

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-