

function). Various guidelines also apply but they usually are summarized by "Think but think simple."

Other factors influencing set up include climatic conditions, existent structures, communication axes, security, and safety. Frequently encountered errors are from neglecting to adhere to the guidelines and the space is too small an area to permit a later enlargement of the post.

This working organization is nothing without the people. The FMP leader is a medic who relies on a Logistic Officer, a Triage Medic, a Regulation Medic, and on a variable number of medics and paramedics (ideally 1 medic for 2 IE victims and 1 medic for 10 RE victims). Distinctive white chasubles or armbands identify them.

A "crisis" implies for managers an immense amount of pressure. The usual approach for coping with a crisis relies on three things: (1) prevention, (2) planning, and (3) training. However, what if your team is unavailable or what if your plans are useless, because they are not adapted to this situation? We propose here an operational crisis approach centred around chaos reduction and casualties reduction.

Chaos reduction is the first unavoidable step resumed in the acronym IRIT: Information, Reinforcement, Immediate action, and Team set up. Information is the first concern; find who is in charge, what's happening, what has been done, what resources are there, verify the sources, make a synthesis. Reinforcements should be requested: remember that more is better, immediate actions denote the use standard operational procedures, and team set up establishes the chain of command. If communication protocols are not predefined, nominate a communication manager who will establish communication network and protocols, nominate a logistic manager who will establish logistic follow-up, traffic procedures, staging areas, vehicles, person and equipment inventory, nominate a medical operation manager who will manage the CCP and FMP.

Casualties reduction is the next step and is summarized by the acronym OSDOR (Objective, Situation, Design, Operational, Reevaluation). Objective identification means team work around rational choice, organizational choice, political choice or team negotiation in the way Allison defines it. Situation denotes looking for the facts, but also survey for crisis potential and probable evolution (What in 30, 60, 90 minutes?). Design a suitable course of actions of at least two different courses of actions (most likely this is between the creation of a "field hospital" and "scoop and run"), evaluate those designs and choose among those actions. Operational implementation means power delegation and mission orders; and finally conduct regular reevaluations (How is the situation evolving? What are the consequences of this evolution on the first 4 points (OSDO) and, if necessary, go again through the entire OSDOR process. Accurate information and managing manpower are the key success factors in crisis management.

Standard procedures are used by the FMP and every victim following the same track. Triage is the first step and victims are assigned to one of two categories: immediate emergencies (IE) or relative emergencies (RE). Registration occurs with the entry secretary. The victim is identified using a simplified medical file. Part of this file is sent to the Regulation Secretary to allow the dispatching of

the victims to hospitals with adapted capabilities. Treatment or simple life support is performed in two different areas (IE and RE zones). Evacuation occurs when the dispatching is done and a team and vehicle are available (priorities are IE followed by RE). We propose to manage a third category of victims (Extreme Emergency or EE) with a specific procedure. For EE victims the simplified file is a specific red file. A member of the collecting rescue team managing the EE victim takes this file directly to the entry secretary and, after registration, to the Regulation Secretary where the dispatching is done without delay. While the team member waits to take this file back, the EE victims and the collecting team simply go through the FMP directly to the evacuation zone. The evacuation occurs as soon as possible, using the collecting team as the evacuation team. Those procedures can be followed only because logistic follow-ups and information treatment (files transit and workout) are strictly managed. Logistic follow-up is the logistic officer's job. Information gathering and transmission are the roles of the FMP Chief. Frequently encountered errors are the arrival of victims in a FMP with the entry secretary not already in function, shunt of the entry secretary, and changes of categorization without transmission of the information at the regulation.

Key words: crisis; field; forward medical post (FMP); information; operations; organization; triage
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Emergency Medicine in the Czech Republic

Jiri Pokorny, MD

Institute for Postgraduate Medicine, Department of Emergency and Disaster Medicine, Prague, CZECH REPUBLIC

During the last decade, the disaster readiness of the Czech Republic has gone through a fundamental systemic transformation determined by two things: (1) the preparation and its later admission into the North Atlantic Alliance (NATO) and, (2) by the preparation of joining into the European Union. To achieve this, the legal environment was transformed to maintain the basic function of the State, even in case of possible crisis situations—whether it is of military or nonmilitary character. A direct result of this change to the security policy of the State became Constitutional Law Nr.110/1998: The Security of the Czech Republic. This law is the foundation for the comprehensive architecture of Crisis Legislation. The central mission of the legal norms that came into operation was the completion of the fundamental obligation of the State to the protection of lives, health, and property.

For this goal, a National System of Crisis Management was developed. The system is based on two organizational structures: (1) a network of crisis management authorities formed by the central and other administrative offices, and (2) on an effective instrument that combines the appropriate aggregation of capacities and means into a system called the Integrated Rescue System (IRS—according to the law). Such a systematic solution ensures cooperation between such bodies as the armed forces, the armed security forces,

the rescue corps (firemen, health, air rescue), and other crews that will respond in any crisis situation.

One of the organizations participating in crisis preparedness is the Health Services, an authoritative power. Therefore, from 1990 to 1994, within the framework of the transformation of the Czech Health System, Emergency and Disaster Medicine began. Its inception coincided with such activities as the proclamation of the International Decade for Natural Disaster Reduction 1990–2000 and followed by the Strategy for a Safer World in 21st Century: Disaster and Risk Reduction (IDNDR Program Forum, Geneva, July 1999), including the reference of the WHO-Secretary General after the Chernobyl disaster in April 1986.

A direct consequence from this has been the creation of Emergency Medicine as an independent medical specialization in 01 January 1999. The specialization includes problems of disaster medicine, creating a medical foundation for the thorough and systematic preparation of the professional health staff to participate in finding solutions for the human health consequences that result from disasters. Currently, 180 physicians in the Czech Republic have passed successfully the examination and have achieved the specialization. Advanced professional education is now a reality in one of the main bodies of the Integrated Rescue System—the Emergency Medical Service. The Integrated Rescue System aids the police and the Firemen Rescue Corps of the Czech Republic. The disaster health consequences are covered by law: all medical organizations are included within the “other bodies” of the IRS with a legal obligation to assist in and control the medical situation.

Contemporarily, intensive efforts on the definitive formulation of Emergency and Disaster Medicine are in progress, in order to prepare for possible risks and to enhance the health service response to meet the severity of the risk. The priorities are specified primarily in the basic document of the Czech Republic—in the Security Strategy—that recognizes the necessity of preparedness for natural and industrial disasters.

The Czech Republic received immediate experience from rescue and restoration efforts during and after the floods that occurred from 1997 through 1999. These floods occurred along the Morava River that runs from north to south through the Czech Republic. It affected persons along the whole riverside, took 50 human lives and created damage in the amount of 62 billion Czech crowns.

Key words: costs; Czech Republic; disasters; emergency medical services; floods; health; Integrated Rescue System; legislation; Morava River; preparedness; priorities; rescue; restoration; risks; strategies; systems

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Flood Disaster in Northern Italy: The Experience of the Azienda Sanita Locale (ASL) 10 in Pinerolo (Torino).

M. Pratesi; A. Lazzero; P. Ribet; M. Ribet; A. Marciello; P. Rolando; G. Falcone; B. Fossat; E. Zelaschi; G. Mathieu; S. Beoletto; F. Massa

Azienda Sanitaria Locale (ASL 10), Pinerolo (Torino), ITALY

The northwestern part of Piedmont was affected by a four-day period (13–16 October 2000) of torrential rain followed by a widespread flooding. Greater concentration of the adverse meteorological phenomena involved the Valleys of the Pinerolese between the 14th and 15th of October. Roads, railways, and bridges were closed by landslides and mudslides with consequent isolation of inhabited centres and hospitals. Severe damage occurred to the electrical network and caused the interruption of the supplies of drinkable water.

The health professionals and hospitals of the ASL-10 had to confront this emergency in order to ensure continuing medical assistance. This communication focuses on the ASL 10 reaction plan.

Key words: electricity; floods; health; hospitals; isolation; landslides; mudslides; plan; rain; water

E-mail: lazzero@dag.it or medipine@libero.it

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System of Rendering Psychological-Psychiatric Assistance to Population of the Chechen Republic in an Antiterrorism Operation

Prof. Victor Preobrajensky

ARCDM “Zaschita”, Moscow, RUSSIA

The problems of rendering psycho-psychiatric assistance to the population of the Chechen Republic had some peculiarities: (1) the location of the great number of temporarily displaced people in camps (>40,000); (2) accommodation of population in private sector, destroyed settlements and cities; and (3) absence of specialized medical institutions for rendering psychological-psychiatric assistance. From October 1999 to May 2000 on the territory of the Chechen Republic and Ingushetia, teams of psychological-psychiatric assistance were working. They included specialists from the ARCDM “Zaschita”, Moscow Research Institute of Psychiatry and State Research Scientific Centre of Social and Forensic Psychiatry of Ministry of Health of Russia. The main tasks of these teams were: (1) rendering specialized psychological-psychiatric assistance to the temporarily displaced population and population of the Chechen Republic; (2) organization of evacuation of psychologically impaired patients for the provision of specialized medical assistance in nearby territories; and (3) determination of the needs for specialization and for an increase in the qualifications of specialists in the psychiatric field. These teams included a psychiatrist, psychotherapist, or psychologist. For examination, special diagnostic questionnaires and tests were used; changes of personal psychological status were determined with the help of special programs. More than 4,500