

and 1999, 121 terrorist attacks using biological and chemical warfare have been registered in the Monterey Database. In the last decade, the risk of a possible attack involving large numbers of people, in particular, civilians in countries not involved in war, has reached an all-time high.

Hospital emergency units must be ready with plans and treatments in the event of a massive influx of victims. Managing these plans requires calculating the extent of the mass emergency and any peculiar clinical characteristics of the victims themselves, for example: premature diagnoses, competency of the biological agents used, procedures for decontamination, ways of protecting personnel, and specific antidotes.

The health workers in the emergency system, with the assistance of the other emergency services, represent the first line of defense against these types of attacks. The nature of the agent may only become evident after the arrival at the hospital of thousands of sick people. It is vitally important to communicate effectively with the staff regarding the pathological treatment needed for various biological agents, chemicals, and nuclear materials. Above all, there must be collaboration, with anti-poison centers, nuclear NBC forces, and other organizations tasked with responding to such an event.

A four-part protocol will be discussed: (1) risk reduction; (2) preparation; (3) response; and (4) recovery.

Keywords: bioterrorism; health workers; Italy; preparations

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A Consensus Process on the Management of Major Burns Accidents: Lessons Learned from the Café Fire in Volendam, Netherlands

L. Welling,¹ M. Boers,² D.P. Mackie,³ P. Patka,²
J.J.L.M. Bierens,² J.S.K. Luitse,¹ R.W. Kreis³

1. Academic Medical Center, Netherlands

2. VU Medical Center, Netherlands

3. Red Cross Hospital, Beverwijk, Netherlands

Introduction: The optimum response to the different stages of a major burns incident still is not established. The fire in a café in Volendam on New Year's Eve 2000 was the worst incident in recent Dutch history and resulted in mass burn casualties. The fire has been the subject of several investigations concerned with organizational and medical aspects. Based on the findings in these investigations, a multidisciplinary research group conducted a consensus study.

Objective: The aim of this study was to further identify areas of improvement in patient care after mass burns incidents.

Methods: The consensus process comprised three postal rounds (Delphi Method) and a consensus conference (modified Nominal Group Technique). The multidisciplinary panel consisted of 26 Dutch-speaking experts, working in influential positions within the sphere of disaster planning and care. In the postal surveys, consensus was reached for 66% of the statements. Six topics were discussed in the consensus conference: three in the plenary part and three during the subgroup meetings. After the conference, consensus was reached for seven statements (one subject generated two statements). In total, the panel agreed on 21 statements. These covered the following top-

ics: (1) registration and evaluation of disaster care; (2) capacity planning for disasters; (3) prehospital care of victims of burns; (4) disasters; (5) treatment and transportation priorities; (6) distribution of casualties (including interhospital transports); (7) diagnosis and treatment; and (8) education and training. A few examples of the statements are:

1. "A uniform mode of registration of the entire emergency care process is needed; it should be suitable for regular, as well as disaster, care."
2. "The government should facilitate optimal collaboration between burn centers in our country and the neighboring countries."
3. "In the current organizational structure behind the medical care in disasters, problems with the hierarchical structure and competencies occur quite often."
4. "The Advanced Trauma Life Support (ATLS) protocol is routinely used for trauma care in Dutch hospitals; in case of admittance of a burn patient, knowledge of the EMBS protocol should be present."
5. "Every rescue worker who attends the scene of the disaster should have received proper training, focused on his tasks."

Conclusion: In disaster medicine, a consensus process is a suitable tool for identifying areas of improvement in the care after mass burns incidents. The statements are useful points to improve planning for future disasters.

Keywords: burns; consensus process; disaster medicine; management; Netherlands

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Meeting the Challenge—Appointment of a Full-Time Emergency Management Coordinator in a Melbourne Healthcare Network

D.L. Dixon

Western Health, Australia

The growing risk of terrorism-related activities, advances in technology, which increases the potential hazard of major incidents, and legal obligations related to staff and patient safety have led to increased executive commitment and enthusiasm for hospital emergency planning in Australia. Historically, hospital emergency plans were based on system redundancy. Now, plans must identify contingent redundancy options, including measures to address principles of prevention, preparedness, response, and recovery in order to cope with internal and external emergencies, which may impact hospital function.

Until recently, emergency management was an often-overlooked area within hospital operations. The tragic events of 11 September 2001, and the continuing threats to national security highlighted with the Bali bombing in 2002 have ended that complacency worldwide. Now, many organizations have an active interest in strengthening their emergency management programs, however, budget limitations and lack of trained personnel often make meaningful improvements difficult.

Western Health recognizes the importance of committing resources and time to develop and implement an emergency management program, consolidating its commitment