concerned ministries, the Belgian Society for Emergency and Disaster Medicine (BeSEDiM), and the field workers. Once an agreement about the entire text was achieved, it was presented to the different authorities and accepted.
Results: The publication of a practical primary text clearly stimulated elaboration of the medical aspects of local disaster plans. In those locations where, prior to this agreement, some medical plans already existed, some resistance to abandon their specific terminology was observed. This is due to the fact that, on the ministerial level, those new directives are not yet official.

25
Emergency Surgery under Disaster Conditions

Zelnicek P, Ochmann J, Svoboda P, Nestrojil P, Necas F
Trauma Center
Brno, Czech Republic

The Czech Republic's trauma team is a mobile unit trained in emergency surgery and traumatology. Established five years ago by the Ministry of Health of the Czech Republic and the Trauma Center in Brno, it operates under the command of the Secretary of State for Health. This unit can perform emergency medical services and trauma care in our Republic as well as anywhere in the world. The team's full readiness response time is eight hours. It is prepared to function under makeshift conditions in disaster areas. The surgical capacity of the unit is 200 major operations within a period of four days, in addition to other constant activity including emergency care and urgent hemodiafiltration. The team can be staffed in four separate units of four to 40 persons. A full range of medical equipment is appropriately packaged and easily transported.

This presentation will describe five years of team experience and activities in disasters which occurred in Nicaragua, Armenia, Romania, and Iran.

27
Triage for Health Emergencies in Technological Disasters

Melorio E
Ministerio Protezione Civile
Rome, Italy

(No Copy Provided)

28
Computer-Aided Planning

Svensson HA
Department of Anaesthesiology, Visby Hospital
Visby, Sweden

Objective: To exemplify in a dozen applications how computing can be used in various fields of Disaster Medicine, e.g., planning, simulation, and education.
Methods: Sit down with a pencil and paper. List the things the program will do and the order in which they will be done: it is a simple sketch. Nearly everything already is done for you in BASIC. One does not need to spend a year learning a computer programming language.
Result: Computer-Aided Planning provides a possibility to compile and print plans and inventories and keep them up-to-date without spending too much time. Simulations present opportunities to test the plan in a way the more expensive full-scale training cannot do. Vary the opening parameters and see what the outcome will be—over and over again. The computer will be an indefatigable and firm, but a fair, teacher in computed education.
Conclusion: If a program is desired that just does not exist—create it. Anything computed will simplify disaster planning and perhaps, sooner or later, make it an enjoyable art.

29
Medical Command for Disaster Shelters

Totten VY, Leviton RH***
* Emergency Medical Department, The Brooklyn Hospital
** Franklin Hospital
New York, New York, USA

Objective: This paper describes the structure and function of a newly devised system for disaster medical control.
Methods: A central hospital command-post system had previously been developed to provide direction to disaster workers. It utilized amateur, short-wave radio operators for communications, and was staffed by emergency physicians (EPs) trained in the Disaster Health Protocols of the American Red Cross.
Results: On 11 December 1992, the medical command system was activated. Radio operators in each shelter established contact with the central command-post. Medical records were maintained. When transport from shelters to hospital emergency departments (EDs) became necessary, the radio operators notified county emergency medical services (EMS). A Red Cross volunteer emergency physician was stationed in one shelter. The scope of permitted medical service was expanded to include the dispensing of usual medications to chronically ill, stable refugees, obviating the need for transport.
Conclusions: Emergency physicians trained in disaster management can effectively direct a disaster medical command-post from hospital EDs. There is a need to develop further a network of trained community medical personnel to conserve scarce resources.