Uncertainty about how an individual can prepare for and respond to an event and what steps the government is taking to protect them can leave the public confused and anxious. However, with education, the public can learn what is true and what is erroneous about bioterrorism.

The authors will address many of the "common knowledge" aspects of bioterrorism and attempt to dispel many of the "facts" so widely accepted throughout society by both professionals and laymen alike. Coupled with this will be a discussion of some of the key aspects of crisis communication and preparation that can help reduce or eliminate much of the confusion attendant to a bio-terror incident. The following eight "myths" will be discussed: (1) we can accurately predict and detect bioterrorist attacks; (2) bioterrorism will be preceded by a warning; (3) bioterrorism preparedness essentially is identical to planning for chemical, radiological, or nuclear attacks; (4) we will be able to rapidly determine whether an epidemic is natural or the result of bioterrorism; (5) nothing can be done to prepare the civilian population for a bioterrorist attack; (6) effective preparedness for a bioterrorism attack can be achieved without major investments in basic bio-scientific research; (7) hospitals can treat a large influx of patients following a bioterrorist attack; and (8) bioterrorism preparedness and response is a national responsibility.

Keywords: auto-immune deficiency syndrome (AIDS); bioterrorism; misinformation; misperception; preparedness; severe acute respiratory syndrome (SARS)
Prehosp Disast Med 2005;20(2):s60–s61

Lessons Learned from Terrorism-Related Injuries in Israeli Civilians

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Introduction: Terror-related injuries have become a threat for people all over the world. In Israel, from October 2000 to December 2003, 6,049 people were injured, and 904 were killed by terrorist attacks. Many lessons have been learned from the necessity to deal with such a large number of frequent mass-casualty events. This presentation aims to share the Israeli experience with other nations that may face the risk of terrorism.

Methods: An analysis of national trauma registry data from October 2000–December 2003 was performed.

Results: Lessons learned will be described and practical information on enhancing preparedness for treating casualties from acts of terrorism will be provided. Lessons include: (1) arrival and hospitalization patterns—do the most severe injuries arrive first?; (2) triage—has triage changed due to new mechanisms of penetrating injuries such as shrapnel nails and bolts included in explosives?; and (3) differences in resource consumption by terrorism-related casualties.

Conclusion: The audience should better appreciate the various aspects of handling of mass-casualty events, identify factors that contribute to the severity and outcome of terrorism-related injuries, know what can be expected under specific attack types, and learn some of the most important implications for preparedness for such situations.

Keywords: characteristics; injuries; Israel; management; mass-casualty events; preparedness; terrorism
Prehosp Disast Med 2005;20(2):s61

Keynote 3: CBRN/HAZMAT

Chair: Per Kulling
Director, Department of Emergency and Disaster Planning, National Board of Health and Welfare, Sweden

Keynote 4: Children and Terrorism: The Dagestan, Nord-Ost, and Beslan Experiences

Chair: Leonid Roshal
Children's Clinical and Research Institute of Emergency Surgery and Trauma, Moscow

Friday 20th May 2005

Non-Governmental Organizations and the WADEM

Chair: Knut Ole Sundnes

Plenary 3: The Politics of Disaster Relief

Medical Capacity of Disaster First Responders in Turkey

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Objective: The aim of the present review was to assess the current medical capability of disaster first-response units such as Civil Defense Units and National Medical Response teams in Turkey and to make recommendations for a model of structure and training of such teams.

Needs Assessment: The Marmara Earthquake in 1999 and several other major disasters since then made it clear that Turkey lacks the availability of well-trained, medical, first-responder teams to perform medical care while working closely with search and rescue (SAR) units during the initial response to disasters.

Current Situation: Turkish Civil Defense Units are the primary sources to respond to disasters and perform SAR operations. While these units' main focus is SAR, they lack the capacity to provide medical care beyond basic life support to other unit members and disaster victims. The Ministry of Health recently has approved a model program to form and train medical response units to operate during disasters. The National Medical Response Teams (UMKE in Turkish) are based on volunteer membership from doctors and other allied health practitioners. However, there seems to be no screening process for appropriateness of team members to specified tasks. The 40-hour curriculum currently taught to UMKE members covers only principles of disaster medical response and is not inclusive enough to address disasters other than earthquakes. This curriculum does not address such critical topics as hazardous materials/weapons of mass destructions concepts, decontamination

procedures, responder safety and survival, and emergency communications.

Recommendations: Medical response to disasters is a complex task. First responders perform in a volatile environment to provide maximum care to the needy. Medical first responders should be screened carefully for physical, emotional and mental fitness as well as relativity of medical knowledge background to perform in these less than ideal settings. Medical first responders should synchronize their practice along with the SAR units, or ideally they should be considered as a part of the SAR Team. They should be rigorously trained in different aspects of SAR, as well as disaster and emergency medical care in the field. They should regularly participate in deployment exercises and scenario-based training in cooperation with the other units to maximize the smoothness of interaction between different units, as well as within the same unit with members of different backgrounds.

Conclusion: Turkey lacks the availability of well-trained, disaster, medical first responders. There has been an attempt by the Ministry of Health to address this need. However, forming and training teams to perform according to specified standards and under a unified disaster command has not yet been successful.

Keywords: capabilities; first responders; medical; response; search and rescue (SAR); Turkey
Prehosp Disast Med 2005;20(2):s61–s62

The Journalist's Experience

Martin Bell, MP
former War Correspondent, BBC

Theme 15: Hot Topic - International Humanitarian Disaster Relief - Tensions and Challenges

Chair: Anthony Zwi

Theme 16: Rural and Remote Emergency Health Care

Chairs: Mads Gilbert; James Ferguson

Theme 17: Landmines

hairs: Berndt Schneider; Ron Stewart

Free Papers Theme 22: Education-1 Simulations

Graphic Simulation System for Preparedness of Emergency Department Staff for Mass Casualty Incidents

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Problem: Drills are an effective yet resource-consuming technique for improving team preparedness to manage mass-casualty incidents (MCIs). Limited-scale drills, mainly tabletop and communication exercises, are good alternatives, but still harbor deficits, which could be overcome with an interactive simulation system with good graphic interfaces.

Solution: The success of designing such a system, created by students using basic tools, like Visual Basic and MS Access, are described. Basic database terms for the incident types, casualties, treatment requirements, as well as capabilities were used from previous work. The graphic representation included not only the location and movement of casualties and staff, but visualization of treatment phases, as well as problems in management.

The trainee of each of four simultaneous regions actually can treat each victim with choosing possibilities (from small right click window) and requires only minimal typing. The dynamic database can provide online reports that also can be used for the debriefing and benchmarking for the management of that MCI.

Conclusion: Several examples of the system tested in various hospitals will be shown, which gained positive feedback especially for its friendliness and documentation of solutions.

Keywords: design; drills; emergency department; mass-casualty incident; simulation
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What is a Disaster!? Hospital Disaster Preparedness: Are Hospital Clinical Staff Well-Informed? Does a Mock Disaster Exercise Make a Difference?

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2. Australia

Historically, hospital disaster preparedness has had limited input from clinicians in Australasia. The existence of the "dusty" Disaster Folder is well documented. However, the current climate of terrorism has heightened public awareness of mass casualty incidents. There is a high community expectation that healthcare systems are prepared to cope with any possible event. In Victoria, Australia, there has been a major upsurge in interest in this field among Emergency Medicine clinicians. Other specialties have been less well represented at statewide tabletop exercises and forums.

A statewide, multi-agency "compressed time" mock train crash, "Exercise Kardinia Express", involving 300 patients, took place in North Geelong on Sunday, 10 October 2004. Forty-five moulage patients visited the Geelong emergency department for triage, assessment, and initiation of treatment. Tabletop exercises were performed for the rest of the hospital. As part of the exercise, there was a hot debriefing in the emergency department that day and an enterprise-wide formal debriefing one week later. A one-hour lecture was delivered to the hospital-wide community in the preceding week. Fifty senior medical and nursing staff were surveyed before and after this process to assess their knowledge of the disaster plan and their opinion of hospital disaster preparedness. The pre-intervention data demonstrated some major concerns and deficiencies in knowledge regarding hospital disaster preparedness among both the emergency department and the non-emergency