

attended three courses and one person had attended four).

For the first scenario, 101 (57%) participants declared the scenario a major incident, S2 was declared a major incident by 82 (46%) people, and S3 was declared a major incident by 156 (87%). Forty-six of those asked had attended a major incident, and the results for declaring a major incident in this group were: S1 = 25 (54%), S2 = 25 (54%), S3 = 44 (96%). Of this group, 44 previously had training before experiencing the major incident. For each of the scenarios, the reasons for declaring or not declaring a major incident were provided and will be presented. Clearly, there were different reasons given for declaring or not declaring the scenario between the different professional groups.

Conclusions: In this self-selected group, there was a high number of individuals who had undergone training in major incident management (86%), with a higher percentage of those who had attended a major incident declaring a major incident in the event of a train crash. There was an increased likelihood of declaring a major incident for the overturned coach, but not for the multiple vehicle pile-up, if the individual had been involved in a major incident.

Keywords: assessment; education; experience; major incident; scenarios; training

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The Anatomy of a Road Traffic Crash—A Socio-Economic Peek into the State of Prehospital Care in India

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Introduction: In contrast to highly motorized countries, the total number of casualties in India has continued to increase for the past 50 years. Despite this, prehospital care and establishment of a National Paramedic Service has not been a governmental priority.

Method: Data related to crashes occurring on the south-bound highways out of the metropolitan city of Mumbai were collected for six months, and the health-seeking behaviors of the crash victims in the prehospital phase were studied. The data were collected by direct observation at the scene of the crash, police records, published government statistics, department of transportation data and from local newspapers reporting the crashes. The nature of the crash, including outcomes, the vehicles involved, the victim's profile, and the path taken to the hospital or medical care facilities were recorded from these sources.

Results: Data revealed that the police department data described fatalities, newspaper accounts were sensationalized, and the transport department data were most accurate. There was no central collection of hospital data of injured patients. Nearly half of the victims were reported to have died on the spot, 20% in the medical care facility, and 10% on the way to the hospital. The victims were predominantly pedestrians or riders of smaller vehicles, such as motorized two wheelers. Nearly 50% the numbers of the offending vehicles were lorries and trucks, and another fifth were buses. Only 20% of the casualties received adequate prehospital care and transportation to the medical facility.

Discussion: The socioeconomic dynamics in the Indian context in the event of an crash has been changing constantly. From being an apathetic passerby, the citizen has grown sympathetic to the crash victim (though he is still petrified of the legal tangle). Another twist to the event is the unusual interest of middlemen and common thieves in helping the victim. While the casualty is very quickly separated from his/her belongings and valuables, often victims are transported to a medical facility before the police reach the crash site. However, whether reaching a medical facility has actually altered their morbidity and outcome could not be determined. Recent evidence shows us that it may not be necessary to have expensively equipped ambulances to provide quality care and modern prehospital care protocols provided with speeding ambulances, such as intravenous fluid administration at the crash site, and advanced trauma life support (ATLS)/drug therapy/anti-shock garments by paramedics do not alter outcome significantly and sometimes may be harmful. At the policy level, most advances in road safety favor car occupants rather than the more vulnerable road users: pedestrians, cyclists and motorcyclists, who constitute 70–80% of all road traffic deaths, while the car occupants constitute 5%.

Conclusion: The road traffic crashes in India are very different from those in high-income countries. Road and vehicle designs that eliminate the risk of serious injuries to vulnerable road users are not available at present. The medical profession needs to be prompted for a National Trauma Registry and Safety Board.

Keywords: cost; India; prehospital care; preparedness; response time; road traffic crashes

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Unique Characteristics of Ambulance Care

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Introduction: Receiving a patient who requests ambulance assistance places special demands on the personnel and requires professional performance. Care and treatment may need to be administered on the spot or a quick decision might be required as to whether transportation to a hospital is the most crucial step. Therefore, the specific context of ambulance care was studied, especially since few studies have looked into this field from those aspects.

Objective: To determine the distinguishing characteristics of ambulance care. In particular, research questions included: (1) what is it like to provide care in the ambulance environment?; and (2) what is the nature of the meeting between the patient and the ambulance nurse?

Method: This study is qualitative, descriptive, and interview-based, with the interviews carried out with eight respondents (four paramedics and four ambulance nurses) employed in different ambulance stations in western Sweden.

Results and Discussion

Working as a real team

A "real" team was expressed as being a team in which one progresses from novice to expert guided by older colleagues.

There is a well-developed *esprit de corps* within the group members, which emerges in the form of a strong professional identity and professional pride, and is demonstrated by rallying around a colleague or the group in especially trying situations. Within the team, there also exists an atmosphere of acceptance, respect, and an attitude that makes it permissible to show one's feelings and to help take care of one another. The team member-team member relationship is stronger than is the ambulance worker-patient relationship.

Providing good ambulance-based care

"Good care" in the daily ambulance-based care means that caregivers normally can devote all their attention to a single patient, and concentrate all of one's efforts on this one individual. The respondents point out that the caring for an ill or injured person is characterized by the observation that a more distinct worker-patient role emerges the nearer the ambulance is to a healthcare facility. Humility and comfort with physical nearness are necessary traits among ambulance personnel. Ambulance personnel meet three categories of patients: (1) those who have complete trust; (2) those who question the ability of the personnel; and (3) those who are unaccepting of personnel assistance. Members of the last group are described as using the ambulance as a taxi or are disrespectful to the care-givers. Missions with those patients can result in non-caring situations.

Conclusion: Ambulance-based care is a complex field requiring flexibility and humility at the time of contact with the patient. The work also calls for a great deal of experience-based knowledge. In addition, there is the existence of a team spirit implying both positive and negative effects. One must be able to rely on one's colleague in demanding situations while at the same time being aware of where the line should be drawn between good care and collegiality.

Keywords: ambulance; care; personnel; team

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Free Papers Theme 2: Public Health-1

Use of the Incident Command System Across Three Sectors of the Healthcare System in the United States

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The Incident Command System (ICS) is used across the United States (US) as a framework for the management of emergencies and disasters. While it originated from the Fire Services of California, it was quickly adopted by the

other uniformed services (police and emergency medical services). Shortly thereafter, it was adapted by the hospital sector, which refers to it as the Hospital Emergency Incident Command System (HEICS). More recently, the public health sector has taken on the task of utilizing the ICS for its emergency response operations. This adaptation is now being referred to as the Public Health Incident Command System (PHICS). Regardless of the type of agency that uses this system, the basic principles remain the same. This presentation will provide a brief overview of the ICS as it is used in the United States. Then, a specific disaster scenario will be used to illustrate how this single system is implemented by three very different sectors of the US healthcare system, namely the prehospital, hospital, and public health sectors.

Keywords: hospital emergency and incident command system (HEICS); incident command system (ICS); preparedness; public health incident command system (PHICS)

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Reverse Triage: Criteria for Immediate Inpatient Disposition for Creation of Hospital Surge Capacity

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Background: The ability to care for a sudden volume of patients during a significant bio-threat or other disaster has been a significant focus for healthcare systems since the attacks in New York City on 11 September 2001. History has shown that during disasters and epidemiological outbreaks, hospitals bear the brunt of caring for the sick and injured. In most hospitals, inpatient capacity is constrained on a daily basis. Thus, hospitals are as concerned with maintaining inpatient capacity as augmenting resource capabilities during surge needs. Risk-based criteria were developed that, in the event of an overwhelming disaster, allow predesignated classification of patients' suitability for immediate discharge or for transfer to an appropriate level of care.

Methods: Using evidence-based techniques combined with expert panel (EP) consensus, a War Analysis Laboratory Exercise (WALEX) was hosted in the Spring of 2004. Following literature/data gathering and evaluation, 39 expert panelists (EPs) were assembled for an 8-hour WALEX. The EPs included: (1) experienced practitioners and nurses representing a wide variety of medical fields; (2) experts in disaster management, triage, risk management, hospital administration, social work, medical law, medical ethics, patient safety; and (3) local, state, and federal government experts in public health preparedness, homeland security, and emergency medical services. Following presentations on disaster management, risk stratification, and surge capacity, the EPs were asked to: (1) determine a Disposition Classification System (DCS) for discharge/transfer, based on tolerance of risk of adverse events (AEs) within the first 72 hours following potential discharge; and (2) propose prognostic indicators (clinical variables) most predictive of AEs to use in a tool for real-time prospective risk classification of patients. An adverse event was defined as the need for a critical interven-