

dominantly urban city, the survey was conducted in five large business district commercial centers in the city.

**Results:** Out of a total of 1,000 responses (200 from each site), 249 responses were incomplete. The remaining 761 were analyzed. A majority (700; 92%) of the respondents thought that the best way for a patient to get to the nearest hospital would be either to take them themselves 68% (518), or call the police 24% (182). Only 7% (54) would call an ambulance. The majority of the respondents knew which number to call for the police (98%; 747), fire services (66%; 499) or to call for an ambulance service (70%; 535). When queried about the possibility of a universal emergency services number, 696 (91%) said that they did not want a single number.

**Conclusions:** The general public has not been introduced to the concept of a universal emergency number and its advantages. The current survey demonstrates the need for administrators, policy makers, and public educators to examine the issue of implementing a universal emergency number as a part of developing emergency systems in India.

**Keywords:** development; emergency services; India; universal emergency number; utilization

*Prehosp Disast Med* 2009;24(2):s83–s84

### (O73) Management of Incoming Information in the Athens Emergency Medical Services Dispatch Center: Preliminary Results

*Costas Bachtis; Maria Ktena; Zafiro Michalaki; Marina Gatsouli; Anastasia Zygoura; Demetrios Pyrros*  
EKAB, Athens, Greece

**Introduction:** The most crucial stage of the response to a medical emergency is the management of the initial information given by a bystander.

**Methods:** A random sample of 100 incoming calls to the Athens Emergency Medical Services Dispatch Center was examined. Calls initially classified as non-emergencies and calls coming from physicians were excluded. The management of the given information by the telephone-operator and the dispatcher were recorded. If needed, the intervention of the physician-on-duty was recorded.

**Results:** In order to collect 100 calls classified as emergencies, approximately 3,000 incoming calls had to be filtered. The quality of the initial, unsolicited information given by the bystander/caller was mostly of very poor quality (82/100), leading to no reasonable conclusion. A small minority (9/100) purposely gave false information for personal interests. Also, a small minority (9/100) gave precise information regarding the current situation, leading to a correct conclusion and rapid response. The initial information (true or false) was interpreted falsely in 27/100 cases by the telephone operator and given as a wrong lead to the dispatcher. The dispatcher responded correctly to 60/61. The physician-on-duty in the dispatch center intervened in 69/100 cases.

**Conclusions:** The management of the information is of very poor quality, due mostly to false information initially provided by the caller. The high percentage of inadequate

management by the operator is surprising. The dispatchers have a high quota of correct responses to emergency calls.

**Keywords:** communication; dispatch center; emergency call; emergency response; information; information management

*Prehosp Disast Med* 2009;24(2):s84

### (O74) Innovations in Disaster Communication

*Constance J. Doyle*

University of Michigan/St. Joseph Mercy Hospital Emergency Medicine Residency, Ann Arbor, Michigan USA

Many after-action reports cite disaster communication failures and miscommunication between responding and receiving entities as system failures. Hospitals have not had robust, interactive communications. Medical Coordination Centers (MCC) are newer entities for facilitating and coordinating emergency medical care operations with public health, state, regional, and county disaster operations. First responders now are linked with hospitals in the distribution of patients to receiving facilities, field areas, or medical transport systems.

Interoperable communications, including common frequencies for field, hospital, and first responder groups with surge capacity and redundancy will greatly increase flow of patient care information to and from all agencies involved. Coordination of patient care with public health oversight, medical first receivers, usually hospitals, and regional and state responses will allow all responders to communicate care capacity and casualty transport, patient tracking, and supply sharing. If off-site field hospital care is necessary, pre-arranged communications equipment, storage, and transport of emergency equipment, plans defining lines of communication within and among all agencies, and common and agreed messages should be part of local, regional, and state planning. Additional equipment available from any stockpiles can be part of the plan.

Pre-event communications should have the rapid ability to surge to handle more messages, add additional capacity as needed, and provide back-up systems in event of failure. Messages, needs, and coordination with joint information centers must be prioritized. Terminology should be standard and uniform and an expansion of ordinary systems to allow responders to keep current without repeated education on seldom-used new systems. Operators should understand equipment limitations and capacity.

Drills can keep personnel familiar with standard scaleable operations systems, but cannot completely simulate real situations. Planning, surge capacity, and redundancy will add to viable disaster medical communications.

**Keywords:** communication; coordination; disaster; innovation; planning

*Prehosp Disast Med* 2009;24(2):s84

### (O75) How US Cities are Using the Web to Communicate Disaster Information to Individuals with Chronic Illness

*Owen D. Kulemeka*

University of Illinois at Urbana Champaign, Urbana, Illinois USA

**Introduction:** Hurricane Katrina demonstrated that individuals with chronic illness face significant challenges during