

### Emergency Medical Services Response to the Athens Riots in December 2008

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**Introduction:** Following the death of a 16-year-old student who was shot by police, spontaneous protests shook many cities in Greece for a number of days. The response to these events in Athens from 6th to 12th December 2008 by the National Centre for Emergency Care was analyzed. The effects to the overall volume of calls and the problems that EMS personnel faced also will be examined.

**Methods:** Records of calls directly related to the riots were analyzed, evaluated, and compared for volume with the previous week. The use of motorcycles with a rescuer/driver and a doctor for getting quick access, triage, and calls for assistance in the areas affected by riots will be presented. The problems created by the use of tear gas by riot police and the other dangers to the responding EMS personnel will be discussed.

**Results:** Only a small number of calls were related directly to the riots. A number of calls were cancelled upon arrival of the ambulance on-site. The use of motorcycles provided a valuable tool for quick access and triage of patients to areas not easily approachable by ambulances.

**Conclusions:** The number of calls was minimal compared to the extent of the riots. The use of motorcycles has many benefits. The policy of not issuing tear gas masks during riots currently is under re-evaluation.

**Keywords:** civil unrest; emergency medical services; motorcycle; riot; tear gas

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### Medical Incident Commander in the UK Ambulance Services

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**Introduction:** A medallion (bronze/silver/gold) system is used as the command structure at major incidents in the UK, mirroring that of the other emergency services. It is described in the guidance issued by the Department of Health for England. The Scottish, Welsh, and Northern Irish services have adopted the same approach. The structure recommends medical support to the ambulance commander at each tier. The guidance, published in 2005, clearly describes the role of the Medical Incident Commander (MIC), and states that doctors taking the role should be trained, competent, and on a fixed rotation to ensure their availability.

**Methods:** During the summer of 2008, all 14 UK Ambulance Services were approached and their Medical Director or Head of Emergency Preparedness was questioned about their MIC arrangements.

**Results:** All 14 services responded, of which 21% (3/14) have chosen not to use the MIC role at all in their command structure.

Of those that use the MIC, 73% (8/11) require training for doctors who fulfill this role. All expect basic Major Incident Medical Management and Support (MIMMS) course certification (ALS(r)), but 36% (4/11) also provide additional in-house training for the command role. Only 27% of the ambulance services (3/11) have a formal MIC rotation as described in the guidance and only three have contractual arrangements with doctors for the role. The remainder of the medical responders fulfills the role on a voluntary basis.

**Conclusions:** Despite the explicit nature of the central government guidance on the command role of doctors at a major incident, most of the medical support to UK Ambulance Services is still provided on an opportunistic and charitable basis.

**Keywords:** ambulance services; civil defense; disaster; emergency medical services; Medical Incident Commander; UK

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### Helicopter Evacuation of Mountain Accident Victims

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**Introduction:** In 2006 and 2007 TOPR helicopter flew 302 missions, 8.7% of the 3,458 rescue missions in the territory serviced by TOPR. It was used in accidents when time was of the essence, unless restricted by weather or time of day. How and to what effect the helicopter was used in rescue missions in difficult mountain terrain were reviewed.

**Methods:** The records of calls for the TOPR helicopter team were analyzed in light of the nature of event, rescue methods, patient medical data, and duration of rescue missions.

**Results:** Of the accidents, 110 (36.4%) occurred in terrain preventing helicopter landing (rescuer and physician descended by rope), and 192 permitted application of Helicopter Emergency Medical Services (HEMS) procedures (landing, direct loading). Due to the condition of the patient or danger of an avalanche, 70 (23.2%) patients required direct evacuation, 34 needed hoist evacuation, and 36 required "long-line" technique applications.

Advanced Trauma Life Support (ATLS) standards were applied to secure the injured person prior to transportation, unless prevented by dangerous conditions or low temperatures.

The average mission time from the notification to arrival to the hospital ranged from 35 to 84 minutes, 59 minutes on the average.

**Conclusions:** Helicopter transportation of mountain accident victims permits achieving the golden hour standard. Physician on the team ensures ATLS standard compliance on-scene. The climbing, hoist, and long-line evacuation techniques shorten the duration of the mission.

**Keywords:** emergency health; emergency medical services; Helicopter Emergency Medical Services; helicopter evacuation techniques; mountain rescue; patients

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