements that will be necessary to prevent, mitigate and better manage future disaster challenges 5 to 10 years from now. These expanded CE competencies will fill critical gaps that may be perfect for normal circumstances, but be more important than the application of known, but overly specialized answers which may risk delivering obsolete or disjointed solutions. The world is clearly in need of professional expertise that can help compress and align the scientific, technological, and operational timelines for life-critical innovations and successful implementation under extraordinary circumstances.

We cannot allow these monumental challenges to deter us from the necessity, now being proven worldwide, to forge a radically different, long-term model of public health stewardship and institutional capabilities that are suited simultaneously to both normal and disaster conditions. The world is already fortunate this day to have many gifted CE's around the world who are ready for such a noble quest – highly educated, energetic, caring, creative, expert in the complex lifecycles of healthcare systems, and now, tested by the high-velocity change, logistical chaos, global uncertainty, economic disruption and human sufferings imposed in the 2020 pandemic. In the coming years, let there be no doubt how these quiet heroes rose to the occasion.

RECOMMENDATIONS

(\textit{Note: Additional in formation and links for many of the following recommendations can be found in the RE-SOURCES section at the end of this document, grouped by topic})

1. Understand your existing local, national, and international frameworks of DP and Management. Don't re-invent the wheel. Investigate with your Ministry of Health and Emergency Preparedness agencies, public health agencies, and local hospitals to identify existing agreements, processes, and resources.

   a. United Nations, WHO, OCHA, CADIR, UN Clusters (UNISDR, UNRCC, IFRC, IOM, FAO, WFP, UNDP, UNICEF, Save the Children), IFRC, ICR, Sendai Framework, GDACS, OS/OC, IN SARRAG (See Resources section)
   b. Your national frameworks: National Incident Management and Emergency Operations Centers.
   c. Your state/province and local hospital and public health frameworks.
   d. Conduct interviews and document existing gaps at any level of preparedness or response capabilities and discuss proposals to remediate them.\textsuperscript{27} Arrange to attend training and simulations, and become subject matter expert in one or more areas of DP/DM.\textsuperscript{32-35}

2. In your organizations (hospital, professional association, standards organizations, R&D consortia, government agency, legislative and regulatory bodies), promote Clinical and Biomedical Engineers as Subject Matter Experts for System Lifecycle Management, with specific applications in DP/DM. Develop DP/DM skillsets and experience through the following:

   a. Schedule specialized DP/DM coursework, interdisciplin ary and cross-functional workshops, conferences, credentialing and certification.
   b. Re-write job descriptions for CE's to include DP/DM as a required competency; set aside time for dedicated assignments to organizational emergency preparedness teams and practice drills. Include readiness research, conferences, and publication in scientific and professional journals\textsuperscript{36,37} as CE performance evaluation criteria.
   c. Arrange for CE's to be permanent delegates to organizational Emergency Preparedness Teams – local, regional, and national.
   d. Delegate CE's to serve on standards committees and medical device design consortia to promote inclusion of DP/DM performance factors in design standards for medical devices and systems.\textsuperscript{38}
   e. Contribute to the design of table-top exercises for DP/DM, with emphasis on functional interdependencies and risk/failure points that other stakeholders might ignore.

3. Promote regional and national purchasing cooperatives to maximize cost-savings over the lifecycle of devices and services, including specific disaster-related terms and conditions.

4. Promote Health Technology Design among CE's as the front-end of the Device Lifecycle management process to integrate best disaster practices into future designs.

   a. Formalize device and system design to provide real-time networked performance feedback of device data to manufacturers (as feed forward into next-generation device/system design, with all necessary safeguards for patient privacy and confidentiality).

   b. Formulate consulting relations between CEs and manufacturers to conduct regular design consultations as part of the contractual relationship.

   c. Define, design, and enforce \textit{Universal Minimum Functionality for medical devices (UMF)}. Most medical device manufacturers emphasize product differentiation from their competitors, and this produces highly specialized devices that may be perfect for normal circumstances, but be
sub-optimal or dangerous under disaster conditions, when there may be a transfer of life-support patients to other sites of care, significant rotation of staff across locations, and staff who have to use medical devices that are different from what they are accustomed to. The specialized differences in user interfaces, IT connectivity, consumables, and performance characteristics may cause significant risk to patient safety. We need to promote UMF requirements for procurement of all medical devices to ensure the lowest common denominator of safety, performance, and user interfaces as a default setting under disaster conditions, to support rapid transport and accurate continuity of patient care across locations, caregivers, and device brands. With the push of a button, the UMF functions can be invoked to provide a specific menu of minimum, universally standardized functions, and user interfaces. UMF device design and training would support patients with generic functionalities that would assure higher overall population benefits than what would result from overly specialized functions that could put patients at risk due to inappropriate use by untrained staff. Inadequate supply chain guarantees and contingency plans to ensure technical support for diverse disaster locations, and plans for universalized consumables.

c. **Develop Capability Maturity Roadmaps** to identify strategic pathways for medical technologies and services with a 5- to 10-year performance horizon. Adjust roadmaps for different economic conditions.

d. **Promote formal collaborations between IT and biomedical forecasting institutions** such as Gartner and ECRI, professional and industry associations. Promote joint assessments of innovative technologies and plots on Biomed/CT/TI hype cycles and magic quadrants.

e. **Design to Cascade**—Devices should be designed for extended use and re-use across diverse economic development zones so that UMF functions eventually become available to LDCs (less-developed countries) through redeployment, using local refurbishing and production where possible, and strictly-managed donations. This will gradually create a predictable minimum of standardized device functionality globally that will increase the safety and efficiency of clinical efforts by clinicians who at times must work at remote and unfamiliar disaster sites.

5. **Include Smart Design requirements** for all medical devices with computing capabilities so they have extensive, built-in capabilities for universal time synchronization, self-monitoring, self-reporting, self-updating, self-diagnosis, and self-healing. Real-time location, performance readiness, configuration, and mobility of medical devices will be critical for rapid emergency deployment and redeployment conditions (e.g., patient transfer to an alternate site of care, with infusion pump and ventilator).

a. **Specify multicore device design**, which will segregate clinical and device lifecycle operations functions on separate computing cores, with a hypervisor bridge. This will enable highly secure, real-time asset, service, and configuration management to be executed without interlinking with clinical performance. This includes device identification, location, configuration history, component provenance, performance and service history making the device an active partner in managing its asset, and service lifecycle. Architect devices to centralize and support external service, security and process control so that devices themselves become active players in managing routine monitoring, compliance, and reporting activities.

b. **Leverage emerging IPv6 capabilities** to Envision devices as intelligent members of the extended IoMT (Internet of Medical Things). Device components can be independently addressed and managed via IPv6 addressing, to significantly improve security, remote patient monitoring, and cloud management of IoMT data which will become increasingly important in “care-anywhere” and behavioral health services.

c. **Build “developmental headroom”** into device hardware and software architecture, to extend usable life and afford built-in capacity for new functionality without burdening replacement costs and inefficiencies.

d. **Coordinate CE tightly with IT asset management and service management** to develop aligned processes, data dictionaries, configuration management, and roles that will support standardized service and performance analytics for primary, transitional and Alternate Sites of Care, including ambulance services and military locations having other network, security, and compatible consumables standards.

e. **Explore secured, cloud-based product development partnerships for device design and prototyping.** Promote interdisciplinary, intersectorial alliances, and collaboration frameworks.

6. **Adopt the ITIL framework of service strategy and service management.** The Information Technology Infrastructure Library (ITIL) is the global standard for business process engineering, based on IT lifecycles, for ensuring alignment and coherence of all services provided within an organization and between organizations. It is an indispensable tool to ensure that all organizational services support healthcare activities that are safe, efficient, effective, and expertly managed. Careful mapping of service processes and accountabilities during normal operations should be used to create parallel process maps that are adapted to disaster conditions.

a. **Obtain training and certification for CE staff** in basic ITIL concepts and methods (3-day course).

b. **Create end-to-end service process maps** for your organization for normal and disaster conditions, working closely with all stakeholders, escalation paths, and decision points.

c. **Where feasible, explore how business process automation** can improve workflows during disaster conditions by guiding staff through automated, pre-defined checklist s and options so staff doesn’t have to improvise randomly amid stressful circumstances.

7. **Prepare Professionally for Alternate Sites of Care (ASOCs).** Certain disaster situations will overwhelm existing hospital facilities and small-scale surge preparation, requiring the setup of emergency hospital capabilities at schools, warehouses, hotels, sports arenas, field tents, military bases, factories, and other sites. CEs should play a major role in anticipating, planning, and executing on ASOC logistics, deployment, testing, and site readiness certification.

a. **Anticipate the need to prepare** to work rapidly and closely with local, national, and international military, National Guard, and local police authorities to manage dynamic disaster conditions and coordinate efforts to plan and deploy ASOCs.

b. **Clarify in advance the hierarchy of decision-making authorities,** geographical jurisdictions, and processes. Use scenarios to anticipate potential decision crises.

c. **Evaluate facility Surge Area design, setup, device requirements, disinfection, patient identification, tracking, and medical record continuity patient transfer processes, patient monitoring, surge capacity limits.** Conduct periodic drills. Establish criteria for transfers from hospital or surge areas to ASOCs.

d. **Develop technology-mediated patient transfer protocols** and process maps to ensure continuity of care: patient transport, infusion pumps, medical belongings, device tracking, ventilators, vital signs, family contacts, data interfaces with electronic medical records, wireless or cellular connectivity.

e. **Evaluate and acquire Early Situation Awareness software,** pre-load critical infrastructure locations, facilities and profiles. Update annually. This will enable instantaneous activation of a regional incident tracking utility, enabling Emergency Operations Centers to know exact the GPS location of incidents, deployed responder vehicles, and dangerous conditions.

f. **Evaluate facility needs** for backup power, space management coordination, utilities, wireless access, medical gasses, waste management, security, maintenance and repair parts, disinfection IT coordination.

g. **Arrange to serve** as a multifunctional Engineer and consultant in Disaster Resource/Emergency Operations Center design, simulations, and response roles.
h. Evaluate the need for additional equipment for decontamination, generators, mobile or field operating rooms, Rapid Assembly Shelters, Containerized Clinics.

i. Perform quarterly updates of ASOC status to identify any significant changes in readiness, resources, staffing, plans.

j. Evaluate the role of portable Emergency Electronic Medical Records and mobile connectivity to medical devices for vital signs, medications, infusions, treatment plans, etc.

k. Review Supply Chain Management practices to address specific disaster conditions.

  i. Use multi-professional scenarios to identify probable stress points, gaps, failures, and decision-making bottlenecks that may impede a rapid ramping up of disaster response actions; vendor contracts, pre-orders, 3-D printing, open-source online design specifications, delivery, receiving, storage, distribution, security configuration for ASOCs.

  ii. Anticipate the need to coordinate with national military logistics agencies and ensure that minimum compatibility standards for devices and consumables are applied in the procurement process.

  iii. Identify critical trigger points in early disaster awareness that will prepare manufacturers to shift from just-in-time production to large-scale emergency production standards.

l. Pre-define equipment lists, rapid supply chain strategies, and ASOC requirements to manage the possibility of multiple-hazard disasters and resulting health threats (e.g., simultaneous pandemic and earthquake victims).

m. Identify multiple constituencies/stakeholders who need to be involved in normal and ASOC capability planning: Building science professionals (air quality, negative pressure, decontamination, medical gasses), contractors and vendors, childcare providers, disaster survivors, emergency managers and personnel, fire services, community safety associations, disabled persons, language translators, time-sensitive treatments (chemotherapies, pregnancy, dialysis, etc.), livestock owners, parents and teachers, pet owners, individuals with physical access and mobility needs, media contacts, tribal representatives, university research partners, volunteer coordinators.

n. Consult with anthropologists, ethnologists, social psychologists and historians to evaluate the impact of cultural, ethnic, religious, and linguistic differences that will significantly affect patient treatment and possible interactions with families, relatives, loved ones, ambulance services, forensic, morvue and funeral services, burial, and grieving practices.

8. Establish Dual-Use Infrastructure - The dual-use concept in traditional military usage refers to civilian materials or processes that can also be used or altered for terrorist purposes. But in our case, the Dual-Use-Infrastructure concept requires that all medical equipment that may be used under disaster conditions shall be designed for maximum compatibility between civilian and military services, and shall include a least-common-denominator of clinical functionality, data standards and user interfaces that enable instant usability by trained clinical staff anywhere, regardless of brand.

a. Build on military alliances for large/complex disasters; identify and establish formal liaisons and schedule periodic meetings to keep current of developments.

b. For all-hazard risks, identify relevant medical devices needed for each risk category, including multiple disaster situations (e.g., simultaneous earthquake, tsunami, radiation), and ensure cross-compatibility between military and civilian applications.

c. Align military and civilian procurement processes, inventory synchronization, and decision-making for disaster procurement, especially for national stockpiles.

d. Ensure interoperability of electronic identity management applications and processes so that military and civilian professionals can interact without obstruction or delay.

e. Review and establish trusted domain rights on DM networks; update credentials as needed for instant, uncontested sign-on in ASOCs.

f. Negotiate with government and commercial network providers to establish dedicated network priority bandwidth during disaster conditions, providing top Quality of Service for all medical system users and devices, and research partners.

g. Require universal wireless location of medical devices and high-value, mobile capital equipment by using built-in radio-frequency identification; use this function to support patient and device transfer to ASOCs and timely return of outgoing devices; formalize control of network credentials, login, and device recovery processes.

9. Ensure Cross-border credentialing database exists to enable rapid verification of professional skills for ASOCs.

a. Volunteers and retirees from other regions/states/countries may arrive to assist in disaster response activities, and it is important to verify in advance their identities, relevant skills, and credentials, and issue necessary identification badges, vests, or wristbands to enable rapid access to different areas of disaster control.

10. Research and compose Mutual Aid Agreements at all levels and ensure clear jurisdictional authorities at each level.

a. Obtain Master Service Agreement templates and confer with local public health agencies to identify existing agreements.

b. Meet with actual and potential partners to review MSAs and adjust as needed.

11. Research and Incorporate Rapid Deployment Technologies for DM

a. Hastily formed networks.

b. IUSHAHIDI (an online tool for aggregating information from the public for use in crisis response).

c. Sahana (open-source DM software).

d. Google Crisis Response, Google Public Alerts, and Fusion Tables.

e. Solar-powered wireless access points.

f. Failsafe communications: Bluetooth walkie talkie; ham radio.

g. SMS messaging.

h. Mobile refrigerated morgue trailers.

12. Plan for Standard Tests and Point-of-Care Diagnostics to supplement or replace centralized laboratory use

a. Evaluate rapid turnaround, automated, and self-administered COVID-19 tests.

b. Evaluate conformal electronic viral signs monitors and wireless links to nursing station monitors or telemedicine monitoring stations.

c. Assess telemedicine/telehealth and automated monitoring technologies annually to determine the best combination of onsite clinicians, offsite monitors, and automated alerts to manage patients who may be treated at home, in ambulance, in hospital, at ASOCs, or post-dischage.

d. Evaluate:

  i. Bluetooth proximity monitoring technologies on smartphones as early detection and contact tracking tools.

  ii. Smartphone diagnostic attachments: microassays, flow cytometry.

  iii. Miniaturized mass spectrometry.

  iv. Lab on a Chip.

  v. Electrochemical detection.

  vi. Saliva test.

  vii. Antibody test.

  viii. Antigen test.

  ix. Molecular/PCR test.

  x. ELISA, IFA tests.

  xi. CRISPR.

13. Identify and track emerging Treatment Modalities (COVID-19 examples)

a. Blood purification, apheresis, and adsorption.

b. Convalescent plasma transfusion.
c. Antivirals.
d. Interferon.
e. Monoclonal antibodies.
f. Hydroxychloroquine.

14. Refine Triage and Fatality Management resources and processes
a. Isolation tents with diagnostic and sterilization tools
b. Wireless patient identification and vital signs monitoring, location monitoring
c. Backup plans for wireless infrastructure during disasters that can include cell towers and hastily formed networks.
d. Refrigerated morgue trailer.

15. Test DP routinely to point of failure, to identify weak links in plans and performance
a. Large-scale stress testing
b. Intersectoral simulations.

16. Include FailSafe and High-Reliability Communications to ensure basic communication capabilities if commercial wireless or Internet services fail or are overloaded.

17. Acquire Early Situation Awareness platform capabilities and integrate to Emergency Operations Centers
a. Evaluate software options; acquire and install the application in Emergency Operations Center and dedicated cell phones
b. Pre-load regional database with critical infrastructure sites, profiles, contacts
c. Establish criteria for distributed use of cellular reporting application by responsible staff and civilians to ensure data reliability
d. Conduct training and simulations.

18. Negotiate Trigger Criteria and Rapid Execution Timelines and Industry Workplans. Negotiate specific terms under which Early Disaster conditions will be officially declared which will trigger initial work plans of academic, professional, government, and industry partners, to prepare for ramping up of pre-defined research activities and production of essential equipment and supplies.

19. Evaluate and Negotiate Manufacturing Alliances for DP/DM to establish contractual agreements that obligate manufacturers to prioritize emergency production requirements specific to the disaster type.

20. Promote an organizational culture of Information Sharing and Tactical Flexibility for DP/DM
a. Promote professional and organizational norms of information openness to ensure that decisions are made based on evidence, not rumor or guesswork.
b. Promote professional and organizational norms that optimize the ability to be tactically flexible and adaptable to changing circumstances and information. Build in specific secondary role assignments and responsibilities (role-shifting) in job descriptions for all CEs and disaster-related staff.

21. Define need for Role Shifting. During early and mid-disaster conditions, routine clinical roles and responsibilities and reporting relationships may need to change significantly to enable proper execution of disaster protocols. Doctors, nurses, CEs, facility, and administrative staff may be shifted to other tasks that over-ride normal job descriptions.

22. Form Strategic Health Intelligence Alliances between academic, government, provider, and medical industry partners.

23. Establish or link to Data Fusion and Monitoring Centers to monitor emergent, multi-hazard conditions that may require rapid changes in disaster response – flooding, landslides, biohazard dispersion, disruption of transport or supply chain plans, power outages, gas leaks, tsunami, wildfires, etc. Establish formal membership for CE liaisons with fusion and monitoring centers.

24. Establish an International CE Rapid-Response Network for rapid-response information sharing in the early stages of any disaster. Convene daily online consultation meetings.

CONCLUSION

Taken together, these aspirational recommendations offer a comprehensive, but not yet exhaustive set of actions that can improve outcomes and alter the historical trajectory of the CE profession and its capabilities worldwide. Certainly, other topics and recommendations can and must be added to the agenda, but this list does offer a plausible foundation of starting points with sufficient breadth and detail to begin the transformational work with a collective framework of efforts. Working individually and in teams and associations, the daunting magnitude of the challenge can be mastered over time, building on the global presence and growing leadership of CEs.
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RESOURCES

NOTE: All commercial mentions are for illustrative purposes only and do not imply a recommendation or endorsement. Links are active as of April 2020.

| TOPIC | DETAIL | URL |
|-------|--------|-----|
| IFMBE/CED | Clinical Engineering Division of the International Federation of Medical and Biological Engineering | https://ced.ifmbe.org/ |
| United Nations | The United Nations | https://www.un.org/en/ |
| WHO | World Health Organization | https://www.who.int/ |
| UNOCHA | UN Office for the Coordination of Humanitarian Affairs | https://www.unocha.org/ |
| CADRI | Capacity for Disaster Reduction Initiative: global partnership of FAO, IOM, UNDP, UNICEF and UNIFPA (executive partners); GDNR, IFRC, OCHA, UNESCO, UNOPS, WFP, WHO, WMO (technical partners) and GFDRR, OECD, ODI, RedR Australia, UNDRR, UN WOMEN | https://www.cadri.net/ |
| UN Clusters | UNISDR, UNHCR, IFRC, IOM, FAO, WFP, UNDP, UNICEF, Save the Children | https://www.who.int/health-cluster/about/cluster-system/en/ |
| UN Clusters (formerly UNISDR) | UN Office for Disaster Risk Reduction | https://www.un.org/condition/ |
| TOPIC | DETAIL | URL |
|-------|--------|-----|
| Mutual Aid Agreement | Mutual Aid Template draft text for customizing to user needs | [https://emilms.fema.gov/IS706/assets/WyomingTemplate.pdf](https://emilms.fema.gov/IS706/assets/WyomingTemplate.pdf) |
| Rapid Deployment | Blockchain Technology for Emergency Response | [https://scholarspace.manoa.hawaii.edu/bitstream/10125/68314/0061.pdf](https://scholarspace.manoa.hawaii.edu/bitstream/10125/68314/0061.pdf) |
| Rapid Deployment | The Evolution of Hastily Formed Networks for Disaster Response | [https://www.researchgate.net/publication/221567937](https://www.researchgate.net/publication/221567937) |
| USHAHIDI | The Ushahidi Platform allows anyone to gather distributed data via SMS, email or web and visualize it on a map or timeline. Its goal is to create the simplest way of aggregating information from the public for use in crisis response. | [https://www.ushahidi.com/](https://www.ushahidi.com/) |
| Sahana | Open-source disaster management software | [https://sahanafoundation.org/](https://sahanafoundation.org/) |
| Google Crisis Response | Google.org supports nonprofits working alongside affected communities from the immediate aftermath of a crisis through long-tail recovery. It includes providing nonprofits with funding and connecting them to the right Google volunteers—whether they’re a data scientist, a communications expert, or an engineer. | [https://crisisresponse.google/](https://crisisresponse.google/) |
| Google Public Alerts | Provides global map with data on floods, earthquakes, fires and other disaster conditions | [https://google.org/publicalerts](https://google.org/publicalerts) |
| Solar-powered Wi-Fi | Solar-powered wireless access points | [https://roboticsvision.com/solar-access-point/](https://roboticsvision.com/solar-access-point/) |
| Ham Radio | Backup radio communication technology in case normal telephone and cell services fail | [https://www.youtube.com/watch?v=LiQ36cVH4Aw](https://www.youtube.com/watch?v=LiQ36cVH4Aw) |
| Point-of-care testing | Geospatial Science and Point-of-Care Testing: Creating Solutions for Population Access, Emergencies, Outbreaks, and Disasters | [https://www.ncsh.nlm.nih.gov/pmc/articles/PMC6988819/](https://www.ncsh.nlm.nih.gov/pmc/articles/PMC6988819/) |
| Point-of-care testing | PATH diagnostics for low-income settings | [https://www.path.org/programs/diagnostics](https://www.path.org/programs/diagnostics) |
| Point-of-care testing | Innovations in Point-Of-Care Testing for Enhanced United States Disaster Caches – American Journal of Disaster Medicine | [https://www.wmpflc.org/oa/index.php/ajdm/article/view/2135](https://www.wmpflc.org/oa/index.php/ajdm/article/view/2135) |
| Point-of-care testing | Smartphone based medical Diagnostics | [https://www.sciencedirect.com/book/9780121704411/smartphone-based-medical-diagnostics](https://www.sciencedirect.com/book/9780121704411/smartphone-based-medical-diagnostics) |
| Point-of-care testing | Lab on a chip | [https://www.zanodisciences.com/article/Health-Applications-of-Lab-on-a-Chip.aspx](https://www.zanodisciences.com/article/Health-Applications-of-Lab-on-a-Chip.aspx) |
| Advanced Diagnostic Lab Technology | Mass spectroscopy | [https://pubs.acs.org/doi/10.1021/acsomega.9b03764](https://pubs.acs.org/doi/10.1021/acsomega.9b03764) |
| Defense Production Act | Enables the government to commandeer national production capabilities in order to meet defense and national emergency needs. | [https://www.fema.gov/defense-production-act-program](https://www.fema.gov/defense-production-act-program) |
| Mobile Morgue Trailer | Refrigerated body storage | [https://www.moppec.com/](https://www.moppec.com/) |
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Fred Hosea, PhD, has worked in different areas of health care and psychosocial development for over 30 years, conducting research on professional development in philanthropy, conducting FBI research on convicted sex offenders, and working as a mental health worker in adolescent psychiatric wards, community-based residential care for adolescents, school-based counseling, and in a maximum security treatment center for the criminally insane. He has taught graduate-level courses in business and professional ethics, and has taught undergraduate courses in “The Art and Science of Innovation” at Yachay Tech University. He worked for 17 years with Kaiser Permanente, the largest non-profit hospital system in the US, responsible for annual clinical technology plans for Northern California, implementing a national process re-engineering, asset management and IT service management systems, and most recently was Director of Research and Innovation in Clinical Technology. He has published articles on disaster management and the future of biomedical and clinical engineering professions. He edited Human Resources for Medical Devices in 2017 for the World Health Organization to promote biomedical and clinical engineering as essential professions for modern healthcare systems worldwide. He lives in Cotacachi, Ecuador and is active in a variety of projects to strengthen indigenous Kichwa culture, improve local health services, and promote sustainable models of development. Fred is currently a collaborating member of the Clinical Engineering Division of the International Federation of Medical and Biological Engineering, and has presented on the future of CE at international conferences in Beijing, Shenzhen, Visakhapatnam, Bangkok, Rome, Geneva, Sao Paulo, and Zagreb.