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An Introduction to the Organization Commonly Known as Doctors Without Borders

Sean Moore

Johnson County Community College, smoore77@stumail.jccc.edu

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An Introduction to the Organization Commonly Known as Doctors Without Borders

Abstract

Humanitarian organizations, like the humans that operate or benefit from them, are filled with challenges, successes, and failures. As the largest non-governmental organization on the planet today, Doctors Without Borders has its own interesting history that falls short of the glory most people ascribe to it when they hear the westernized version of its French name, Médecins Sans Frontières (MSF). In researching this organization, the author studied several books, reviewed dozens of articles and web-sites, listened to the full recruitment pitch while watching the concurrent online presentation, and watched the movie “Living in Emergency: Stories of Doctors Without Borders”. The reader has approximately fifty hours of research condensed into about twenty minutes of reading. The final product attempts a neutral presentation of the positive and negative of MSF’s history, a description of their current locations and specific work in those areas, and information on what the prospective candidate (specifically the nursing applicant) needs to consider before engaging in a personal affiliation with the organization. MSF is rooted deeply in its French heritage. It isn’t a place for the glory-seeker, the casual traveler, or the average American. Is it worth the time to pursue? That is up for the reader to determine.

“There are two main levels. One level is the attachment anybody would have to the place in which you’ve been; and, the other is the nonsense of...of not doing something once you know something needs to be done.” So states the Italian ex-patriot Doctor Chiara Lepora in the movie *Living in Emergency: Stories of Doctors Without Borders*. “You’re driving somewhere and you have a car crash happening in front of you, you have the duty of doing something. And, Liberia is a huge car crash...it’s not about Liberia, it’s about Congo, Sudan, Pakistan, Darfur, wherever, lots of places. Car crashes everywhere.”ⁱ There are stories that we, as servants in the field of nursing, like to remember whether they involve us or not. There are also stories that we would rather forget. Then, there are the stories that we, usually, don’t know or wouldn’t want to know. Those are the stories that call to us to make a decision to get involved in one way or another, much like a sermon in our house of worship does. The stories about and within Doctors Without Borders are too numerous to cover in brief, too troubling for a compassionate person’s soul, and too graphic for most people’s stomachs.

Today, Doctors Without Borders/Médecins Sans Frontières (MSF) is the world’s largest non-governmental organization providing medical and humanitarian assistance. MSF sends teams to locations of conflict, disease, and disaster in over sixty countries to assist tens of thousands annually.ⁱⁱ They are not a religious organization; they are people who see the need of others who cannot care for themselves in locations that we in the developed world can only imagine truly exist in our world of relative luxury. Are others needed? Yes. Can you get involved? Yes. Will you be utilized if you try? Maybe.

The onset of an organization is normally quite heroic; the early attempts at living are normally fraught with chaos. The story of MSF is no different. The roots of MSF start in the late 1960’s in a country far away from its birthplace, in an environment not unlike what the streets of Paris have seen so many times in its own past. Civil war erupted in Nigeria in May, 1967, when the eastern part of the country, Biafra, declared itself to be independent. The International Red Cross (IRC) sent a number of medical aid workers in to Biafra to tend to the

injured and refugees of the conflict. Before entering the theater, the IRC required that its volunteers sign a promise of discretion. Doctor Bernard Kouchner, a gastroenterologist from France, went in to work at Biafra after reluctantly signing the agreement with the IRC. When he returned to France, he broke the agreement in order to bring to light the inhumane suffering that was entirely too prolific within the confines of the breakaway region of Nigeria. “The sights appalled Kouchner, who 35 years later could still recall the hungry children ‘like dry plants finally withered.’ But the French doctors soon realized that these Biafran civilians were not simply caught in the crossfire. They were being deliberately starved by the Nigerian Forces who had created a food blockade ensuring that ‘all would perish, so light, so frail in our hands.’ The doctors believed they were witnessing a genocide.”ⁱⁱⁱ The Nigerian military forces would not budge on their hardline stance, even going so far as to murder a number of ex-patriot and national hospital staff who were attempting to help. Upon his return to France, Kouchner and a number of his colleagues tried multiple ways to raise awareness about the plight of the Biafran people. The neutrality exhibited by the International Red Cross, even at the death of its own people, could not be tolerated any longer. In the mind of Kouchner, the IRC was allowing the genocide to continue. “‘To give medical care and keep quiet, to give medical care and let children die, for me it was clearly complicity,’ he told students at the Harvard school of Public Health in 2003. ‘Neutrality led to complicity. The duty to interfere was born.’”^{iv}

The French word *Frontieres*, where “Borders” comes from in *Doctors Without Borders*, loosely correlates to “Repression.” The trick in establishing an effective medical organization that operated outside the boundaries of colonialism was quite a task. The first hurdle was finding like-minded people. Bernard Kouchner developed that like-minded group that met, informally, in his home. The stand of this group of “Biafrans”, as they came to be known from their ties to the region in Nigeria, was that the rights of those oppressed must trump the borderlines established in the international vision of sovereignty. By the early 1970s another group, spurred on by the editor of the medical journal *Tonus*, came to the same conclusion as the

Biafrans. Raymond Borel, that editor, put out the call for French doctors to aid those in need as a result of the natural disasters in Iran, Yugoslavia, and Eastern Pakistan.^v The editor argued that aid was under-expedited and overloaded with bureaucracy and political meddling.

It didn't take too long before the two groups found each other. Though the two groups had much in common, there was a major sticking point that was later to become a cause of division within the fledgling organization. Trying to put a charter together that all could agree upon was a challenge for the assembly that met in the office of *Tonus* in December of 1971. The whole "neutral vs. active" contention was revived in the fourth article of MSF's charter: They maintain professional discretion and refrain from making judgments or expressing public opinions – favorable or hostile – with regard to the events, forces, and leaders who accepted their aid.^{vi} The reader can guess whether or not Bernard Kouchner was in favor of this article being in the charter. There were thirteen men at the table when the final charter was approved – perhaps it was an omen of the trouble soon to come.

Early on in the history of MSF, there were only about 140 volunteers that were all too busy to really help where they were needed and there was little money in the coffers to send them anywhere with supplies. The goal of MSF was to be first on the field when needed; that part fell short as well. The first major test for them came a little after their first anniversary and involved deployment of people and supplies to Managua, Nicaragua in response to a major earthquake there. When they finally arrived, they were three days late. Again, in 1974, they were not quite the first in response to the area of Honduras that had been ravaged by Hurricane Fifi.

As referred to earlier, the "honeymoon" ended soon after the "marriage." In 1974 a Kurdish envoy met with Bernard Kouchner about supporting the Kurdish revolt against the government of Iraq and to solicit support from MSF. Kouchner agreed and Borel countered. Kouchner sent the team, according to his side of the story, only as a source of medical service.

Apparently the disagreement worked in Kouchner's favor because he and a friend were elected to the two highest posts within MSF at the 1975 annual meeting and one of Borel's allies was given the boot from the board of directors. It was now up to the Biafrans to lead the organization in the direction that it ought to go.

Along came 1976 and MSF's first real successes. The budget was still puny due to a lack of marketing strategy on the board's part. Direct mailing was not yet used in France. But, in the troubled nation of Lebanon MSF was alive and well. It was the first war mission opportunity for Doctors Without Borders and they took it. A group of fifty-six volunteers rotated through a Beirut hospital and the world began to take notice. MSF was given its first free advertising: *Dans leur sale d'attente 2 milliards d'hommes (There are two billion people in their waiting room).*^{vii} *Time* magazine wrote an article about MSF's work in Lebanon and called it "an extraordinary...medical organization."^{viii}

A young doctor with experience in the Cambodian refugee camps of Thailand took charge of MSF's Paris office in 1977, after receiving high praise from Bernard Kouchner. His name was Claude Malhuret. It was short-lived agreement between Kouchner and Malhuret. The younger man had a new vision for MSF: longer mission times and logistical wizardry. The latter goal was to 1) keep doctors focused on the patients and 2) get the teams out to the field as quickly as possible with the right equipment at hand. Along with Malhuret came his generation of thinkers that became known as *le bande de Cochon*, from the Paris university they came from. The head-butting about that pesky article in the charter began anew. The "old-guard" was concerned that the "new blood" was rearranging MSF into "an overly technical medical delivery service."^{ix} The fourth article of the charter was successfully removed by *le clans Biafrais* in 1977. Malhuret's group, like Borel's, was still opposed to speaking against the local government borders in areas in which MSF operated. MSF, while operating successfully on the outside, was eroding and evolving on the inside. Board meetings, with Kouchner at one end of the table and

Malhuret at the other, became verbal debates that quickly shifted the balance of power from Kouchner to Malhuret.

Ironically, the end of Kouchner's association with MSF came not from governmental rebuke but a logistical contention. The Vietnamese boat people took the front page and lead stories of news organizations world-wide in 1978. Kouchner started his own committee, "A Boat for Vietnam", and asked MSF for support. The peak immigration of boat people was near 21,500 in November of that year. Would one boat be enough to service the needs of that many people? Would intervention only spur more refugees to undertake the dangerous journey at the hazard of hundreds or thousands of lives? Malhuret's side of MSF chose to side with caution and Kouchner's moved to action, sailing to the southwestern Pacific Ocean without MSF – and out of MSF entirely, Kouchner feeling betrayed by the group he had helped birth.

The Soviet Union invaded Afghanistan in December of 1979 and MSF was the first expatriot organization within the borders to assist the nationals. It was not a matter of scientific genius to understand that the benefactors of the medical aid would be those who fought against the invaders, the mujahideen. Rony Braumann one of the new leaders of MSF commented, "There was never any question as to whether MSF should offer its services in Kabul in order to be able to sit on the fence. Like our forerunners in Biafra, we had implicitly picked our side. We all saw it as our duty to expose the scale of this war to the world."^x The first time MSF openly protested a government was a march held in February 1980 with some celebrities involved in an unsuccessful attempt to have medical aid cross the Thailand-Cambodia border in order to assist the refugees of the Khmer Rouge purges. It was obvious that the new leadership was reverting to the tactics of one of the founders, Bernard Kouchner.

MSF's beliefs and practices evolve even in the current day: "Humanitarian aid has always been reactive, responding to the political climate in the world at large...MSF emerged on the world stage not because of its logistical ability but because it was a brash and fearless group that went where others would not go."^{xi}

It was in 1980 that the corporate arm of MSF expanded internationally with the addition of a small office in Brussels. The next year Geneva opened an office. The Belgian office supported the opening of a Dutch location but the French office did not for several weeks after the September 1984 start. Once it was recognized, MSF-Holland opened its doors in Amsterdam with one full-time employee.

In the mid 1980's Bob Geldof, the actor/musician/activist of *The Wall* and *Amnesty International* fame put together Live-Aid concerts to bring awareness and nutritional aid to the Ethiopian people. The aid that poured in to the effort was delivered to Ethiopia and abused by the country's dictator to forcibly move those in the barren north to the more fertile south. The aid organizations were used as tools for the dictator's ends, unable to provide for the needs of the nationals until those people agreed to the relocation. MSF-Belgium kept silent in the face of this abuse; MSF-France did not and was promptly "invited" to leave the country in late 1985. The international community promptly stepped in and informed the Ethiopian government that it would receive no more aid until the deportations ceased – they did.

Spain and Luxembourg opened local offices in 1986. The fame of MSF grew throughout the world and was not neglected in its own country; the dream job listed by French citizens in 1989, with an overwhelming 32% selecting it: working for MSF. In 1989 a Canadian doctor, Richard Heinzl, traveled to Paris to research the possibility of opening a branch in his own country because the foothold was not yet strong in any English speaking location. The response was a rather back-handed approval, "And he basically just gave me a flat no. Then puffing on his big cigar, he winked and said, 'But if you have the will...' That's all I needed to hear."^{xii} America started its own office in New York in 1990; the Canadians didn't quite get their ducks in a row until 1991. It was at this time that the Anglicized version of Médecins Sans Frontières emerged: Doctors Without Borders. Almost all of those who are in the organization shun the English name and refer to it primarily by the French initials: MSF. More countries added offices by 1995; but, operations remain consolidated within France, Spain, Belgium, Holland, and

Switzerland. There are thirteen other offices in existence which are paired with operational offices in other countries. For example, New York's operational section is in Paris and Canada has been paired with Holland. The primary role of the subordinate is to fund-raise, recruit, and raise awareness in their respective countries. The United States is the leader in fund-raising: \$55 million in 2003.^{xiii} MSF moved its international headquarters to Geneva and is guided as a whole by an International Council. It does not see itself as a normal organization that runs its operation from the top down. Rather it prefers to think of itself as a movement with common goals. The five operational sections have their own distinct cultures which add a taste of malcontent to the whole. One veteran doctor who has worked within the bounds of three of those five groups said, "You have to see a fight between sections to understand what it is to be MSF."^{xiv}

Shortly after MSF was awarded the Nobel Peace Prize in 1999, the idea of the recognition rested uneasily upon many within the organization. The president of MSF-France, for instance, fretted over the coming discussions that would follow the prize that had nothing to do with the mission and organization of MSF, "If you have a meeting about an issue that you are really not involved in – for instance, the death penalty – you will have people saying, 'An organization like MSF, with the Nobel Prize, should have a public position on that.'"^{xv} By 2004 MSF came to reconcile itself with the Nobel. It also helped raise funds when people read "Nobel Laureate" on the letterhead of MSF stationery. It also brought an amount of undesired recruits due to the fame of MSF. Kenny Gluck of MSF-Holland commented, "Different kinds of people join us now that we're big and famous. When you're little, scrappy and rebellious, different kinds of people come forward to be volunteers."^{xvi}

"MSF provides assistance to populations in distress, to victims of natural or man-made disasters, and to victims of armed conflict. They do so irrespective of race, religion, creed, or political convictions."^{xvii}

Where are they now?

The Spanish, Belgian, and French operational sections started operation in Central and South American countries in response to the need to properly manage the Chagas (American Trypanosomiasis) outbreak in the region. The protozoan parasite *Trypanosoma cruzi* causes malarial symptoms in the acute phase and then can move into the chronic phase which attacks the cardio-pulmonary and gastro-intestinal systems. The disease is more prevalent in the poorest areas of nations such as Honduras, Bolivia, Guatemala, and Nicaragua. It affects an estimated 50,000 people annually and kills approximately 14,000 of them. MSF treated over 3100 individuals for Chagas in Honduras, Guatemala, and Bolivia between 1999 and 2008. The focus was, as mentioned earlier, a management method with all areas being treated in more of a cross-sectional study rather than a continued clinical setting. The treatment was provided free-of-charge and pediatric only. MSF's function was aimed at informing, educating, and communicating their findings with those who would stay in the area and, hopefully, continue to inform, educate, and communicate with others.^{xviii}

MSF has operated in Zambia since 1999. Each year, during that country's rainy season, an outbreak of cholera causes thousands of illnesses and over one hundred deaths. This year MSF set up three cholera treatment centers with 567 beds and is helping to support another seventeen cholera treatment units at different locations within Zambia with seventeen expatriots and over five hundred national staff. The action is not only a direct treatment of patients; but, it also works to prevent and educate. The outbreaks come primarily from limited access to clean water sources, poor hygiene, and unsanitary conditions aggravated by excessive rainfall. Chlorinated water sources are provided, drainage ditches are dug, affected person's living quarters are disinfected, and populations are educated on the prevention of spreading the

endemic further. This year was reported to be more problematic than the previous decade with over one thousand admissions.^{xix}

Two of five active relief sections in the Darfur region of Sudan were ordered out of the country in March 2009. Upon the expulsion, the assets of MSF were seized – along with passports of many of MSF’s senior staff members, making it impossible to lawfully comply with the order for over one month. The aid organization has been active in Sudan since 1979 and moved into Darfur in late 2003. From 2004 to 2008, MSF provided over 3 million medical consultations; 60,000 admissions; and 110,000 children in Darfur with health/nutritional assistance.^{xx} On the 11th of March, 2009, a female Canadian nurse on her fourth mission with MSF was kidnapped along with three colleagues by gunmen who demanded ransom for their release. She was reported to have been released on the 13th – unharmed, no ransom was paid. MSF policy in all of over sixty countries that it operates in, except one – Somalia, is that no weapons are used by or for MSF workers.^{xxi}

MSF has cooperated with other relief organizations in order to provide more affordable medicines in the under-developed nations in which they serve. For instance, with the increase of the AIDS epidemic on the continent of Africa there was a need for the anti-retrovirus (ARV) to stem the flow of people being diagnosed with an automatic death sentence. The ARV existed in the Western world in 2002; but, in order for a person to receive the correct therapeutic doses there was the small matter of \$10,000 per year. MSF joined forces with Oxfam, Health Action International and other activists in order to wade into the morass of legalities, copyrights, and trade agreements in order to help those who were helpless otherwise. The pharmaceutical companies that develop drug therapies charge extremely high prices to recoup their costs and lay capital to fund their future research and development. They are given the green light to produce their medication in a monopolistic manner for a period of time before other companies can produce a generic substitute. It’s in the interim that people who don’t have the money to buy the cure suffer while those who have that cure refuse to sell for the price that the poor man

can pay. The period of patent safety for the original manufacturer is twenty years according to the Trade-Related Aspects of Intellectual Property Right, aka TRIPS, that the World Trade Organization established between 1986 and 1994. There are two loop holes in the TRIPS agreement. One is the ability of certain governments to issue “compulsory licenses” to local manufacturers to replicate a patented drug during times of crises. The other is the ability of one government to purchase a generic offering of a drug from another country without the original maker’s approval; this is known as “parallel importing.” These medications must be approved by the same authority that approved the original drug; but, the cost is a small fraction of what the patented company is asking. Another advantage for the patient: in the case of ARVs, the therapy is normally three different drugs from three different providers who aren’t interested in combining the drugs – whereas the generic manufacturer will combine the three into one and make it that much easier for the sufferer to stay on the therapy. There was a balance sought in the TRIPS agreement. The developed countries wanted to protect companies that spent time and money and employed others and the under-developed countries had to look out for their own countrymen without irking the developed countries with powerful drug lobbies. South Africa passed a law under the TRIPS agreement in the face of the rising AIDS problem in 1997. They were challenged by thirty-nine drug companies. It took four years and multiple activist activities – including MSF’s “Drop the Cause” campaign – for the pharmaceuticals to back down in the light of bad public relations. In those four years hundreds thousands of South Africans perished from ARV.^{xxiii} In the wake of the terrorist attacks of September 11, 2001 Americans found out first-hand what the people of the poorer countries were putting up with. The anthrax scare drove a demand upon the Bayer company for Ciprofloxacin that they more than happy to supply at the price of \$4.67 per dose. That would put the cost to each American at \$700 per year. Ciprofloxacin is not patented in India and sold by Bayer, because the market there is competitive, at around \$17 per month. Bayer was still making a profit at this price. The U.S. Department of Health and Human Services asked Bayer to produce 100 million doses for an

emergency cache; Bayer offered a price of \$1.83 per dose. The U.S. and Canadian governments tested the legal waters by attempting to invoke the TRIPS agreement in order to utilize a generics manufacturer that would sell at around \$.40 per dose. Bayer threatened to sue and the governments backed down. Eventually, in preparation for the Doha conference of November 2001, there was an agreement that Bayer sell to the governments at \$.95 per dose.^{xxiii} The Doha conference involved much wrangling within and much more wrangling post-conference and issues have *yet* to be officially ironed out. There were other agreements made that were thought to benefit the poorer countries; but, in reality continued to favor the industries that dwelt within the borders of the country making the agreements. MSF challenged/and still challenges these flimsy attempts at “seeming to be generous” from the developed countries. For instance the Free Trade Areas of the Americas (FTAA) agreement was due to be completed in 2005 and model itself upon the North American Free Trade Agreement (NAFTA). MSF argued that FTAA was forcing Haiti to “give up their exemption from licensing patents on medicines.”^{xxiv} As of now, the FTAA was still dead in the water with no hopes of rescue.^{xxv} MSF also accused the U.S. of placing duress on Cambodia to change its own laws regarding the allowance of generic drugs within the country. MSF and the other activist organizations that work with MSF have shown that the price of ARVs could be reduced to 1/30th of the offered selling price and the companies could still stay out of financial trouble. Still, MSF can only do so much. Richard Bedell of MSF-Holland said, “It’s so much bigger than us; but, we can’t be paralyzed by the absence of a perfect solution.”^{xxvi}

The activities of bringing affordable AIDS treatment to the people of developing countries is a very recent program where MSF is taking a lead. The program is called “Europe! Hands Off Our Medicine.” Specifically, it is taking a stand against the European Commission’s attempts to stop all generic pharmaceutical trade between India and European organizations. This would threaten the flow of life- preserving medicines reaching the people who cannot afford to pay the higher prices that Western nations are accustomed to paying. Interested

people can electronically sign a letter of protest and send it to the European Commission at https://action.msf.org/en_CH/action/index^{xxvii}

MSF had been active in Haiti for nineteen years before the earthquake that leveled so much of that country on January 12th, 2010. A number of buildings that housed MSF operations in the country were damaged or destroyed. Many of the workers, mostly nationals, were killed. It was only a matter of hours before there were hundreds of people lined up at what was left of MSF's facilities with dead and wounded needing triage. At first, MSF responded by setting up trauma services and operating rooms in shipping containers and tents. Haitian MSF workers came to help quickly. Within a couple of days after the earthquake, over 1,000 patients were treated. MSF sent ex-patriot teams in to help, most of them and their supplies had to be shipped in through the Dominican Republic. Emergency amputations, caesarian sections, and other urgent care treatments were attended to as quickly as possible. Most of the amputations were required due to the septic conditions that quickly led to gangrene; rapid intervention was needed to stop the patient having to deal with septicemia. MSF dispatched psychologists to Haiti to help the victims cope with the disaster. Inflatable hospital shelters were brought in and MSF began integrating with the Haitian hospitals. As in other countries, MSF has also focused heavily on the logistical necessities of Haiti. Potable water was needed and delivered there, along with latrines to keep human waste separated from the humans that produce it. At the peak of MSF operations in Haiti, there was a capacity of 900 beds.^{xxviii}

Before the earthquake in Haiti, MSF had already raised a ruckus, of sorts, regarding the sad state of Haitian health facilities in the capital of Port Au Prince. There are three hospitals in Port Au Prince that are run solely by MSF. The poorest of the poor in the poorest country in the Western Hemisphere rely on the free medical care provided by MSF. The operations in Haiti, before the quake, ran about \$17.5 million per year. Even at that funding, the limits of MSF were stretched enough that they were sending overflow patients to the national hospitals. Patients who already had been there protested with claims that the national facility was under-

staffed and under-provisioned or just sending the patients out without treating them at all. "Our medical structures are overwhelmed by patients and sometimes we have no other choice but to send patients to other public hospitals, even though they will face many obstacles to get treated," said Massimiliano Cosci, head of mission for MSF projects in Martissant. "Many patients tell us stories that there were no drugs in the structures or no staff to receive them or that they were sent back home because the structures were full. In many cases, they had to abandon treatment for lack of money to cover the costs. For patients in need of lifesaving care, this can be fatal. The situation is very alarming."^{xxxix}

One other area in which MSF is actively involved is Pakistan. Even though the United States has not invaded the country, the war rages on somewhat unabated there. Thousands have been killed and refugees flee the fighting. On February 3, 2009 two MSF workers were killed in Swat Valley where mortar fire rained down on hospitals. The two men, in their twenties, were fired upon by gunmen as they returned in a clearly marked aid vehicles from picking up victims of fighting in another city.^{xxx} Earlier this year, at an encampment at Munda (Lower Dir, North West Frontier Province) established by MSF along with others who had moved in close by, 7000 people were forcibly evacuated. The people were given only four hours to collect whatever they could and leave. MSF and the other aid organizations in the same area had no forewarning and were forbidden to assist – *they* were moved against their will as well. The people were evacuated to a forty minute road trip away at Waylay Kandow where the United Nations High Commissioner for Refugees (UNHCR) was running a similar encampment. But, in the new location, the facilities were far from adequate to support the new arrivals.^{xxxi} More recently there has been the problem of the floods in Pakistan. All areas of the country were affected and MSF continued to provide assistance as it could. It ramped up production to provide over 140,000 gallons of water per day, almost 15,000 packages of supplies, and over 4800 tents. Cholera ran rampant through several areas of Pakistan as a result of the floods and MSF answered the need with six separate diarrhea treatment centers.^{xxxii}

As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.^{xxxiii}

Recruitment of Volunteers

Many organizations recruit for new members; MSF is no different. Their recruiting method, however, is. That is, volunteers seek out and apply to MSF. This application opportunity is limited to only a few times per year and takes a while to complete. After all is said and done, the average seekers probably feel as if there would be no way that MSF would even consider taking him/her. Each year MSF sends approximately 3000 ex-patriots overseas. In 2003, MSF only took a total of 135 volunteers from the United States.^{xxxiv} According to the recruitment information, 80% of all applicants are rejected out of hand. The remaining 20% are interviewed. Of those, half are asked to improve their skills in certain areas – it all depends upon what position they desire to fill and what experience they have. The final 10% is put into a pool and utilized when the qualification fits the need.

What is MSF looking for in the field of nursing? Specifically they require Registered Nurses at the minimum. They also are recruiting Nurse Midwives and Nurse Practitioners. Midwives are highly sought after at this time. On the Operating Room side, they are looking for OR nurses and also Certified Registered Nurse Anesthetists. Both of these are highly sought after. Any qualification is superseded by the need to be flexible. According to the recruiters, the program changes from one day to the next; also, know that it's not about volunteers; it's about the needs of the field. The applicant must have a minimum of two years of relevant professional experience. Registered nurses are asked to promote their Charge Nurse roles as the majority of their time in the field (70%) is spent training the national staff. Only 30% of the time is occupied in the clinical setting.

As far as availability is concerned: the Registered Nurse is looking at a first mission period of nine to twelve months. OR Nurses spend less time in the field on first missions due to the intense nature of their needs, that and the fact that they are literally “on call” 24/7. MSF also asks the applicant to be able to work with an international team. Much of the time you will not be sent out with fellow Americans and the team you go with may not even speak English.

This leads to the next point – expediting the mission deployment: MSF is a French organization and many of the countries where missions are located are primarily French speaking. If the applicant speaks a good amount of conversational French, then the chance of being used quickly is increased dramatically.

MSF is also looking for those who have excellent communication skills, management, teaching, and training skills. As stated before, the majority of the time in the field is training national staffers. Then there is also the opportunity, if the person enjoys the work that much, that he/she could be promoted to a mission director position or higher. There have been times when a nurse with experience in the field was placed in a supervisory role over a surgeon.

One last point to raise for the prospective applicant: MSF wants a person who can function outside their comfort zone. Words will not necessarily do here, either. Most people travel the world to nice comfortable places. MSF wants to know where that person has been that not too many people would like to be. They want to know about the applicant’s relevant travel or work experience in developing countries or even developing areas within developed countries such as remote Northern Canada.

Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

Members undertake to respect their professional code of ethics and to maintain complete independence from all political, economic, or religious powers.^{xxxx}

Conclusion

Of the movie *Living In Emergency: Stories of Doctors Without Borders*, Dr. Chris Brasher – an Australian surgeon and nine-year veteran of MSF missions related, “I have always been extremely disappointed with any representation of what we do. It always looks so polished and like things are going along as if no problem.”^{xxxvi} The organization is not the greatest thing in the world, nor is it the worst. Like other things centered on the existence and well-being of the species *Homo sapiens*, MSF has its share of good and bad things that either need more repair or polish. “MSF doctors possess undeniable courage, often accompanied by an irresistible sense of style. In Peshawar, Pakistan, where the organisation's Afghanistan programme was based, the French team lived in ‘The White House’, ran a bar, rigged up a sound system, and kept horses so that their people could learn how to ride across the mountainous border. ‘We are les chevaliers blancs,’ said MSF France's director of public relations, Francois Dumaine, explaining their attraction. ‘We are les aventuriers.’ But ‘aventuriers’ roughly translates as cowboys, according to some British aid agencies, which do not approve of the way MSF rushes to the scene of disasters.”^{xxxvii} Well they are, primarily, French. If their main critic is the Englishman, they may shrug their shoulders with an off-handed “C'est La Vie” and go about their business.

End Notes

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- i *Living in Emergency: Stories of Doctors Without Borders* Directed by Mark Hopkins, 2008. Film.
ii www.msf.org Web.
iii Bortolotti, Dan. *Hope in Hell – Inside the World of Doctors Without Border*. Buffalo, New York: Firefly Books, 2004. Print. Page 43.
iv Ibid. Pages 43-44.
v Ibid. Page 46.

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